Knowledge generation processes and the role of the case study method in the field of psychotherapy

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Declaration

I declare that this thesis, *Knowledge generation processes and the role of the case study method in the field of psychotherapy*, represents my own work, except where otherwise stated. None of the work referred to in this thesis has been accepted in any previous application for a higher degree at this or any other University or institution. All quotations have been distinguished by quotation marks and the sources of information specifically acknowledged.

Submitted by Greta Kaluzeviciute

Signature of Candidate: 

Date: 08/03/2021

Abstract

The present thesis seeks to explore knowledge generation methods in the field of psychotherapy, with a focus on qualitative clinical and systematic case study narratives. Currently, evidence–based practice (EBP) in psychotherapy prioritises quantitative methods (e.g., systematic reviews and meta–analytic reports, which summarise the findings of randomised controlled trials; RCTs). However, recent studies exploring psychotherapists' decision–making processes in clinical practice suggest that there are significant difficulties in applying randomised and decontextualized statistical findings onto individual patients and their specific mental health experiences. Some of the concerns about large–scale quantitative findings include overlooking complex individual differences in treatment processes and outcomes. This contributed to an ongoing issue of research–practice gap: a lack of integration between the findings disseminated by researchers and the practical decisions made in the consulting room by therapists.

To aid with these issues, this thesis considers the role of the case study method in psychotherapy research. From its inception, psychoanalysis used case studies to produce complex, longitudinally sensitive and detailed narratives to discuss clinical decision–making processes and theoretical advancements. However, criticisms about researcher's subjective bias, unclear research focus, and lack of generalisability continue for both classic psychoanalytic and contemporary psychotherapy case studies. Whilst there have been several historical misconceptions about case studies, there are also persisting methodological issues, such as lack of epistemic guidance for hypothesis generation and generalisability of case study findings. Crucially, there are currently no research appraisal tools for psychotherapy case studies. The thesis therefore seeks to i) address the long–

standing criticisms directed at the case study method, ii) develop epistemic knowledge generation strategies for case study researchers, iii) address the philosophical underpinnings of thinking in cases as a scientific style, and iv) introduce a novel *Case Study Evaluation–tool* (CaSE), which will improve the evidential status of systematic psychotherapy case studies.

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This PhD has been one of the most intense, exciting, and arduous journeys of my life, and I would be lying if I said I completed it without several holding environments and good objects (excuse the psychoanalytic terminology) supporting me in the last several years.

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Prof Willemsen inspired me to become a rigorous psychotherapy researcher, with a critical outlook on the concepts of validity, evidence, and data.

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I am grateful to everyone who helped me in my PhD research and teaching journey at the Department of Psychosocial and Psychoanalytic Studies (PPS), including: Dr Kevin Lu, Sue Kegerreis, Dr Norman Gabriel, Rodrigo Sanchez Escandon, Dr David Henderson, Prof Roderick Main, Dr Carolyn Laubender, and Dr Bethany Morgan Brett. They have all inspired me to become a better researcher and teacher and enabled me to work at an intersection of psychoanalysis, psychology, psychotherapy and social sciences.

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"*Though here at journey's end I lie in darkness buried deep, beyond all towers strong and high, beyond all mountains steep, above all shadows rides the sun and stars forever dwell: I will not say the day is done, nor bid the stars farewell.*"

— Samwise Gamgee (J.R.R. Tolkien, "*The Lord of the Rings*")

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Author's note

Chapters 2 through to 5 of this thesis were written as independent pieces of research, with the intent of being submitted as manuscripts for peer–reviewed scientific journals. For this reason, there may be some overlap between chapters, particularly in terms of background literature and explanations of key terms and concepts (e.g., definitions for clinical and systematic case studies).

At the time of writing, Chapter 2 has been tentatively accepted with revisions by *Contemporary Psychoanalysis* journal. Revisions have been completed and returned in March 2021. Revisions for this chapter involved shortening the paper to fit the journal requirements and including case study examples from relational and interpersonal forms of psychoanalysis to address the specific journal audience. The theoretical and conceptual components of the manuscript remain as they are presented in this thesis.

Chapter 3 has been submitted to *Pragmatic Case Studies in Psychotherapy* (PCSP) journal in February 2020. The journal returned the paper for revisions in March 2020. Revisions for this chapter involved adding a separate section on how systematic case studies can utilise multiple epistemological frameworks, with a detailed clinical example based on two systematic case studies from PCSP. These revisions were required due to the specific journal audience, as PCSP readership is largely geared toward systematic case study research. The revised manuscript was sent back in May 2020. The chapter in this thesis includes PCSP revisions, specifically the addition of the section 3.5 *'The use of multiple epistemological concepts in systematic case studies'*. At the time of writing, the revised manuscript remains under review due to COVID imposed delays.

Chapter 4 has been published in *The International Journal of Psychoanalysis*, as of September 2020 (please note that due to journal requirements this chapter is in US English). This paper was co–written with one of the PhD supervisors, Prof Jochem Willemsen. The work was delegated and carried out in the following manner: 75% of research and writing carried out by the PhD candidate (the main author), 25% of research and writing carried out by the PhD supervisor (the co–author). The co–author's specific contribution is section 4.3.1 *'Thinking in cases as exemplars for analytic generalization*' (and the relevant discussion of this particular section in other areas of the manuscript). In January 2021, the published manuscript received a letter response (titled *'Letter to the Editor'*) from psychoanalyst Dr Nathan Szajnberg, to be published in the *International Journal of Psychoanalysis*, Volume 1, 2021. *The International Journal of Psychoanalysis* has invited the PhD candidate (the main author) to write a letter response to Dr Szajnberg. The response letter was sent and accepted in February 2021, also to be published in the *International Journal of Psychoanalysis*, Volume 1, 2021. The letters discuss further epistemic issues in scientific thinking styles, with a particular focus on developing a clearer psychoanalytic standard of verification for thinking in cases. The letters also consider the potential significance of integration between different thinking styles (rather than their permanent exclusivity). This academic dialogue has been fruitful and will be used by both manuscript authors in the development of a follow–up paper.

At the time of writing, Chapter 5 has been tentatively accepted with revisions by *Psicologia: Reflexão e Crítica / Psychology: Research and Review* in February 2021. Revisions have been completed and returned in March 2021. Revisions for this chapter involved refining key terminology pertaining to evidence–based practice and practice–based evidence paradigms and clarifying the introductory state of the paper. The chapter in this thesis is presented with the journal revisions.

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Chapter 1: Introduction

1.1 Motivation

In his now classic article, *Five Misunderstandings about Case–Study Research* (2006), social scientist Bent Flyvbjerg argues that, for a long time, the 'conventional truth' about the inferiority of single (N=1,"N" referring to the population size of individuals in the study) case studies to larger N studies (e.g., statistics) has been accepted by researchers in social sciences overwhelmingly uncritically. Flyvbjerg refers to textbooks and dictionaries in the field of sociology, which frequently defined case studies as incapable of "providing reliable information about the broader class" (Abercombrie, Hill & Turner, 1984, p. 34). Well–known authors in the fields of social and psychological research have also publicly scrutinised the use of single cases, noting that "one can validly explain a particular case only on the basis of general hypotheses" (Dogan & Pelassy, 1990, p. 121) and "[case] studies have [...] a total absence of control as to be of almost no scientific value" (Campbell & Stanley, 1996, p. 6). In his later works, Flyvbjerg (2011) acknowledges that case studies are still held in low regard, despite recent efforts to demonstrate their methodological utility.

In psychology, and, more specifically, psychotherapy, the use of a specific method contributed to the (perceived) scientific status of the field. Statistical methods, traditionally associated with natural sciences, cause–and–effect relationships, and outcome measures, have become essential for the establishment of evidence–based psychotherapy (Aveline, 2005). This is because large N studies are seen as ideal for assessing whether particular interventions (e.g., therapeutic approach or technique)

have a measurable effect (e.g., positive outcome) across different clinical populations. The status of the single case study method, however, remains ambiguous in this modern, evidence–driven psychotherapy (this is explored in detail in the section 1.2.3 '*Methodological Controversies'* and is central to discussions in thesis Chapters 2 through 5).

In broad terms, case studies and single–subject research designs in psychotherapy are descriptive reports, which include (but are not limited/restricted to) components like detailed patient history and experiences, therapist interpretations, clinical assessment methods, therapeutic interventions, treatment processes and outcomes, theoretical applications, diagnostic conclusions and differential diagnosis (Foster, 2010) (specific case study definitions are provided in the section 1.2.1 *'Different Forms of Case Study'* and 1.2.2 *'Case Studies in Different Therapeutic Modalities'*). However, how (and, indeed, whether) these descriptive components in a *single* case study contribute to evidence in psychotherapy in a *broader* (i.e., beyond N=1) sense is less clear. It is therefore not uncommon to see questions and criticisms posed to researchers who choose to work with single case studies: '*why N=1*?'

Following historian John Forrester's argument that *the specificity of the case is central* (in the sense that describing methodological components without referring to the clinical narrative is epistemically superficial) (Forrester, 1996, 2017), I will discuss the main reasons for why I chose to undertake case study research in the present thesis with a reference to a case study example. Clinically rich material will be connected to methodological and theoretical components unique to single case studies; this will form the basis of my motivation to, on one hand, work through misperceptions of the case

study methodology, and on the other, to develop its epistemic practices in psychotherapy research.

1.1.1 'Why N=1?' – a case example

In a case study by Levine and Faust (2013), a patient called Edward described his experience of life as though he was "living in a personal hell" (p. 202). Edward saw himself as a profoundly flawed individual, "tortured by envy every second of every day" (*ibid*). He reported feeling unable to derive pleasure from day–to–day activities, was terrified of failure, and felt that he was not good enough. Edward learnt to internalise lengthy citations and mannerisms from famous philosophers, poets and musicians that he could spontaneously identify with and utilise in moments where he would lose his confidence and sense of identity. Additionally, Edward suffered from depressive tendencies, caused by feelings of inadequacy and inferiority; this led to intensified and persistent experiences of suicidal ideation, loss of appetite, inability to leave the house, and, finally, inability to form meaningful interpersonal relationships. Feeling irrevocably "damaged" as a human existence, Edward discarded omnipotent fantasies of marrying the woman he wished he could "merge" with (i.e., become as one with), which ultimately left him feeling isolated, lost, and meaningless.

The patient attributed his relational difficulties to genetically predisposed neurological problems. He recounted a memory of being in a gym class at the age of 7, and not being able to follow the teacher's instructions for tying shoelaces. When asked how he felt about this, Edward replied, "it made me feel like I was mentally retarded" (p. 203). The case authors picked up this and similar expressions pertaining to Edward's self–assessment as potentially causal to the patient's interpersonal impairments and lack

of relatedness. However, Levine and Faust are clear in their case narrative that the *reported problem* (patient's perceived neurological deficit) is not necessarily central, causal or congruent with Edward's personality issues; that it is not necessarily the presenting or *underlying issue* in the case (Levine & Faust, 2013):

> Edward's substantial stress [...] stems from persistent thoughts about having a "defected" brain [...] was ruled out. [...] Although he has completed numerous neuropsychological evaluations that fail to discover the existence of memory problems, he continues to believe "something has been missed". Nevertheless, he is able to consider the possibility that he does not actually have a serious cognitive defect; Edward has gone as far as saying "it might be all in my head," thus constituting a rule out of delusional disorder (p. 206).

Considerations about patient's self–assertions and perceptions are part and parcel of case study research. This is because case studies in psychotherapy are particularly attuned to the *contextual research component*, with which multiple psychological, social, economic, and demographic factors are examined and assessed in ways that are not possible with larger participant samples (McLeod & Elliott, 2011). Following the example of Levine and Faust's (2013) case, particularly detailed attention is drawn to Edward's family history and early social life: Edward grew up in a harsh interpersonal environment, with a mother who was unable to congruently address and mirror Edward's psychological needs, and experiences of regular bullying from classmates at school. The case authors argue that these experiences effectively caused Edward's personality to become split into the repressed (real) self and presenting (false) self; the real self, containing Edward's

grandiose and affective needs, is concealed by his false self, which seeks to avoid further humiliation and rejection previously experienced with his mother and peers. The detailed contextual analysis enables the case authors to get one step closer in identifying the underlying issue in patient's mental experiences (Brigati, 2009).

According to McLeod and Elliott (2011), the contextual element of single–subject research is deeply intertwined with the *complexity of the case narrative*. While large N studies produce typically small and/or less complex observations in relation to each research participant, case studies focusing on single individuals produce a large number of observations, leading to detailed analysis of complex therapeutic factors and processes. This is particularly important for diagnostic considerations: in Levine and Faust's (2013) case, Edward was assessed for a variety of personality disorders due to his interpersonal problems. Furthermore, there is the challenge of Edward's self–reported neurological issues; however, as noted earlier, the patient presented doubts about this self–assessment. A complex analysis of Edward's family relationships and social history allowed the case authors to consider an additional diagnosis: narcissistic personality disorder (NPD). Across multiple of Edward's relationships, Levine and Faust observed Edward's constant pre–occupation with his self–perceived cognitive limitations. However, this pre–occupation appeared to be most intense when Edward was no longer merged with some idealised object (e.g., a fantasised romantic partner, musician, poet, philosopher). This led the case authors to consider the possibility of closet narcissism (or Depressed/Depleted narcissism): a form of narcissism through which the individual becomes obsessed with their unfulfilled expectations of self, while repressing feelings of envy and resentment toward objects that are perceived as more successful. By identifying a new diagnosis (as well as a specific subtype of the diagnosis), Levine and Faust were able to formulate a suitable therapeutic plan (psychodynamic treatment),

with which they could target the patient's underlying issue (impaired object relations and narcissistic defence mechanisms).

The intensive study of single individuals is particularly significant for clinicians who are interested in *learning about therapeutic techniques*, *relationships, and interventions 'in action'* (Mackrill & Iwakabe, 2013; Dattilio, Edwards, & Fishman, 2010). Indeed, case descriptions, whether formal (e.g., published as a case report in a scientific, peer–reviewed journal) or informal (e.g., a non–written clinical vignette used as an example in a teaching context), are considered to be central to the teaching and training of psychotherapy principles: "Without various forms of case materials, teaching of psychotherapy would be difficult and ineffective, if not impossible" (Mackrill & Iwakabe, 2013, p. 251). In this sense, Levine and Faust's (2013) case goes beyond the description of patient's reported and underlying issues to concrete techniques, transference themes, and relational responses, all of which are presented in an attempt to address the patient's specific treatment needs and, equally, to inform practitioners who are working with similar clinical issues and/or patients.

Due to their *high clinical attunement*, case studies have been identified as a potentially significant methodology in bridging the research–practice gap. The research–practice gap has been defined as a gap (or a lack of integration) between the findings disseminated by researchers and the practical decisions made in the consulting room by therapists (Stinckens, Elliott, & Leijssen, 2009). In psychology and psychotherapy, this gap is often described as unidirectional, i.e., focusing exclusively on the flow of knowledge from researchers to clinical practitioners (Teachman et al., 2012; Westen, Novotny, & Thompson–Brenner, 2004). However, a bidirectional model of science and practice is increasingly suggested in the field of psychotherapy (Teachman et al., 2012). A

bidirectional model of knowledge generation would include the development of research–supported psychological treatments *as well as* increasing the role of clinical practitioners in the research process. Case studies and single–subject research designs are often developed by researchers who are simultaneously clinical practitioners (psychotherapists, psychologists, psychoanalysts, mental health and social care workers, etc.), which offers a methodologically unique perspective (Dattillio et al., 2010). The case example by Levine and Faust (2013) is no exception: Levine (the first author) conducted psychotherapy with the patient, while Faust (the second author) acted as a clinical supervisor. This enabled the case authors to link up clinical observations (e.g., Edward's narcissistic defences) with methodological considerations (e.g., developing congruent countertransference reactions) in much greater detail.

Case studies in psychotherapy are also valuable in demonstrating the application of psychological theories 'in action', thus contributing to the *theoretical advancement* of the field (Mackrill & Iwakabe, 2013). Although it is argued that larger N studies (in particular, randomised controlled trials; RCTs) are already testing theories (in the form of therapeutic interventions) on a 'macro' level (by confirming or disconfirming the effectiveness of a therapeutic intervention within a specific clinical population), case studies are able to achieve this on a 'micro' level (Onwuegbuzie & Teddlie, 2003; Onwuegbuzie & Leech, 2005). A single case study can make systematic observations about how theoretical ideas apply in practice with a specific patient in a way that would not be possible in a large–scale RCT: "The case study strategy is to compare each of many theoretically–based statements with one or a few [clinical] observations. [...] Because many statements are examined, the gain in confidence in theory may be as large as that from a statistical hypothesis testing study" (Stiles, 2007, p. 123). The key element here is particularisation, not generalisation: while RCTs demonstrate whether interventions

work on average in a group, case studies demonstrate whether they work with individual patients through a detailed description of therapeutic microprocesses (e.g., patient symptoms, treatment needs, therapeutic relationship dynamics, therapist attitudes, etc.). In Levine and Faust's (2013) case, the detailed analysis of patient's interpersonal issues, family history, and displays of grandiosity allowed the case authors to expand the theoretical definition and symptoms common to closet narcissism, a relatively uninvestigated clinical phenomenon. The analysis of 'micro' elements in case studies indicates a potentially significant contribution to evidence–based psychotherapy, and, specifically, findings from RCTs (Iwakabe & Gazzola, 2009).

Finally, there is something to be said about the value of *narrative knowing* in psychotherapy case studies (McLeod & Elliott, 2011). The idea is that reading case studies is more than just deciphering therapist interpretations and engaging with 'micro' data on patient experiences; it also involves an emphatic assimilation into a 'closed world' between the therapist and the patient (Mackrill & Iwakabe, 2013). This is the closest we can get to observing 'live therapy', which is usually not part of routine psychotherapy training. The psychological dimension of the case narrative elicits an empathic response (Von Wright, 1971) in many different kinds of readers. This includes not only therapists and trainees, but also students, researchers, social care workers, and, ultimately, patients and their own family members (Miller, 2004):

> It is only in the rich narrative possible in a case study that the clinical reality of human suffering and healing can be captured. The case study can describe the context, the meaning of the problem, to all those affected by the client's problem

or illness, and the practical obstacles and resources available for its solution. (p. 36).

From this point of view, Levine and Faust's (2013) case is significant not just in terms of its clinical techniques or theoretical advancements in the field of narcissism; it also conveys a lived experience of fragmentation and brokenness associated with early parental neglect and lack of a 'real' self.

As can be observed from the above review, different fields and authors have identified several strengths of the single case study method: the deeply contextual research component, complexity of the case narrative, pedagogical capacity (demonstrating treatment techniques 'in action'), high clinical attunement (practice–based element), theoretical advancement (via particularisation), and narrative knowing. However, these elements are rarely considered in a comprehensive and pragmatic manner. For example, narrative knowing is often seen as uncomplimentary or unnecessary for theoretical advancement, leading to some ambiguity of what constitutes a 'good' case study (McLeod, 2010a). However, as shown through Levine and Faust's (2013) case example, all these components may be present in a single case study in a congruent and helpful way. Although this does not mean that each case study should contain all the different elements (as, indeed, case studies may be structured quite differently accordingly to their research aims; see Chapter 5 *'Appraising Psychotherapy Case Studies in Practice–Based Evidence: Introducting Case Study Evaluation–tool (CaSE)'*), it is crucial to assess how all of the aforementioned research components may contribute to the further development of the case study method.

In this thesis, I seek to consider the significance of the key case study components by looking at how they may contribute to:

(1) Epistemic knowledge generation practices in psychotherapy (broadly, across different forms of therapeutic schools, such as psychodynamic and Cognitive Behavioural Therapy) and psychoanalysis (specifically, given the historical significance of the psychoanalytic case study method for Freudians and post–Freudians);
(2) A specific form of scientific thinking called thinking in cases (which utilises different forms of non–statistical generalisation that can be seen 'in action' in both classic and contemporary case studies);
(3) The body of evidence in psychotherapy in a broader (beyond N=1) sense (by exploring the role of contemporary case studies in evidence–based practice, EBP, and practice–based evidence, PBE).

This thesis can therefore be considered as both a defence of the case study method in psychoanalysis and psychotherapy (as it seeks to address the methodological misperceptions and general biases toward single case studies) as well as a developmental project (as it acknowledges the ongoing methodological weaknesses in single case studies and presents further suggestions for knowledge generation practices and critical appraisal procedures).

The development of this thesis is timely, given the growing interest in the case study method in the past two decades. Case studies have been increasingly discussed and

used in social sciences (Hammersley & Gomm, 2000; Yin, 2014), psychotherapy (Iwakabe & Gazzola, 2009; Fishman, 1999, 2005; Stiles, 2007; Wedding & Corsini, 2013), and psychoanalysis (Desmet et al., 2013; Willemsen et al., 2015; Meganck et al., 2017). There are currently two case–based journals in the field of psychotherapy: *Clinical Case Studies* (which publishes innovative clinical case studies with individual patients, couples, and families) and *Pragmatic Case Studies in Psychotherapy* (PCSP) (which publishes rigorous, systematic case studies and papers that enhance knowledge generation practices in case studies). The Single Case Archive (SCA; https://www.singlecasearchive.com/) is the first online archive that compiles clinical, systematic, and experimental single case studies in the field of psychotherapy. SCA enables therapists, researchers, and trainees to search for relevant case studies in a variety of therapeutic schools. All these developments signal a move toward the singular in psychological sciences, which makes it all the more important to conduct a detailed investigation into the case study method.

1.2 Case study method: a background

A "case" is typically defined as "an instance of a particular situation; an example of something occurring" (Oxford English Dictionary). This definition exemplifies a key aspect of the case study method: it studies a *particular instance* of human behaviour or an event (whether related to a single individual, a group community or a society), with the goal of producing a rich description that captures "the actual state of affairs" (Midgley, 2006a, p. 124). This is true of all case–based disciplines: in psychotherapy, medicine, law, and criminology, cases are used to describe diagnoses, investigations, crimes, and histories of particular events.

Flyvbjerg (2011) notes that case studies have been "around as long as recorded history" (p. 302). Besides psychology (where one may argue case studies had a constitutive role), case studies had a significant impact in the fields of sociology and history (Stewart, 2014; Simons, 2009), while their methodological origins can be traced back to detailed ethnographic studies of individuals and cultures in anthropology (Harrison et al., 2017). Such investigations took place in naturalistic settings: researchers sought to understand people's experiences within the social and cultural context of their world, i.e., how individuals understood, interpreted, and constructed the meaning of their life experiences (Johansson, 2003). Some of the most famous anthropological case studies include Thomas and Znaniencki's (1958) study of Polish peasants' experiences in Europe and America and Malinowski's (1913/2013) ethnographic work in the Trobriand Islands, Melanesia on the Australian Aborigines. Both case studies are considered to be foundational in the fields of sociology and anthropology due to their explicit focus on the relationship between the individual and the society, as well as detailed experiential accounts of culture in group dynamics. In particular, Malinowski's work is considered a first of its kind qualitative research that involved the researcher (i.e., Malinowski himself) in the "*imponderabilia*" of everyday life of the Australian Aborigine culture. Malinowski argued that the researcher's daily contact with a different culture leads to a better understanding of the research subjects' worldview. This novel approach toward the research process and researcher's role undoubtedly contributed to further development of the case study method, and, in particular, its focus on human historicity (Hanly, 1996).

In the fields of psychoanalysis and psychotherapy, case studies are at the origin of theory development and research (Meganck et al., 2017). According to Pletsch (1982), the intellectual history of psychoanalysis is directly engraved into classic case studies by Sigmund Freud, namely: the case of Dora (1901/1905), Ratman (1909a), Little Hans

(1909b), Schreber (1911), and Wolfman (1918). These case studies include the development of key psychoanalytic techniques (e.g., dream analysis), the changing theoretical positions and attitudes (e.g., from seeing transference as something that must be 'dispelled' or 'avoided' to using it as an analytic toolkit), and discoveries of novel clinical phenomena (such as paranoia, hysteria, infantile neurosis, psychosis). Even Freud's less known cases, such as *A Child Is Being Beaten* (1924) and the analysis of Freud's dream of Irma's injection in *The Interpretation of Dreams* (1900), continue to function as "canonical examples" and "points of reference" for psychoanalytic theories (Creager, Lunbeck, & Wise, 2007, p. 2).

Freud, who began his career as a neurologist (Solms, 2000) and saw himself as a man of science (Kaye, 2003), described the shift from his earlier scientific work in neurology to psychoanalytic case studies in the following manner (Freud, 1895/1950):

> Like other neuropathologists, I was trained to employ local diagnoses and electroprognosis, and it still strikes me myself as strange that *the case histories I write should read like short stories and that, as one might say, they lack the serious stamp of science*. [...] The fact is that local diagnosis and electrical reactions lead nowhere in the study of hysteria, whereas *a detailed description of mental processes such as we are accustomed to find in the works of imaginative writers enables me, with the use of a few psychological formulas, to obtain at least some kind of insight into the course of that affection* (p. 160–161, emphasis added).

This passage is historically significant for both the genre of case study writing and psychoanalysis as a discipline. Initially, Freud intended to develop psychoanalytic psychology in line with a neurobiological tradition. For example, the early concept of psyche was described by Freud as a neurobiological apparatus; its disturbances were associated with perceptual neurones and mnemic images of the object that causes (or excites) the pain. Pain itself, however, was not understood as a subjective experience. Instead, it was explained as a property consisting "in the irruption of large Qs [Quantities] into ψ [impermeable neurones]" (Freud, 1895/1950, p. 307). Subsequently the patient's subjective experiences of pain and displeasure were to be understood under the general neurobiological concepts of "stimulus", "response", "drive", and "instinct". Freud envisioned that these concepts would be used to explain the constitution of the psychic world, just like physics and chemistry explain the constitution of the corporeal world (Harrington, 2000). However, Freud quickly discovered that such an approach (or, more specifically, reasoning style) was not sufficient in the study of mental phenomena; that it "led nowhere".

After his first real dream analysis (the analysis of Irma's injection), Freud began to direct his scientific ambition *inwards*, towards the subjective and hidden meanings of the psychic life (Freud, 1900). Freud began to postulate that understanding the meaning of the dream requires an uncritical attitude to all of the dreamer's free associations (expressions containing unconscious material): "The dreamer does know what his dream means: only he does not know that he knows it and for that reason he thinks he does not know it" (Freud, 1924/1963, p. 101). In other words, thinking about external causes and biological processes for Freud was not enough: in order to reveal the underlying unconscious processes of mental phenomena, one must attend to patients' life histories, their subjective experiences, as well as their own attempts to understand their problems.

Freud's shift from neurological to psychological thinking had a direct influence on his choice of research methodology. First, Freud needed a format through which he could disseminate qualitatively rich data and observations about patients' unconscious processes, behaviours, and feelings to the medical community (Willemsen et al., 2017). Second, this format would need to be suitable for the theoretical advancement of psychoanalysis as a science (Freud, 1926). The medical case study format seemed appropriate for the fulfilment of these two tasks but pending further changes that would enable Freud to attend to the psychological (rather than physiological) material (Forrester, 2017). Medical case studies were standardised accounts, which included patient's name, occupation, medical family and social history, and a pathological report (Sturdy, 2007); consequently, medical cases were rarely more than several paragraphs to several pages long (Sealey, 2011). Indeed, brevity was regarded as a sign of seriousness in the medical community (Nowell–Smith, 1995).

However, cases in medical practice have been used not only as professional examples (depicting specific patient scenarios and treatment processes that could then be used for similar cases in the future) but also as teaching examples. In the 19th century, French neurologist Jean–Martin Charcot (who supervised Freud's work for a brief period in 1885) used case presentations as a special form of teaching, in which patients suffering from neurological diseases would demonstrate their symptoms in front of the students (Kumar et al., 2011). Using real–life patient cases as teaching examples made Charcot's Salpêtrière Hospital famous: it was a direct and powerful representation of medical pathologies and human suffering. These case presentations were more convincing and moving than any medical article due to their sheer experiential quality (despite such 'demonstrations' involving ethically questionable practices; see Stephenson, 2001).

Although Freud did not choose the medical 'demonstration' format for his case genre (unsurprisingly, given the privacy required for the therapeutic relationship and the analytic task; see Freud, 1912), he nonetheless maintained that there was something important in keeping – and, indeed, developing – the detailed description of mental processes in the same powerful manner as Charcot's expositions (even at risk of losing what Freud earlier identified as a "serious stamp of science"). As such, the psychoanalytic case study underwent a dramatic transformation from the classic medical case: it was no longer a data file, in which the patient was described through a number of classifications and diagnostic evaluations (Forrester, 2017). Instead, the Freudian psychoanalytic case became a kind of "*Kranken Geschichten*" (Willemsen et al., 2017), bravely and wildly placing the reader into the patient's world. This creates an immersive effect, with which the readers are able to experience patient's interpersonal family drama, transference struggles, and neurotic symptoms as if they were 'played' out (or 'acted' out) right in front of them, within close psychological proximity. For example, in the case of Dora (Freud, 1901/1905), Freud clearly goes beyond depicting patient's hysteric symptoms: he writes in detail about her emotional experiences, family life, traumas, and desires, as well as his own ability (or lack thereof) to understand her as a psychoanalyst. Not unlike Malinowski (1913/2013), Freud describes his regular contact with Dora's psychic experiences and unconscious conflicts: "I found it totally inadequate for dealing with the finer structure of neurosis. I now let the patient [herself] choose the subject of the day's work, and in that way I start out from whatever surface [her] unconscious happens to be presenting to [her] notice at the moment" (Freud, 1901/1905, p. 12). Therefore, the research process in classic Freudian case studies is revelatory not just of patient history and unconscious conflicts, but also of changes in theory (e.g., the move from therapist–initiated interventions to free association), initiated via the therapeutic process.

Although Freud's case studies are now a century old, they remain among the most famous psychological artifacts of the 20th century (Sealey, 2011). The clinical techniques described in Freud's cases are still discussed during clinical training and education (Ellman, 2002), while Freud's theoretical postulations continue to be studied, criticised, and re–assessed by contemporary psychoanalysts, social theorists and psychologists (Sulloway, 1991; Berkenkotter, 2008; Mahony, 1996; Hinshelwood, 2013). It is evident that, despite fierce criticisms put forward for the psychoanalytic case study method and theory (this is explored further in the section 1.2.3 '*Methodological Controversies*' and Chapter 2 '*Learning from Past Practices: An Overview of Criticisms for Psychoanalytic Case Studies*'), Freud was able to utilise this genre in order to effectively disseminate his mode of scientific thinking (Kaluzeviciute & Willemsen, 2020) and further cultivate communal psychoanalytic activity (Bazerman, 1988).

After Freud, due to increasing influence from the French model of patient observation and German model of laboratory experimentation, case studies generally became less popular and entered a state of flux (Sealey, 2011). However, as a medium, the case study found a way to shift, develop, and transform in spite of these challenges. This is particularly evident in the field of psychotherapy: new modes of single–case experimental designs (Smith, 2012), systematic case study research (McLeod & Elliott, 2011; Davison & Lazarus, 2007), meta–analytic case study findings (Timulak, 2009) and case–comparison techniques (Iwakabe & Gazzola, 2009; Willemsen et al., 2015) continue to emerge at an exciting speed. The resurrection of the case study method is undoubtedly instigated by the persisting research–practice gap, in which the chosen methodology (large N studies, such as RCTs) is seen as incongruent or insufficient for the study of the object (namely, the human mind and mental health experiences) (Meganck et al., 2017; Cartwright, 2015; Longhofer, Floersch & Hartmann, 2017).

1.2.1 Different forms of case study

Following recent methodological innovations in psychotherapy research, it is important to point out that the case study method has become increasingly pluralistic, both in terms of its research process and research aim (Widdowson, 2011). This contributed to several different types of case studies, which need to be clearly differentiated.

Clinical case studies are narrative reports written by therapists. They usually involve detailed descriptions of treatment processes as well as therapist interpretations (Iwakabe & Gazzola, 2009). Although it is not impossible that quantitative methods (such as questionnaires or psychometrics) might be used in a clinical case study, the therapist using them will still discuss the findings in relation to clinical interpretations, which are seen as central to the case.

In psychotherapy, clinical case studies are particularly suitable for teaching and training: clinical trainees can learn about therapeutic interventions from detailed narratives with 'real life' patients, including descriptions on how to navigate therapeutic issues (Miller, 2004). Furthermore, clinical case studies are useful for generating hypotheses: since they start off with a "thick" description containing many contextual data points (Geertz, 1973), the case researcher can begin to make inferences between patient's history and their current experiences. However, how (and if) research hypotheses generated in clinical case studies featuring single patient observations can be confirmed or falsified is a subject of ongoing methodological debates (Midgley, 2006a) (this is explored further in the section 1.2.3 '*Methodological Controversies*'). Clinical case studies typically revolve around *experiential or narrative* questions ("What is the story of

what happened, from the patient's or therapist's point of view?"); however, contemporary clinical case studies may also tackle *pragmatic questions* ("What strategies and methods did the therapist use in this case that contributed to the eventual outcome?") related to clinical practice or *theory–building questions* ("How can the data in this case be used to test and refine an existing theoretical model?") focused on the application of a specific theory and/or concept in the treatment process (McLeod, 2010a).

In *systematic case studies* (otherwise known as naturalistic), data is gathered from multiple different sources (questionnaires, observations by the therapist, interviews, statistical findings) in order to construct a comprehensive account of the case. Data is then triangulated among a team of researchers (which may include therapists, data analysts, researchers, clinical supervisors) to see whether findings from different sources converge or differ. This enables a more rigorous and critical outlook on case study findings (McLeod, 2010a).

Systematic case studies are considered to be an accessible method for developing research evidence–base in psychotherapy (Widdowson, 2011), especially since they 'correct' some of the methodological limitations inherent to classic clinical case studies (Iwakabe & Gazzola, 2009). Fishman's (1999, 2005) work has been particularly significant for developing standardised guidelines for published systematic case studies. Systematic case studies will often include a "thick" description of patient's presenting problems, similar to clinical cases; beyond this, however, a systematic case narrative should also include researchers' theoretical approach, intervention methods, professional experiences, and a review of related research (Fishman, 2005). The standardisation of case study narrative enables systematic case studies to address *outcome* ("How effective has therapy been in this case?"), *theory–building* and *pragmatic questions* (McLeod, 2010a) in a clear and structured manner. *Experiential* or *narrative*

questions may still be important, although to varying and/or lesser degree than in clinical case studies. It is important to note, however, that systematic case studies maintain descriptions of treatment processes and clinical encounters 'as they occur' (hence the term *naturalistic*, i.e., without the manipulation of the therapeutic set–up or decontextualization of specific variables).

Experimental case studies (otherwise known as single subject designs or N=1 subject experiments) are used for testing hypotheses about treatment effects. Experimental case studies are considered an alternative to large–scale outcome research (Barlow & Hersen, 1984). Researchers utilising experimental cases record and address changes observed in patients that can be attributed to administration of specific interventions (e.g., medication). Standard behaviour assessment is conducted and recorded regularly, and changes are then compared with a baseline of target behaviours (Iwakabe & Gazzola, 2009).

Given the focus on behavioural change, experimental case studies have been used almost exclusively for research of behavioural therapies (Widdowson, 2011). The experimental case material usually consists of a time–series analysis comparing the effect of interventions along with graphic presentations of data. This enables the reader to examine and identify clinical changes visually (Iwakabe & Gazzola, 2009). Although the theoretical rationale and general treatment processes are reported, these case study components are usually not central to experimental case studies. As such, experimental cases are mostly concerned with *outcome questions* (McLeod, 2010a).

Although the terminology for different case study types may vary in psychotherapy literature (e.g., Fishman developed the term *pragmatic case study*, which generally corresponds to systematic case study; see Fishman, 1999), while other researchers developed separate modes of case–based research (e.g., Elliott developed

Hermeneutic Single Case Efficacy Design (HSCED) Studies to address single outcome variables based on both qualitative and quantitative data; see Elliott, 2001), Iwakabe and Gazzola's (2009) terminology of clinical, experimental and systematic case studies remains to be the most frequently used case study identifier, and as such, these terms will be used throughout the thesis.

Furthermore, since this project is at an intersection of psychoanalysis and psychotherapy, it will predominantly focus on developing the first two types of case study: clinical and systematic. Although experimental case studies (or single subject designs) have been used in psychotherapy research (Smith, 2012), their methodological components are significantly different from clinical and systematic case studies due to high focus on physiological (specifically, observable and measurable) patient responses. However, as will be shown in the section 1.3 *'Approach of this thesis'*, this work seeks to address the ongoing issue of capturing qualitatively rich psychological data in psychotherapy case studies. As such, experimental case studies were deemed to be less relevant than other types, both in terms of their methodological standing (experimental case studies are generally considered to be more credible in terms of their validity than, for example, clinical case studies; see Aveline, 2005) and research material (which is generally less invested in exploring complex micro–processes like therapeutic relationships, patient responses, therapist attitudes, etc.).

1.2.2 Case studies in different therapeutic modalities

Most forms of psychotherapy utilised clinical case studies at (or during) their origin: theoretical developments were often based on direct clinical observation and experience

with innovative interventions, long before outcome studies or controlled empirical research (e.g., laboratory studies) were implemented (Stiles, 2005). Freud's classic psychoanalytic case studies are exemplary of this approach.

Contemporary clinical case studies, such as those published in the journal *Clinical Case Studies*, tend to be mainly from psychodynamic/psychoanalytic, CBT (Cognitive Behavioural Therapy), DBT (Dialectical Behavioural Therapy), and object relational approaches. On the Single Case Archive, out of 1915 clinical case studies, 1211 case studies were found to be psychodynamic/psychoanalytic (accounting for 63,2% of all clinical cases), 189 case studies were found to be CBT (accounting for 9,8% of all clinical case studies), 107 case studies were from Client–centered/Humanistic/Existential therapeutic approaches (accounting for 5,5% of all clinical case studies), with the rest of clinical case studies coming from mixed therapeutic modalities. These results indicate that the clinical case study format is still prominent within psychodynamic and psychoanalytic approaches, which have been historically close to this mode of writing.

It is also worth noting that the contemporary mode of clinical case study has significantly changed since Freud's time: clinical case studies published in psychotherapy journals are generally shorter (which is partly due to journal word length requirements, although it may also be seen as a consequence of increasing standardisation; see Sealey, 2011), and are usually more structured (including not only therapist interpretations but also a theoretical and/or research basis, case introduction, presenting complaints, course of treatment, complicating factors, etc.). These developments undoubtedly contributed to the relatively recent theoretical diversity in clinical case studies, especially since CBT research has been historically aligned with experimental case studies.

Systematic case studies are becoming increasingly common in contemporary psychotherapy research (Meganck et al., 2017; Fishman, 2005), and have been used in a

variety of therapeutic modalities. For instance, systematic case studies published in *Pragmatic Case Studies in Psychotherapy* (PCSP) are very diverse: recent issues (from 2017 to 2020) feature case studies from Telephone–Based CBT and DBT, CBTp (Cognitive Behavioural Therapy of psychosis), AEDP (Accelerated Experiential Dynamic Psychotherapy), and CBIT (Comprehensive Behavioral Intervention for Tics) therapeutic modalities, to name a few. On the Single Case Archive, out of 1101 systematic case studies, 427 case studies were found to be CBT (accounting for 38,7% of all systematic case studies), while 283 were psychodynamic/psychoanalytic (accounting for 25,7% of all systematic case studies), with the rest of systematic case studies coming from mixed therapeutic modalities. The theoretical diversity in systematic case studies indicates that methodological developments initiated by psychoanalytically–oriented researchers (like Wallerstein's first of its kind Menninger Foundation research project consisting of 42 systematic psychoanalytic case studies; see Wallerstein, 1989) have also brought in practitioner–researchers from other therapeutic approaches, such as CBT. Moreover, there is growing evidence that clinical psychodynamic and psychoanalytic case studies are also becoming increasingly systematic in terms of their methodological components (Meganck et al., 2017; Desmet, 2013), which could indicate a more general shift in case study writing practices.

Historically, experimental case studies have been closely aligned with behavioural therapies (pioneered by Watson, Skinner and Pavlov), and later, CBT (McLeod, 2010a). This remains to be the case: on the Single Case Archive, out of 214 experimental case studies (single case experiments), 143 were found to be from behavioural therapeutic approaches and interventions (e.g., Applied Behavior Analysis, Third–Generation Behavioural Therapies, Aggression–Contingent Physical Restraint, etc.) (accounting for 66,8% of all experimental case studies), and 51 were found to be CBT (accounting for

24,2% of all experimental case studies), with the rest of experimental case studies coming from mixed (systemic, cognitive, and other) therapeutic modalities.

1.2.3 Methodological controversies

According to Midgley (2006), cotemporary criticisms against the case study method can be grouped into three distinct categories: *the data problem* (observations in case narratives are not reliable and/or valid), *the data analysis problem* (the methods used for analysing and reporting observations in case narratives are lacking validity and accuracy), and *the generalisability problem* (even if some of the observations in the case narratives are reliable, they cannot be generalised beyond the particular case narrative).

The first issue of clinical data is relevant to all forms of case reporting: it is difficult, if not impossible, to separate the case–subject (e.g., patient) with the case author's (e.g., therapist's) understanding of the subject's psychological reality (Walsh, 2020). This feeds into a broader debate on whether there can be 'clinical facts' that are epistemically constitutive of another subject's experiences in the 'real' world, or whether all case narratives are constructions within the therapist's mind (O'Shaughnessy, 1994; Gabbard, 1997). The American Psychoanalytic Association reported this issue in the late 1980s, highlighting the fact that most clinical observations are gathered retrospectively, lack primary data about patient history and clinical assessment, and conflate observations with causal inferences (Klumpner & Galatzer–Levy, 1991). Increasingly, video and audio recordings have been suggested as ways to combat unduly case reporting, although not without clinical and ethical objections (Tessier, 2012).

The second issue of clinical data analysis can be related to Donald Spence's (1984, 2001) criticism of "narrative smoothing": a selective portrayal of the clinical situation by eliminating contradictory evidence. According to Spence, since we cannot directly observe therapists at work, they may freely substitute clinical evidence with a variety of narrative truths that are convenient for theoretical confirmations. As an example, Spence cites Burland's (1997) article, in which a sample of 450 case reports was evaluated. In each and every one of the cases, Burland found the same exact patient scenario: "A step–by–step regression into a revisitation of their past, in memory, in the transference, and in current reality [...] The patients struck me as sharing more or less common repertoire of affects and struggling with them in similar ways" (Burland, 1997, p. 469). Both Spence (2001) and Burland (1997) note that it is highly unlikely for a sample this large to report narratives of such high similarity. Spence suggests a variety of reasons for "narrative smoothing" in psychotherapy case studies: therapists may feel the need to generate normative or unexceptional case studies in order to get more easily certified; received theory may influence the analyst on a conscious or preconscious level; the narrative may be significantly modified in order to protect patient's identity; and lastly, the narrative may be generated in a way that would reassure the theoretical field about the stability of its core theoretical concepts (Spence, 2001; Widlöcher, 1994; Goldberg, 1997).

Lastly, the issue of generalisability is arguably the most detrimental criticism for classic and contemporary case studies, as well as the most debated criticism in social sciences (Wallerstein & Sampson, 1971; Fonagy & Moran, 1993; Hanly, 1996; Lincoln & Guba, 2000; Yarkoni, 2019; Shean, 2014; Donmoyer, 2000; Meganck et al., 2017; Iwakabe & Gazzola, 2009; Tacq, 2010; Longhofer et al., 2017; Hinshelwood, 2019; Kaluzeviciute & Willemsen, 2020). This criticism follows from the first issue of data (Midgley, 2006a): since case studies provide (what might be perceived as) unregulated clinical observations

as well as deeply contextual data, it is unclear how (if at all) findings from a single case can be generalised or transferred onto a broader population. This criticism is usually made by the proponents of the statistical method and thinking style: since randomisation techniques (pertaining to study samples) and decontextualisation of specific variables, components that are crucial to most statistical models, are not relevant or possible in the case study method, statistical inferences pertaining to a general population cannot be made.

It is worth noting that the issue of generalisability is also highly contested in statistical psychology, which was recently described as experiencing a 'generalisability crisis' (Yarkoni, 2019), and has become a dividing point between qualitative (relying on in–depth, contextual data obtained by researchers from first–hand observation, interviews, questionnaires, case narratives, participant–observations, etc.) and quantitative (relying on data acquired through experimental control, manipulation of variables, and statistical analysis) research methods (Tacq, 2010; Lincoln & Guba, 2000). Numerous authors suggested other forms of generalisability that are more attuned with the case study method (Stake, 1995; Yin, 2013, 2014; Kaluzeviciute & Willemsen, 2020). This, as well as the previous two criticisms, will be addressed in greater detail throughout the thesis.

1.3 Approach of this thesis

Following recent developments in case study methodology (Meganck et al., 2017; Datillio et al., 2010; Desmet et al., 2013; Goodheart, 2005; Stiles, 2015; Timulak, 2009), this thesis seeks to perform a two–fold task: to defend the significance of case studies (and, more broadly, the significance of idiographic clinical narratives) as a quintessential

methodology for psychotherapy research, and to address some of its persisting methodological shortcomings. This section will briefly explain how both elements are approached in this thesis, along with an outline of key research questions explored in Chapters 2 through to 5.

First, it is important to clarify how the term "case study" is understood in this thesis. The rationale for focusing on clinical and systematic case studies (Iwakabe & Gazzola, 2009) has been outlined in section 1.2.1 *'Different forms of case study'*; these terms will be used to differentiate between the two methodologically distinct types of case study. Instances of therapeutically–oriented case study terminology, such as "psychotherapy case studies" or "psychoanalytic case studies", should be understood in the following manner: case studies in psychotherapy refer to contemporary clinical and systematic case studies published in psychotherapy journals according to recent research criteria and guidelines (Fishman, 2005; Willemsen et al., 2017). Case studies in psychoanalysis refer to classic Freudian and other 'originating' cases developed by early psychoanalysts. Lastly, the term "case" should be understood in a broad manner: case as an epistemic genre (not only in psychoanalysis or psychotherapy but also in social sciences) encompassing written clinical cases, cases as teaching examples, cases for supervision (clinical vignettes), patient case files, etc.

As identified earlier, the case study method is uniquely equipped in approaching research data: complex and contextually embedded case narratives allow readers to 're–live' therapeutic relationships, reactions, attitudes, and changes in close psychological proximity (Mackrill & Iwakabe, 2013). This approach – central to case studies but also common to all forms of idiographic narratives (Jupp, 2006) – has proven to be problematic in recent methodological discourse. Multiple authors noted the exclusion of

complex patient and treatment data in contemporary diagnostic evaluations (e.g., *Diagnostic and Statistical Manual of Mental Disorders*, DSM; see Vanheule, 2012), evidence–based practice (Cartwright, 2007, 2011) and big data (Kitchin, 2014; O'Neil, 2016) approaches. A radical move toward the general (i.e., tightly controlled clinical populations, diagnostic classifications, and data systems) risks omitting those data components that can only be explicated via small N research: the complexity and singularity of each patient's history, treatment needs, therapeutic approach, treatment outcome, etc.

Furthermore, it has become evident that these data components are not just 'additional' to large N studies like RCTs; that, in fact, case studies containing detailed micro–processes and/or specific treatment outcomes have the potential to inform and revise research findings from large–scale studies (Dattilio, Edwards & Fishman, 2010). This is an unsurprising yet often omitted fact: although RCTs are excellent in establishing the efficacy of treatment interventions in large groups, they cannot trace symptom, outcome or treatment process deviations in individual patients (Westen et al., 2004; Westen & Morrison, 2001), which is central to case studies in psychotherapy.

Therefore, this thesis will seek to reposition the significance of the case study method by capitalising on its qualitatively rich approach to psychological experiences in therapeutic practice. The latter has been identified as foundational for psychotherapy research, clinical practice and training (Mackrill & Iwakabe, 2013), despite the obvious difficulties in observing and measuring complex psychological data like patient attitudes (Truijens et al., 2019).

In defending the status of the case study method, however, the thesis does not seek to diminish the significance of other methodologies, such as RCTs. On the contrary, the

thesis considers a pragmatic dialogue between case studies and large N studies in an attempt to capture the complexity of clinical practice. Although this form of methodological pragmatism has been suggested by several authors (Fishman, 2005; Dattilio et al., 2010), unfortunately there remains a large divide between qualitative and quantitative research methods, leading to a form of methodological "fetishism" in scientific discourse (Burman, 1997). Therefore, as a case study researcher, I sought to offer some perspective on how qualitative and quantitative methods (specifically, systematic case studies and RCTs) may work together (or at the very least, co–exist) in the field of psychotherapy without losing their epistemological roots.

Some of the key questions that will be explored in relation to the defence of the case study method in Chapters 2 to through to 5 include:

i. What is the historical significance of the case study method in the fields of psychoanalysis and psychotherapy?
ii. What are some of the persisting misconceptions and biases toward the case study method?
iii. What is the role and significance of subjective experiences in psychotherapy research?
iv. How did the case study method evolve post–Freud?
v. How can case studies contribute to systematic research in psychotherapy?
vi. What are some of the epistemic practices and forms of reasoning used (but not necessarily explicated) in case studies since (and post–) Freud?

As a project that seeks to contribute toward the development of the case study method, this thesis identifies some of the key methodological weaknesses that can be observed in both classic psychoanalytic as well as contemporary psychotherapy case studies, discussed in the earlier section 1.2.3 *'Methodological controversies'.* In an attempt to respond to some of these drawbacks, the thesis offers a set of epistemological concepts that would equip practitioner–researchers in the fields of psychotherapy and psychoanalysis with much needed methodological guidance pertaining to retroductive reasoning (Sayer, 2000), analytic generalisation (Yin, 2013, 2014) and working hypothesis (Crombach, 1975) research models. The thesis also offers a more explicit discussion of different forms of non–statistical generalisation through three distinct styles of thinking in cases (Forrester, 2017). Lastly, the thesis includes an introductory paper to a novel *Case Study Evaluation–tool* (CaSE), containing a checklist and framework approach with guidelines for systematic case study appraisal.

Some of the key questions that will be explored in relation to the development of the case study method in Chapters 2 through to 5 include:

vii. How can case study researchers justify their findings on formal epistemological grounds?

viii. What are some of the guidelines for researchers interested in retroductive reasoning, analytic generalisation and working hypothesis research models?

ix. How can social science theories and concepts be utilised in research situated within psychotherapy and psychoanalysis?

x. What are some of the alternative modes of generalisation (beyond statistical), appropriate for case studies in psychotherapy and psychoanalysis?

xi. How do clinicians and researchers 'think and reason' through case studies?

xii. What is (or what may be considered as) evidence in psychotherapy case studies?

xiii. How should case study researchers approach critical appraisal?

xiv. What are some of the guidelines in developing a high–quality systematic case study?

Although these developments do not fully solve all methodological shortcomings in the case study method (as, indeed, no method is without flaws, whether quantitative or qualitative; see, Shean, 2014), the thesis introduces new modes of epistemic practices, thinking and reasoning styles, and critical appraisal procedures, which previously were not considered or sufficiently explicated in psychotherapy and psychoanalytic case studies. Continuing with the pragmatic approach, many of the suggested developments for the case study method in this thesis draw from other fields and disciplines, such as philosophy of science and social sciences (e.g., education, management, science and technology studies, social work, etc.). Concepts from other fields are translated and explained in a way that would be accessible to researchers in psychotherapy and psychoanalysis, with references to clinically rich and systematically rigorous case study examples from the Single Case Archive, *Pragmatic Case Studies in Psychotherapy, Clinical Case Studies* and other relevant venues.

1.4 Outline of thesis

The thesis is structured as follows:

Chapter 2 highlights the key criticisms put forward for psychoanalytic case studies at different (yet interrelated) levels: *suggestive influence and scientific judgment* (case study as a form of classification and judgment); *(counter)transference as a 'problem child'* (case narrative as an emotionally biased communication); *validation* (case study as an anecdotal report with non–generalisable findings). In doing so, the chapter also reviews some of the historical responses to the said criticisms, including the response from the scientific community (a move toward context–independent, generalisable research) and the psychoanalytic community (a move toward insularity and unresponsiveness). Explicating these historical strands is relevant for contemporary case studies in psychotherapy since they 'inherited' many of the original criticisms. The chapter shows how the case study method developed since Freud (and subsequently, how these developments address some of the criticisms aimed at classic psychoanalytic case studies) and suggests how contemporary case studies can move forward. The chapter is aimed at psychoanalytic and psychoanalytically informed practitioner–researchers.

Chapter 3 seeks to attend to the widespread issue of lack of formal epistemological reasoning in case study research. In the fields of psychotherapy and psychoanalysis, lack of epistemic rigour contributed to the decline of the case study method as a form of valid evidence. Drawing from different social science resources, the chapter provides detailed discussions of three epistemological concepts that were established as relevant for the case study method: retroductive reasoning, analytic generalisation and working hypothesis. All three epistemological concepts were found to be implicitly present in psychoanalytic and psychotherapy case studies; however, all three concepts also suffer from methodological limitations and lack of research guidelines. The chapter develops some of the existing epistemological rules and provides

novel suggestions for those concepts that are underdeveloped, along with further considerations about canons of evidence. The chapter is positioned at an intersection of case study research in psychotherapy, psychoanalysis and social sciences; as such, it is aimed at researchers within these fields who are interested in conducting epistemically rigorous case study research.

Chapter 4 attends to a style of scientific thinking and reasoning called "thinking in cases". The aim of this chapter is to clarify what Forrester meant by referring to thinking in cases as a distinct form of scientific reasoning. The chapter argues that some of the criticisms for psychoanalytic (and, later, psychotherapy) case studies are misdirected due to a confusion between statistical and experimental thinking styles and thinking in cases. The chapter outlines how thinking in cases differs from other forms of scientific thinking styles not only in *how* (process) but also *what* (end–goal) knowledge it produces. Beyond Forrester, the chapter proposes that there are several ways of thinking in cases: we can think not only in cases as exemplars for analytic generalisation (Forrester's initial point), but also in cases as exemplars for analogical learning and cases as part of a population for empirical generalisation. The chapter is positioned at an intersection of psychoanalytic theory, social sciences and philosophy of science; as such, it is aimed at psychoanalytic and psychoanalytically informed practitioner–researchers and philosophers. The chapter involves collaboration with Prof Jochem Willemsen (details of which can be found in Author's note).

Chapter 5 introduces a novel *Case Study Evaluation–tool* (CaSE). The chapter is presented as an epistemological exposition, showcasing the process of developing a critical appraisal tool for systematic case studies. This format was chosen consciously, due to the fact that the majority of existing critical appraisal tools for qualitative and quantitative research methods provide little (if any) epistemological rationale and

guidance for reviewers. Since CaSE is the first critical appraisal tool for systematic psychotherapy case studies, it is also important to discuss the significance and utility of a critical appraisal tool, the relationship between systematic case studies and the notion of 'evidence', and the relevance (or lack thereof) of existing appraisal tools. The chapter develops purpose–oriented evaluation criteria for systematic case studies through *CaSE Checklist for Essential Components in Systematic Case Studies* and *CaSE Purpose–based Evaluative Framework for Systematic Case Studies*. A case example from the Single Case Archive is used to demonstrate the application of the tool 'in action'. The chapter also indicates further research trajectories and some of the limitations in using the tool. The chapter should be seen as an introductory piece to what will (hopefully) flourish as an ongoing, long–term project beyond this PhD thesis. The chapter is positioned at an intersection of systematic psychotherapy research and practice–based evidence; as such, it is aimed at practitioner–researchers in psychotherapy who are interested in critically appraising case study findings.

Finally, **Chapter 6** is the concluding chapter, in which I draw together all the different lines of research presented in this thesis, discuss limitations of the current work, and outline future perspectives for the case study method in psychoanalysis and psychotherapy.

Chapter 2: Learning from Past Practices: An Overview of Criticisms for Psychoanalytic Case Studies

Abstract

Since Freud, psychoanalytic case studies have been scrutinised as irredeemably subjective anecdotal reports. This paper explores criticisms at three different levels: *suggestive influence and scientific judgment* (case study as a form of classification and judgment); *(counter)transference as a 'problem child'* (case narrative as an emotionally biased communication); *validation* (case study as an anecdotal report with non–generalisable findings). In exploring these different criticisms, the paper also considers two historical reactions toward the genre of psychoanalytic case study and the practice of case writing. The first response is from the scientific community, which prioritised context–independent and generalisable research. The second is from the psychoanalytic community, which has been described as insular and unresponsive toward sceptics. By bringing these criticisms and responses together, the paper seeks to provide a snapshot of how case studies survived the sceptics, and what past lessons can be learnt in developing the case study method further.

Keywords: *Psychoanalytic case study; Clinical case study; Freud; Transference; Generalisability; Research pragmatism*

2.1 Introduction

Through Freud's psychoanalytic *oeuvre*, the case study genre underwent a transformation from a medical case file to a psychological case narrative (Willemsen et al., 2017). In his now classic five long case studies – Dora (1905), the Rat Man (1909a), Little Hans (1909b), Schreber (1911) and the Wolf Man (1918) – Freud was interested in much more than just making diagnostic observations about his patients (whether they were patients in his clinical practice or patients 'via proxy', such as Schreiber's autobiography or Little Hans' analysis through Hans' father's notes); he also sought to trace *how* these patients developed their symptoms.

Consequently, psychoanalytic case studies became home to mental phenomena that are difficult or impossible to study in a decontextualized manner. Detailed and intricate case narratives allow clinicians to gain an in–depth understanding of specific mental experiences across concrete clinical populations (McLeod & Balamoutsou, 1996). This understanding is achieved due in no small part to therapist's interpretations and reasoning processes in unique clinical scenarios: "Our tacit knowledge of psychotherapy derives from *personal experience* with people generally and from formal practice and supervision but also from others' verbally reported experience" (Stiles, 1995, p. 126). In other words, the psychoanalytic case study seeks to reveal the subjective experience of the patient's psyche as well as the interpretive and relational work carried out by the therapist.

But psychological experiences and their representation in psychoanalytic case studies soon fell under pressing scrutiny. Scepticism about the irredeemably subjective nature of case studies can be observed at several different (yet interrelated) levels, of which this paper will explore: *issues of suggestive influence and scientific judgment*

(psychoanalytic case narratives as forms of classification, judgment, and correction between the psychoanalytic expert and the passive patient); *(counter)transference as a 'problem child'* (psychoanalytic case narratives as inherently flawed modes of communication due to emotional bias in therapeutic relationships); *issues of validation* (case study as an unscientific anecdotal report with non–generalisable findings).

In exploring these different criticisms and scepticisms, the paper considers two historical reactions toward the genre of psychoanalytic case study and the practice of writing psychoanalytic (and more broadly, clinical) cases. The first, and most debated, response is to move away from context–dependent knowledge of subjective experiences to the study of predictable and generalisable signs and symptoms. Historically, this response falls in line with the rise of positivism and the prioritisation of quantitative methods (Miller, 1999). More recently, a similar research prioritisation can be seen in evidence–based research and practice hierarchies (Aveline, 2005; Truijens, 2016). Since case studies do not prioritise (or, as some argue, are incapable of) producing generalisable data, they risk falling into the category of 'anecdotal reports'. This remains to be one of the most persistent issues not only for the genre of psychoanalytic case study but also for psychoanalysis as a science (Luyten et al., 2006).

The second, and perhaps less discussed, response is that of the psychoanalytic community itself. Although it is tempting to argue that the decline of the case study method occurred due to a broader shift in scientific research priorities, some argue that the psychoanalytic community was all too quiet in its response to the sceptics. Kline and Sonnenberg (2001) assert that many psychoanalysts chose to respond to scepticism about their discipline and methods with a scepticism of their own: "no one ever thought that psychoanalysis was a science anyway—it's [just] an art" or "case histories were never meant to be evidence for the theory, they're just instructive parables of technique"

(p. 241) as examples. Furthermore, in an article titled *The Impending Death of Psychoanalysis* (2001), Bornstein controversially states that "psychoanalysis is dying, and maybe it should" (p. 3). For Bornstein, psychoanalysis committed too many self–destructive behaviours, some of which are specific to the attitudes of psychoanalytic researchers and clinicians: indifference, inefficiency, and insolence. The key to saving psychoanalysis, according to Bornstein, is to save it from the psychoanalysts.

By reviewing the different sceptical accounts and responses to them, this paper seeks to explicate a few concrete historical strands that contributed to the problematic status of psychoanalytic case studies. The paper does not seek to resolve or respond to all sceptics and critics; rather, it seeks to draw on divergent theoretical accounts and perspectives to point out both misunderstandings amongst sceptics as well as genuine methodological shortcomings in the case study method. Particular attention is drawn to transference and countertransference issues, the process of generalisation, and the significance of research pragmatism in clinical research. Although the paper looks back at historical trends and developments, it also provides considerations on how the case study method has developed since Freud (and subsequently, how these developments address criticisms aimed at Freud's classic case studies), and how it can move forward.

2.2 The 'irredeemable' subjectivity of psychoanalytic case studies

Early criticisms by philosophers of science Popper (1959) and Grünbaum (1984, 1988) stressed that psychoanalytic case studies fail to meet the criteria for good scientific evidence. Case study data was deemed untested and selective, leading to biased confirmations of the analyst's theoretical expectations (Luyten et al., 2006). More recently, psychologist Frank Sulloway argued that Freud's case studies were no more

than a powerful rhetoric set to develop ritualistic functions amongst Freud's followers. Sulloway labelled Freud's cases as "dramatic showpieces of the healing powers of psychoanalysis […] and of Freud's own brilliance as an investigator and physician" (Sulloway, 1991, p. 271–272).

These and similar criticisms are not simply suggesting that there is room for improvement. Rather, they seek to show that psychoanalytic case studies are inherently flawed and irredeemably subjective. As a result, many of these critical accounts call for alternative, systematic modes of research, that would ultimately replace the genre of psychoanalytic case studies. In the next three sections, I will review some of the most persistent issues in psychoanalytic case studies as they emerge in classic and contemporary writing.

Whilst much of the psychoanalytic literature has focused on responding to criticisms and misunderstandings that are specific to Freud's work, this paper aims to show which criticisms are still pertinent to contemporary case studies, and which criticisms are less relevant to post–Freudian case studies due to recent developments in case study research and methodology. The paper considers how recent psychotherapy and social science research informs the practice of writing psychoanalytic and clinical case studies.

For purposes of clarity, the paper refers to two kinds of case studies: classic psychoanalytic cases (most notably Freud's five long case studies) and contemporary clinical case studies (which feature therapist narrative reports but may also include other forms of data such as (semi–)structured assessments, questionnaires, interviews, etc.). The term 'practitioner–researcher' is used to describe the special status held by analysts and therapists who are simultaneously producing research about their clinical practice.

The term 'analyst' is used to refer to psychoanalytic clinical practice and research, whilst the term 'therapist' denotes a wider relevance to the field of psychotherapy.

2.2.1 (Counter)transference as a 'problem child'

Freud (1912) defined transference process as the *sine qua non* of analytic treatment: the patient engages with the analyst not only as a helper and advisor, but also as an unconscious reincarnation of some past figure (usually a parent or a lover). The patient transfers some of the feelings or reactions from the prototype figure onto the analyst; these feelings are often highly charged emotionally, verge from expression and repression, and contain positive, negative and/or ambivalent reactions toward the analyst and the analytic relationship (Saul, 1962). In return, the analyst is able to access the patient's life history by re–experiencing their past relationships in a way that goes beyond patient's own narrative (i.e., instead of reporting it, the patient *acts it out*).

Although the concept of transference has been central to psychoanalysis and psychoanalytic treatment (Freud, 1901/1905, 1912, 1915, 1937a), it has been used widely in all psychotherapy orientations. Furthermore, transference feelings, reactions and patterns are some of the most frequently discussed topics in psychoanalytic and clinical case studies.

And yet, transference is also thought of as a 'problem child'. The idea of an analyst becoming involved personally and emotionally with a patient naturally distances any clinical interpretation from being objective and bias free data. Furthermore, there is a concern that transference and countertransference exchanges may lead to a trespassing of boundaries in therapeutic relationships. Freud acknowledges this by stating that, when mishandled, transference may be a "source of serious dangers" (Freud, 1940/1949, p.

175). In contemporary literature, Gabbard (1995) describes the paradox of the analytic situation: the analyst who functions as a clinical authority on the basis of their expertise, training, and experience, generates a cure (an interpretation) in the face of most sensual and fundamental human emotions arising in positive and negative transference processes. As such, it is impossible to write off the emotional complexity of transference (and subsequently, the emotionally taxing nature of the analytic encounter) despite its clinical (or as some may say scientific) task.

This emotional complexity can be seen in many psychoanalytic and clinical case studies. Freud's case of Dora (1901/1905) exemplifies the intricate challenge of, on one hand, acknowledging and responding to patient's transference, and on the other, producing an interpretation. Freud agreed with Dora in that her experiences of sexual abuse led to a hysterical disorder. At the same time, however, Freud also maintained that Dora's hysteria is an expression of a forbidden wish. That is, Freud interpreted that Dora had repressed sexual impulses towards her perpetrator, Herr K., as well as her father and Freud himself. As her analyst, Freud contended – to Dora *and* the psychoanalytic community – that Dora's "no" signified "yes", all whilst being aware of Dora's personal history, abuse and family circumstances (Renn, 2007). This had a severe impact on the therapeutic relationship: after 11 weeks, Dora left the treatment.

The case of Dora has been dubbed as an exemplary case of mishandled transference. Mahony (1996) described it as:

> …one of the greatest psychotherapeutic disasters; one of the most remarkable exhibitions of a clinician's published rejection of his patient; spectacular, though tragic, sexual abuse of a young girl, and her own analyst's published exoneration of that abuse; an eminent case of forced associations, forced remembering, and

> perhaps several forced dreams, forced remembering of dreams, even forced remembering of forced dreams (p. 148–149).

The scientific validity of Freud's conclusions in the case of Dora have also been contested for several reasons. First, there is the issue of Freud prioritising the advancement of psychoanalysis over genuine engagement with his patient's emotional crisis and trauma. Modern reviews point out Freud's lack of engagement in building a therapeutic alliance with Dora (Greenson, 1967; Dickes, 1975). Indeed, Freud acknowledged that he failed to facilitate a productive therapeutic relationship with his patient, stating that he was "anxious to subject [his] assumptions to a rigorous test" (Freud, 1905, p. 31).

Second, speculations about Freud's research bias remind us that the original title for the case was *Dreams and Hysteria* – Freud had a clearly set out ambition to write up a case study that would confirm his theory and hypotheses about hysteria, potentially at the cost of an objective interpretation (Mitchell, 1993).

Finally, and perhaps owing to many of the aforementioned issues, Freud failed to acknowledge his own countertransference feelings: "Owing to the readiness with which Dora put one part of the pathogenic material at my disposal during the treatment, I neglected the precaution of looking out for the first sign of transference" (Freud, 1905, p. 118). Collectively, these issues demonstrate what McLeod (2010) called "profound limitations of the traditional clinical case study method" (p. 4): unacknowledged transference and countertransference issues leading to various forms of bias that prevent case studies from being regarded as reliable forms of evidence.

Difficulties associated with describing and documenting transference and countertransference phenomena are not exclusive to Freud's work. In a paper called *Love in the Countertransference: Controversies and Questions* (2003), Rabin argues that much

of the post–Freudian psychoanalytic literature remains concerned with the classic 'patients falling in love with their analysts' narrative (Rapaport, 1959; Menninger, 1958). The analyst's feelings, on the other hand, remain largely a taboo subject. Experience–near terms such as 'love' are usually masked by technical terms such as 'libidinal' or 'countertransferential reaction'. It took at least a few decades for literature on 'analysts falling in love with their patients' to emerge (Gabbard & Lester, 1995). This is unsurprising: while many analysts might feel discomfort about caring and potentially loving their patients (Coen, 1994), *revealing* these feelings to patients and the psychoanalytic community may sabotage the credibility of their clinical work, professional status and personal life. Indeed, this may have been a significant reason behind Freud's choice to not disclose his countertransference feelings in the case of Dora (1901/1905) or to denounce his role as an acting analyst altogether in the case of Little Hans (1909).

Rabin (2003) refers to three of his own clinical cases to illustrate the challenges of countertransference feelings. In one of the clinical vignettes, he provides a rather transparent account of how he fell in love with a female patient 'Louis', and the kinds of personal and professional doubts this led him to (Rabin, 2003):

> I began to feel strong loving and sexual feelings toward Lois. I imagined us very happily married, taking long walks, laughing together, sharing intimate thoughts, and even raising a family. *This shocked me and scared me to death*. So, I became deeply involved with self–analysis and discussed these issues with my peer supervision group. Was my sexual and love life with my wife poor or mediocre? Did I have a history of sexual exploitation or unfaithfulness with women? Was this patient being especially seductive? My peers and I, with careful deliberation over

> a period of weeks, could not answer affirmatively to any of these questions. But with my powerful feelings still worrying me, I wondered: *Could I really keep my head about me and continue this effective treatment? On both ethical and clinical grounds, should I consider referring Lois to another analyst?* (p. 680)

In a more recent paper, Sharma and Fowler (2016) consider how unexamined countertransferential reactions impact clinical interpretations and create ruptures in therapeutic relationships. In one of the clinical vignettes, Sharma (the therapist) was working with a female patient 'Jenny' who deeply wished to be liked by Sharma and her colleagues. However, Jenny seemed to treat most of her interactions as battles in which desire for affection was often mixed with hostility and defensiveness due to anticipated rejection. As a result, Sharma found it difficult to own up to her own countertransference feelings of hostility and anxiety, which can be seen in the case interpretations (Sharma & Fowler, 2016):

> I experienced dealings with Jenny as extremely challenging and exhausting, an experience shared among the other members of the staff. The main dynamic seemed to be that of her feeling under attack, or attacking the staff. To my extreme frustration, *I found myself pulled into this dynamic*. *Encounters with her left me feeling disappointed, defeated, and defensive*. I experienced her as needy but extremely difficult to comfort and satisfy. Her response to my attempts to help felt rejecting and brought up feelings of inadequacy and incompetence, which I countered by irritation and impatience toward her, instead of acknowledging my limits. She felt unheard and demanded more time and attention. I tended to withdraw in order to escape her [demands] and she experienced me as depriving.

> Faced with the mounting feeling of being defeated and failing Jenny, I turned to my colleagues, but remained unable to successfully navigate the cyclical relational pattern playing out between the two of us. Slowly and gradually, I began to feel wary of Jenny and started to avoid interacting with the outside of the scheduled meetings (p. 303).

The above cases by Rabin (2003) and Sharma and Fowler (2016) demonstrate challenges that can also be observed in Freud's classic case studies. Practitioner–researchers, of all times and of all clinical orientations, straddle two difficult sides: one in which they provide treatment to patients (and as such, engage with their subjective experiences through the analytic encounter), and another, in which they document treatment processes, many of which will ultimately involve not only patients but also therapists. As Hinshelwood (2019) puts it, the subjective patient data unique to psychoanalytic and clinical cases can only be gained by "using a subjective instrument of observation; that is, *the mind of the analyst*" (p. 108). The obvious difficulty is that using our mind as an instrument can lead to severe bias and disacknowledgement of one's own countertransference feelings.

Differently from Freud's case of Dora (1901/1905), however, Rabin (2003) and Sharma and Fowler's (2016) cases not only identify (counter)transference phenomena but also explicitly engage with the issues that arise from them. That is to say, their cases are not positioned exclusively at a *cognitive* level of thoughts and beliefs; they also demonstrate the underlying *emotions* and *feelings* behind complex clinical situations and dialogues with patients. This indicates a degree of reflexivity on behalf of the clinician that some find lacking in Freud's classic case studies and clinical writing (Sulloway, 1991).

A high degree of reflexivity and transparency about therapeutic processes enables the reader to understand *how it might have felt* to be in the session with patients in concrete clinical situations. Rabin's (2003) case involved personal feelings of love and sexual desire that he identified to be inappropriate and potentially harmful for patient's therapeutic progress. Sharma and Fowler's (2016) case involved difficulties in examining and working through Sharma's countertransference reactions of hostility and hatred. There is no doubt that the degree of reflexivity exercised in such narratives can be difficult to achieve due to reservations around exposure, particularly when it comes to describing professional doubts, feelings of inadequacy or clinical malpractice. Rabin (2003), for example, noted that "in writing this article, [he] struggled with what and how much of [his] own subjectivity [he] could reveal to the analytic public and still feel comfortable enough with my exposure" (p. 678).

An in–depth case narrative *should* expose something private not just about patients but also about their therapists. By documenting their own subjective experiences, particularly countertransference feelings, practitioner–researchers are more likely to develop robust and reflexive case narratives that are more closely attuned to clinical situations 'in real life' (Willemsen et al., 2017). This allows other therapists working with similar clinical situations identify techniques and theories that may be relevant to their practice. Furthermore, a high degree of reflexivity can help practitioner–researchers process difficult feelings *post hoc*, days or years after therapeutic work has taken place. Rabin (2003), for instance, reflected on his feelings for 'Louis' 30 years after his therapeutic work with her; this time frame likely provided for a very different reflection on Rabin's feelings and attitudes.

In a somewhat similar way, Freud revisited his work on hysteria three weeks after publishing *The Aetiology of Hysteria* (1896) in a much–cited letter to Wilhelm Fliess: "Let

me tell you straight away the great secret which has been slowly dawning on me in recent months. *I no longer believe in my neurotica"* (Freud, 1950, p. 215–216). At this time, Freud began to doubt whether hysteria derived from real occurrences of sexual abuse. Increasingly, he considered hysterical symptoms as derivatives of unconscious wishes and phantasies. The insistence on unconscious, phantasised sexual motivations can be undoubtedly seen in Dora's case. But the scientific doubt that Freud was able to profess in *private letters* to Fliess was crudely lacking in Dora's treatment and case narrative dedicated to the *psychoanalytic scientific community*. As Kahane (1985) argues, Freud confidently constructed a narrative of Dora's compulsory sexuality whilst, ironically, excluding himself – along with his scientific doubts and countertransference feelings – from the case entirely. The lack of transparency on Freud's behalf had immense repercussions on the scientific reputation of psychoanalytic case studies (Pletsch, 1982).

2.2.2 Issues of suggestive influence and scientific judgment

Psychoanalytic case studies have also been criticised as dichotomous narratives that classify and define patients, which in turn allows the practitioner–researcher to correct or modify behaviour and attitudes that are deemed pathological. This criticism emphasises issues around the processes of *scientific judgment* and *suggestibility*: as the subject of a case narrative produced by the expert figure (e.g., the analyst), the patient becomes de–individuated, understood via subject–specific criteria (e.g., symptom criteria associated with the experience of neuroses) prescribed to him or her by the clinical discourse (e.g., psychoanalytic theory).

The danger is that the expert narrative can be inaccurate, reductive or flat out incorrect; that there may be a genuine disparity between the patient's psychic reality and

the case narrative. In this sense, case study data can be 'contaminated' not just by unacknowledged countertransference reactions but also by overconfident or suggestive expert assumptions about the patient's subjective experiences (and there is no reason to assume that the two issues cannot overlap) (Hanly & Hanly, 2001).

According to sociologist Nikolas Rose (1990), this criticism is not exclusive to the psychoanalytic case study; rather, it encompasses the entire field of psychology. 'Psy' sciences – sciences that focus on the theory and treatment of the human mind – hold different yet overlapping promises on how the 'self' can be changed, and which rationalities and techniques can be utilised for this: "On the territory of the therapeutic, the conduct of everyday existence is recast as a series of manageable problems to be understood and resolved by technical adjustment in relation to the norm of the autonomous self aspiring to self-possession and happiness" (Rose, 1990, p. 11).

At the same time, Rose reminds us that 'psy' sciences claim to generate truthful knowledge about the subject's 'self'. Thus, there is an uncomfortable juxtaposition between the claim to cure and 'make better' and the claim to understand the psyche 'as is': "The healthy self is to be 'free to choose'. But in embracing such an ethic of psychological health construed in terms of autonomy we are condemned to make a project out of our own identity and we have become bound to the powers of expertise" (*ibid*, p. 13).

The latter issue is central to Michel Foucault's body of philosophical work. Foucault acknowledged that, unlike psychiatry, psychoanalysis played a different part in the way it conceptualises and treats pathology. While psychiatry focused on the biological assessment of intelligence, race, gender, and sexuality, psychoanalysis rejected essentialist biologism (Foucault, 1979). Freud, for instance, challenged Charcot's biologistic formulation of hysteria; appearance and visually observable signs were

deemed to be insufficient markers for mental pathology (Cartwright, 1995). By focusing on *listening* to the patient (instead of simply *observing* and *seeing*), psychoanalysis effectively moved away from empirical proof based on visual observation (Gilman, 1988). This is also evident in psychoanalytic case studies: they do not focus on physically observable signs and symptoms (as in early medical case files) but instead rely on verbal exchanges and subjective experiences.

Nonetheless, Foucault maintained that psychoanalysis played a critical role in outlining psychic deviations and anomalies as well as developing the psychological practices that allow for their management and correction. During an interview with the editorial collective of *Quel Corps?*, Foucault (1975) stated that "[Freud] was aware of the superior strength of his position on the matter of normalisation. So why this sacralising modesty that insists on denying that psychoanalysis has anything to do with normalisation?" Foucault criticised psychoanalysis as a *discipline that 'disciplines'* through its 'confessional' nature, and in particular, its evaluative method – the psychoanalytic case study.

The processes of normalisation and scientific judgment re–emerge in Foucault's definition of the psychoanalytic case study *vis à vis* case studies in jurisprudence and law (Foucault, 1979):

> The case is no longer, as in casuistry or jurisprudence, a set of circumstances defining an act and capable of modifying the application of a rule*;* it is the individual as he may be *described, judged, measured, compared with others,* in his very individuality*;* and it is also the individual who has to be *trained* or *corrected, classified, normalized, excluded,* etc*.* (p. 203).

The psychoanalytic case turns the individual into a "describable, analysable object"; instead of reducing the patient into naturalistic and concrete biological categories as in psychiatry, however, it maintains the "individual features, particular evolution, aptitudes or abilities under the gaze of a permanent corpus of knowledge" (Foucault, 1979, p. 190).

Foucault argues that the psychoanalytic 'corpus of knowledge', used by psychoanalytic experts (clinicians, practitioners, therapists) in case narratives, is not free from socio–political and epistemological influences, and it can go wrong. We do not have to go all the way back to Freud's classic psychoanalytic cases to see how theoretical assumptions and unacknowledged countertransference dynamics may impact the way in which patients' pathologies are described and 'corrected'. Contemporary psychotherapy research points out ongoing issues in conceptualising and diagnosing patients' experiences, which often leads to incorrect therapeutic applications and further patient distress (Ruggero et al., 2010). Newspapers regularly report on 'misunderstandings' between practitioners and patients in mental health (Devlin & Smith, 2009). There is a general awareness that the expert 'corpus of knowledge' is not infallible.

This fallibility, however, can become incredibly difficult to identify in the privacy of psychoanalytic (or therapeutic more broadly) treatment or within the asymmetrical relationship between the case study researcher and case subject. After all, psychoanalytic case studies are not just neutral documentaries of patient experiences or, as Foucault put it, "madness at the level of its language" (1961, p. 198); they also retain the 'doctor–patient', 'expert–subject' division within the linguistic landscape of the case narrative. The case author is "an unreachable Judge" (Whitebook, 2006, p. 323) who uses the case narrative to ascribe (whether consciously or unconsciously) scientific, moralistic, and personal assumptions onto the patient.

Furthermore, the patient may become convinced by the expert psychoanalyst's narrative. Grünbaum notoriously called this *suggestibility*: the patient is at risk of becoming an 'ideological disciple' of psychoanalytic psychotherapy, succumbing to 'proselytizing suggestion' (Grünbaum, 1984, p. 130).

For psychoanalytic case studies, scientific judgment and suggestibility pose two problems at once: the practitioner–researcher has *linguistic leverage* over the patient (e.g., by describing, judging, and comparing the patient with others in the case narrative as per Foucault's criticism) as well as *epistemic leverage* (e.g., by suggesting false or self–confirming theories and techniques and indoctrinating patients as per Grünbaum's criticism). Both criticism deem the case study method as incapable of producing reliable data 'from the couch'.

Sulloway's (1991) criticism seemingly hit the final nail in the coffin for case studies. Following Grünbaum's footsteps, he proposed that Freud's psychoanalytic narratives are exemplary of suggestibility. Patients like Dora (1905) and Little Hans (1909b) were, according to Sulloway, epistemically bombarded by Freud's hypotheses about hysteria and Oedipus complex in order to "get the case history to come out in a *psychoanalytically correct* fashion" (Sulloway, 1991, p. 252).

The case of Schreber (1911), on the other hand, removes the necessity to enforce psychoanalytic concepts onto the patient altogether; Freud has never met Schreber and conducted the case on the basis of a published memoir. Sulloway contends that the linguistic leverage in Schreber's case allowed Freud to disregard important information about Schreber's father, Moritz, which conflicted with his theory of paranoia: "Why Freud suppressed information about the father becomes clear from Zvi Lothane's reappraisal of the evidence for Schreber as a homosexual. Freud was anxious to show that paranoia originated in repressed homosexuality, which in Schreber's instance was supposedly a

repressed homosexual attachment to the father" (p. 253–254). Although Freud described Moritz Schreber as "an excellent father" (Freud, 1910b, p. 215) in the published Schreber case, in a letter written to Ferenczi he revealed that Schreber's father was in fact a "despot in his household" (Freud, 1910b, p. 78). Once again, there is a discrepancy between what is revealed to scientific colleagues in private communications and published case studies aimed at psychoanalytic and medical communities.

Accusations of suggestion and scientific judgment remain pressing for post–Freudian therapists and case study researchers. But these criticisms have also enabled lasting changes in the way psychoanalytic and clinical case studies are formulated. One immediate difference is the presentation and amount of interpretive material in contemporary case studies. Published case studies (e.g., in *Clinical Case Studies* and *Pragmatic Case Studies in Psychotherapy* journals*)* generally feature the following components: theoretical and research basis for treatment, case introduction, presenting complaints, patient history and assessment, case conceptualisation, outcomes, follow–up, recommendations to clinicians and researchers, etc. Explicit clinical interpretations are usually included in case conceptualisation and assessment components, with clear differentiation from other case components. The interpretation to data ratio in contemporary case studies is a stark contrast to classic Freudian cases, which, although detailed in patient and treatment descriptions, focused largely on Freud's theoretical expositions and the novelty of psychoanalytic treatment (Sealey, 2011).

Where possible, case studies are also accompanied with raw data in the form of transcripts, case notes, audio and/or video recordings (Cutts, 2012). Although the ethics of using recorded material from clinical sessions are still debated, this material seeks to counter the issue of narrative smoothing (Spence, 2001) by which analysts may eliminate contradictory evidence. These developments should be acknowledged when reviewing

criticisms posed by Grünbaum, Foucault and others who focused predominantly on Freud's work.

In addition, increasing efforts have been made in researching treatment failures and the nature of therapeutic relationships, two aspects that both Sulloway (1991) and Grünbaum (1988) found to be lacking in classic psychoanalytic case studies. For example, Bowie et al. (2016) provide important qualitative observations about cases in which patients found it difficult to communicate their dissatisfaction about therapeutic progress to expert therapists. A sample of 10 participants who engaged in different forms of psychotherapy (psychodynamic, person–centred, bodywork and integrative) reported instances in which they felt abandoned, unseen, distressed, and unimportant to their therapists: "The theme of destructive use of therapist power runs through many client accounts of experiences of having been harmed or damaged by therapy. [...] [Some] participants used the term 'shell shocked' to describe the point when they realised that they knew that therapy was not helping" (p. 80, 83). The study legitimises the previously discussed concerns about narrative construction, patient de–individuation, and suggestibility.

In response to these issues, case studies should provide transparent narratives that attend to both therapist and patient experiences, including experiences of therapeutic failure, rejection, and malpractice. Recommendations for presenting patient experiences, therapist interpretations, interpretive heuristics and reflexivity can be found in Willemsen et al.'s (2017) guidelines for psychoanalytic case studies.

It is also worth pointing out the difference between *abuse* of therapeutic power (which is implied in Foucault's scientific judgment and Grünbaum suggestion) and genuine *professional errors* (Tasca & Mcquiad, 2016). Although Bowie et al.'s (2016)

study reports patient experiences with disengaged therapists, it is not always clear whether this disengagement is a result of therapeutic abuse or a professional error.

In another study, Rabu and McLeod (2017) explored how therapeutic relationships are experienced by senior practitioner–researchers in Norway. Their research findings provide a different perspective to Grünbaum's criticism about patients' compliance to clinical treatment via analytic suggestion. Most senior therapists reported frequent feelings of struggle and humility rather than feelings of suggestive power. Beyond this, therapists reported difficulties in applying therapeutic concepts in clinical practice and maintaining clear boundaries between professional and personal lives (Rabu & McLeod, 2017):

> The most difficult cases, and patients with very early, deep injuries, in cases where it also appeared a very strong negative transference that I struggled to handle, and have needed help from colleagues to deal with [are those] I feel I have learned much from. Perhaps they have taught me [….] that one must have both a space for oneself and a space for the patient [….] with this kind of patients; they live within you… I think one important aspect is to have an inner boundary and to keep an inner space for oneself (p. 9).

The study found that collaboration, trustworthiness and real engagement with patients are considered to be the key criteria for the development of a safe therapeutic space by therapists. This is important as it demonstrates the vital role played by patients in treatment, something that is scarcely acknowledged by Grünbaum: "Much more is happening in the [patient] than meets the eye. Grünbaum's account of suggestion pictures

[patients] as passive victims of the suggestive influences of psychoanalysts, and suggestion as an insidious and undetectable force" (Jopling, 2008, p. 212).

Finally, the analyst's influence, as Jopling further suggests, can be very far from that of suggestion or scientific judgment. Indeed, case studies from various psychotherapy orientations have documented instances where patients disengaged from therapeutic process or rejected therapist techniques altogether (see for example, Strupp, 1990; Bugatti & Boswell, 2016). It is therefore crucial to consider how different patients – and therapists – may experience issues of scientific judgment, suggestion and narrative construction *beyond* the scenarios laid out by Foucault, Grünbaum, Sulloway and others, where patients are implicitly defined as passive recipients of psychoanalytic treatment.

2.2.3 Issues of validation

The last and most persistent criticism against case studies is that they generate anecdotal reports rather than actual clinical evidence. This criticism emphasises the context–based component of psychoanalytic case studies: the case researcher seeks to understand patient experiences within the social and cultural context of their world. In turn, the case narrative involves what might be called a *meta–subjectivity:* the case researcher documents how patients understand, interpret, and construct the meaning of their own life experiences (via dialogue and self–report measures), whilst also presenting their own understanding of the said experiences as clinical practitioners and researchers (via interpretations, inferences, clinical techniques and interventions) (Hanly, 1996).

But the historicity of human nature and the context it finds itself embedded in, once so valued by anthropologists, sociologists, and psychoanalysts alike, has been slowly pushed away due to the lack of generalisability. Since case studies provide detailed,

context–dependent knowledge of individuals (or small samples), it is difficult to decontextualise and specify which data variables can be generalised onto which populations: "One can validly explain a particular case only on the basis of general hypotheses. All the rest is uncontrollable, and so of no use" (Dogan & Pelassy, 1990, p. 121). This shortfall is considered to be a scientific dead–end by many researchers: "If there is no generalizing beyond the data, no theory. No theory, no insight. And if no insight, why do research?" (Mintzberg, 2005, p. 10).

The concept of generalisation can be traced back to the British philosopher John Stuart Mill who insisted on discovering the "uniformity in nature" (Mill, 1843/1988, p. 386), thus creating a long–lasting standard for successful scientific research. A 'good' science is that which is capable of producing "increasingly successful prediction and control of the environment" (Hesse, 1980, p. 188). As a result, base predictions and controlling actions became part and parcel of research in both natural and social sciences. The end result is knowledge that is context free and of enduring value, applicable to each and all of a class or order (Lincoln & Guba, 2000), and conveying "real" knowledge about natural phenomena, a conception of "something which really is in the facts" (Mill, 1843/1988, p. 651). It is argued that knowledge of this kind can be found in statistical data, such as randomised controlled trials (RCTs), meta–analytic and systematic reviews.

The ability to generalise knowledge has become equivalent with the ability to validate knowledge. Through *internal validity* researchers can measure the degree to which populations, settings, treatment and measurement variables can be generalised (Campbell & Stanley, 1966). *Replicability* is at the heart of internal validity: "Would the results be reproducible in those target instances to which one intends to generalize – the population, situation, time, treatment form or format, measures, study designs and procedures?" (Krathwohl, 1985, p. 123). Since case studies (arguably) feature neither of

these components, positivist critics argued that case study findings cannot be validated (Janis in Wallerstein & Sampson, 1971). Several critics have accused Freud of pseudo–science in his case studies on the grounds of generalisability and replicability as key scientific standards (Eysenck & Wilson, 1973; Wolpe, 1981).

As of recently, however, there have been significant re–evaluations of just how generalisable research findings can be. One reason for this is the so called 'generalisability crisis' in the human sciences and, most notoriously, psychology: generalisations drawn from isolated or decontextualised studies are difficult, if not impossible, to apply in real–life situations or even situations with similar (yet not identical) variables. For example, Yarkoni (2019) argues that generalisations in psychology research are often formed too fast and are (wrongfully) conceptualised as near–universal:

> I think it's readily apparent that the vast majority of psychological scientists have long operated under a regime of (extremely) fast generalization. One has only to scan the table of contents of our journals to observe paper titles such as "Local Competition Amplifies the Corrosive Effects of Inequality", "The Intent to Persuade Transforms Language via Emotionality", and "Inspiration Encourages Belief in God". Such claims are typically supported by a small number of experiments conducted under narrow conditions, with virtually no discussion of the presumed boundary conditions of the effect. The assumption appears to be that a phenomenon demonstrated once (or twice, or five times) under very narrow conditions can be expected to hold in general, pending new evidence to the contrary (p. 2).

These concerns are not new to the fields of psychoanalysis, psychotherapy, counselling, social care, etc. Clinicians often struggle to make use of large–scale findings in practice

(Shean, 2014). Randomly selected samples are difficult to apply to particular individuals and their unique situations; as such, clinicians will always be required to determine whether research generalisations apply to their patients, sometimes having to abandon generalisations altogether (Donmoyer, 2000).

It is perhaps unsurprising, then, that despite the shift toward generalisable scientific research, clinical practitioners prefer reading and learning from case studies rather than statistics or RCTs (Miller, 2004; Stewart & Chambless, 2007; Safran et al., 2011). This is because case studies *particularise* different clinical scenarios and show the use various clinical approaches and techniques. Through systematised case study archives such as The Single Case Archive (https://singlecasearchive.com/), clinicians can search for cases that are highly relevant to their particular clinical model or patient population.

The newly re–invigorated interest in psychoanalytic and clinical case studies shows that generalisation is not a be–all and end–all criterion in scientific research. According to Mackrill and Iwakabe (2013), reading detailed and intricate case studies has a cardinal importance to clinical research and training:

Table 1. The contribution of case studies to clinical research and training in psychoanalysis/psychotherapy
(1) Offers trainee and novice clinicians access to a closed world; (2) Demonstrates the application of psychological theories 'in action'; (3) Provides practical explorations between different clinical approaches; (4) Encapsulates significant therapeutic moments, including therapeutic relationships, outcomes, follow–ups, as well as mishandled therapeutic situations and instances of therapeutic failure.

From Macrill and Iwakabe's (2013) point of view, even questionable or rigour lacking cases can be thought of as exemplary of 'bad' practice or 'poor' interpretations: "Even case studies that are methodologically questionable and lack necessary research requirements can be important educational tools, for example, if used to develop critical thinking by having trainees engaged in assessing the validity of interpretations, inferences, and interventions" (p. 251).

Take, for instance, Freud's case of Dora (1901/1905): although it is frequently considered to be an exemplar case of therapeutic failure (Mahony, 1996; McLeod, 2010a), it is a case that all clinicians and researchers return to in order to learn about the significance of transference (and the consequences of unacknowledged transference).

Similarly, Freud's case of Schreber (1911) enables clinicians and researchers to critically study Freud's interpretations alongside Schreber's autobiography. Different and contrasting perspectives about Schreber's symptoms and condition have emerged since (Schatzman, 1973; Lothane, 1992). The detailed analysis of a single case can help case study researchers and clinicians compare and assess interpretations, inferences and interventions with scrutiny; this is particularly important when combating insular attitudes in scientific communities and knowledge generation methods (Bornstein, 2005).

A contemporary example featuring contrasting approaches to a single case study is Dumont and Corsini's book *Six Therapists and One Client* (2006), which demonstrates how six different therapists would approach the same case from different theoretical orientations (Ericksonian Hypnotherapy, Rational Emotive Behavior Therapy (REBT), Multimodal Therapy, Individual Psychotherapy, Person–centered Therapy, and Cognitive Behavioural Therapy (CBT)). Although the book revolves around one particular case, it

provides invaluable insight into how several different therapeutic schools work 'in action'.

Finally, there is no reason to assume that idiographic, qualitative narratives cannot exist alongside nomothetic, quantitative data. Indeed, a long–existing polarisation between quantitative and qualitative research paradigms promoted 'purist' views that exclusively focus on either 'positivist' or 'interpretivist' ways of studying the human mind (Onwuegbuzie & Leech, 2005). However, focusing exclusively on one kind of methodology and abandoning other forms of data would lead to a reductive perception of complex behavioural and mental health phenomena: "This posture ignores the fact that we are not dealing with an either/or proposition; the alternatives include more than deciding between generalizations, on the one hand, and unique, particularized knowledge, on the other" (Lincoln & Guba, 2000, p. 27). A third way approach emphasising research pragmatism is discussed later in the section '*Case studies in systematic research'*.

2.3 'What now?': responses from the sceptics

Although this paper sought to demonstrate not only the key criticisms but also the recent developments in psychoanalytic and clinical case studies and psychotherapy research, it is evident that the case study method is still considered a problematic mode of research. Currently, case studies lie at the bottom of evidence–based practice and research hierarchies dominated by systematic reviews and meta–analytic reports (Aveline, 2005). Specifically, psychoanalytic case studies fall somewhere in the bottom categories of *uncontrolled*, *descriptive*, and *expert opinion* studies. As discussed in *'Issues of validation'* section, systematic modes of research are prioritised over case studies due to their ability

to generalise research findings onto broader populations. For similar reasons, psychoanalytic case studies are rarely integrated into public health policy research (Fotaki, 2006).

Beyond these issues, there is also an overarching concern about the way in which the psychoanalytic community generates (arguably scientific) knowledge. Psychoanalysis is still seen as a reigning theoretical orthodoxy by many; case study narratives, then, are not used to illustrate the veracity and qualitative depth of patient experiences but to simply confirm pre–existing theories and hypotheses (Messer, 2007).

Although this criticism has been considered earlier against Freud's case studies (Sulloway, 1991), it must be acknowledged that a certain degree of orthodoxy has remained in post–Freudian psychoanalytic knowledge generation practices (Bornstein, 2001; Plous, 1993). This includes writing psychoanalytic case studies in a way that that does not acknowledge competing viewpoints, alternative perspectives, and different research methodologies and/or techniques. This leads to ritualistic inhibitory effects, insularity, and 'groupthink' in the field.

Below I briefly discuss two responses associated with the above issues coming from psychoanalytic and scientific research communities. Although issues surrounding (counter)transference, suggestibility, scientific judgment, and lack of generalisation have certainly contributed to the problematic status of psychoanalytic case studies, I argue that the responses to these criticisms have been equally problematic. Calls to move from context–dependent, subjective knowledge in scientific research on one hand, and scepticism toward any form of objectivity or validity in psychoanalytic communities on the other, contributed to a stagnant division between case studies and quantitative research methods more broadly (Hoffman, 2009; Fonagy, 2002, 2013; Safran, 2012).

Further suggestions and considerations are provided on what the case study method can offer for systematic *and* clinically attuned forms of research.

2.3.1 Case studies in systematic research

A basic presupposition and criterion amongst positivist proponents (Popper, 1959; Hempel, 1965) is that there is, at a general and suitably abstract level, a single kind of scientific truth that responds to the causal question '*why?*'. This question can only be tackled by models of scientific explanation that investigate objects "from the outside" (such as experiments and statistics), rather than "from the inside". The former position is unreachable for practitioner–researchers who are simultaneously involved in the therapeutic process as well as the creation of the case narrative. This difference contributed to a long–standing division and polarity between quantitative and qualitative research methods (Onwuegbuzie & Leech, 2005).

This division, however, goes beyond methodological difference. Qualitative and quantitative researchers employ entirely different thinking and reasoning processes or what Tacq (2010) calls languages. A statistician thinks, reasons and interprets data by using concepts such as *things, events, laws, causes*, and *causal explanations*. A case study researcher, on the other hand, refers to the concepts of *persons, actions, rules, reasons, motives*, and *mental explanations* (understanding). These are by no means exhaustive lists of concepts, but they point to what is considered to be at stake in qualitative and quantitative forms of research (Tacq, 2010):

> Exact measurement and generalization as opposed to being close to the data, to do no violence to the unique character of reality and its complexity, to let the persons

> involved formulate their own interpretations, to let concepts emerge during the research; further also a deductive as against an inductive approach; statistical testing as opposed to exploratory research; "testing" versus "gauging"; objective against subjective approach; searching for laws that hold for all time–periods and contexts as against looking for insights into the "here and now context" (p. 271).

It is clear, then, that there is a difference not only in the choice of method but also in research priorities more generally: quantitative methods prioritise general, objective, context–independent knowledge over subjective, practical, context–dependent knowledge (Flyvbjerg, 2005). Increasingly, significant efforts have been made to combat this research–onesidedness by demonstrating the value of context–dependent and clinically attuned forms of qualitative research (see for example, Iwakabe & Gazzola, 2009), some of which were discussed in the earlier sections about the irredeemable subjectivity of case studies.

But the pathway toward methodological pluralism – where both context–dependent and context–independent knowledge are considered on *equal grounds* – is yet to be properly paved. And, potentially, for good reason: quantitative researchers are wary about irrevocable epistemological differences (Onwuegbuzie & Leech, 2005), whilst those on the psychoanalytic territory argue that a nonobjectivist hermeneutic paradigm is best suited for psychoanalytic and clinical research (Hoffman, 2009).

Despite these difficulties, several suggestions have been put forward by researchers in the fields of psychoanalysis, psychotherapy, and social sciences on how we may tackle and think about this research polarity. First, there is the acknowledgment of subjectivity as a crucial data point rather than a research difficulty. Such experiences as trauma, abuse, fragmentation, loss, and mourning are embedded in patient's social,

cultural, and physical environments; as such, they are not context–independent and may change over time (Shean, 2014; Markova & Berrios, 2009). The articulation of patients' subjective experiences has always been important for psychoanalytic case histories: although analysand's statements are not taken at face value, the analyst is interested not only in the "realness" of these subjective experiences (in the sense of historical truth) but also in the underlying unconscious motivations to resist the truth (Brigati, 2015). Psychoanalysis continues to teach us that if we want to arrive at causal explanations, we cannot conveniently ignore the subjective – albeit messy – elements of the clinical encounter.

The second point concerns the epistemic presentation of the said subjective experiences in case studies. Wolpert, for example, argues that the epistemological claims made in case narratives are significant but often lack a coherent theoretical framework, which means that there is "nothing useful to be learned from a case report on an individual that could help other patients. Each case is essentially the relationship between an analyst and the patient" (Wolpert & Fonagy, 2009, p. 483). If case studies are to be considered part of systematic research, then they should provide the necessary theoretical framework to account for their findings.

In light of these considerations, *research pragmatism* has been suggested as a third–way solution to research polarity. Onwuegbuzie and Leech (2005) define research pragmatism as a flexible approach toward investigative techniques regardless of researchers' philosophical orientation. They argue that it is much more useful to consider quantitative and qualitative methods as *exploratory* and *confirmatory* modes of inquiry. Onwuegbuzie and Teddlie (2003) developed a model in which quantitative (descriptive statistics and cluster analysis) and qualitative (thematic and narrative analyses) are conceptualised as exploratory. Confirmatory research, on the other hand, features

quantitative data–analytical techniques (inferential statistics) and qualitative confirmatory techniques (analytic generalisation). In this way, both quantitative and qualitative forms of research are able to produce research driven (replicability of previous findings) and theory driven (testing new theories) findings. The remaining challenge is to choose which methodologies are best suited for a given research purpose (or how to combine multiple methodologies in a pragmatic manner).

Research pragmatism of this kind can be seen in psychotherapy case studies. Fishman (2000) developed the concept of a *pragmatic psychology* as an alternative to positivist epistemology: it takes place in context–dependent individual case studies, where patients' problems are described in detail along with the therapeutic mode that is being offered by the clinician. On the other hand, pragmatic psychology embraces aspects of the positivist model, such as testing hypotheses, applying them to individual situations, seeking to replicate research findings, etc. In this sense, pragmatic psychology is an epistemologically integrative approach that blends the standardised measures associated with the positivist tradition with the qualitative case formulations and descriptions. Crucially, pragmatic psychology revolves around real–life problems, and as such, it maintains the significance of concrete case studies and practice: "actual cases should be the *starting* and *ending points* of psychological research" (Fishman, 2000, p. 6).

The epistemology of pragmatism can be seen 'in action' in a case study by Truijens et al. (2019), which combines quantitative (self–report questionnaires such as The Beck Depression Inventory) with qualitative data (phenomenological and visual analysis of patient's therapeutic narrative and annotated paper–and–pencil questionnaires). By combining several different methodologies, Truijens et al. (2019) found that there are significant issues in translating patient experiences into numerical language via self–report questionnaires: "Respondents are asked to reflect on their feelings, attitudes, and

behaviors and then translate those into a quantitative language, which puts a weight and therefore an evaluation to their experiences" (p. 3). Their case study demonstrates how *(1)* phenomenological observation of patients' therapeutic narratives enrichens the treatment process and contributes to positive treatment outcome, and *(2)* how the descriptive precision of meaning–making process contributes to quantitative data analysis: "If we treat the numbers as a story and actively listen to how that story is told, it is possible to gather valid data on the nature of symptoms, the changes of symptoms, and even their development throughout psychotherapy" (p. 40). In this sense, pragmatic case studies can contribute to the advancement of both clinical and methodological techniques without losing the in–depth clinical narrative.

2.3.2 Case studies in psychoanalysis

When behavioural, biological, and cognitive perspectives grew and expanded in the field of scientific psychology, only some psychoanalytic authors wrote about how new theories and methods will impact psychoanalysis (Wachtel, 1977; Epstein, 1994). Similarly, not many psychoanalysts tackled the philosophical challenges posed to psychoanalytic causal claims or case study efficacy (for a review of these issues, see Hinshelwood, 1997): "Philosophers, so far as they took notice of psycho–analysis at all, condemned its basic concepts as muddled and self–contradictory. And analysts silently responded by dismissing philosophy" (Money–Kyrle, 1958, p. 102). Bornstein (2001) argues that unresponsiveness of this kind in psychoanalysis is a form of ritualistic 'group thinking' and a historical 'deadly sin': the sin of *indifference*.

Instead of actively engaging with the sceptics, Bornstein asserts that psychoanalysts have decided to "look backward (at seminal but dated contributions of

early psychoanalytic practitioners)" and "inward (at their like–minded colleagues' own analytic writings)" (p. 7). This created an isolated "psychoanalytic universe of ideas" (p. 9), disconnected from other disciplines and discourses. The issue, as Bornstein contends, is not about whether psychoanalytic theory and psychoanalytic case studies are 'valid' or 'systematic' enough *as they are*. Rather, the question is whether psychoanalysts are willing to *develop* their research and practice in a way that responds to new challenges and issues.

Although Bornstein's (2001) article is now nearly 20 years old, we can still see the consequences of earlier indifference amongst psychoanalytic practitioners and researchers. Psychoanalytic theory and methods have been misrepresented, oversimplified or 'written off' as dead in universities and scientific discourse. Take, for instance, the following descriptions of psychoanalysis and psychoanalytic case studies: "From a scientific point of view, classical Freudian psychoanalysis is dead both as a theory of the mind and a mode of therapy" (Kihlstrom, 1999, p. 376); "Knowledge about singular isolated objects, is found to be illusory upon analysis [...] It seems well–nigh unethical at the present time to allow, as theses or dissertations in education, case studies of this nature (i.e., involving a single group observed at one time only)" (Campbell & Stanley, 1966, 6–7).

Although these views may appear unwarranted and extreme, many authors remind us how earlier indifference amongst psychoanalytic thinkers contributed to negative perceptions about our discipline and methodology. For example, Shakow and Rapaport (1964) discuss American psychologist Saul Rosenzweig's laboratory data supporting Freud's core psychoanalytic concepts. Freud, who received the data directly from Rosenzweig, was reluctant to accept the idea of "extra–clinical" research that does

not come from the 'analytic situation' and dismissed it as an unnecessary form of research.

Moving past Freud, Turkle in her book *Psychoanalytic Politics* (1992) writes about signs of repression, schisms and hierarchy amongst psychoanalytic practitioners and researchers in the international analytic community. She notes that the development of *psychoanalysis as a science* is subverted by the essentially political nature of *psychoanalysis as an institution*, which she characterised as "a curious amalgam of [...] literary school, professional association, political party, and church" (p. 97). Similarly, knowledge generation in psychoanalysis has been notably compared to religion by Lacan (1953) who was concerned by its increasingly dogmatic functions (complete with "'mysteries,' and a pope"; Turkle, 1992, p. 126).

Beyond the issue of insularity, Bornstein (2001) pushes further by claiming that psychoanalysis has also failed to generate theoretical and clinical knowledge *efficiently,* in a way that clearly demonstrates the relevance and effectiveness of psychoanalytic treatment. This issue has an obvious implication for psychoanalytic case studies: many case studies are still read as a form of 'argument by authority', serving a long–standing dialectical tradition of psychoanalytic theory rather than documenting genuine therapeutic processes and outcomes. Indeed, Kernberg (1993) observed that authoritarianism of this kind is particularly widespread amongst younger analysts who are forced into providing inaccurate descriptions of their case histories in order to appease senior analysts' views and well–established theoretical principles.

Although we may think that case studies have been used to validate the effectiveness of psychoanalytic treatment ever since Freud, it is not clear how, if at all, they were 'measuring' or 'documenting' the effectiveness of psychoanalytic treatment

and techniques (especially since most Freud's long case studies overtly report therapeutic failures).

Kline and Sonnenberg (2001) argue that even psychoanalytic clinicians and researchers underestimate the importance of clinical narratives in empirically based research:

> Some practicing analysts ignore the controversies, sometimes with a complacent attitude of confidently superior knowledge [...]. Some analysts take a somewhat bitter comfort in theories that expressly adopt a skeptical posture about the possibility of objective knowledge, such as those that stress the coconstruction of personal narrative as the central experience of analysis (p. 242).

The above attitudes and epistemic positions are part of a longer discourse on the attainability of objective facts in the clinical realm (Gabbard, 1997). Indeed, many sceptics overlook the importance of 'researcher–as–instrument' (Morrow, 2005): the practitioner–researcher is an unapologetic participant within the analytic dyad as well as the co–construction of the case narrative. Because of this, therapeutic relationships should also be considered as radically different researcher–participant relationships from those in quantitative investigations (Eide & Kahn, 2008):

> [Psychotherapy] research requires a mutual standpoint, researcher to participant, human being to human being. We cannot query a microbe or engage in conversation with a star; however, conversation and dialog between people are among the expected processes in qualitative research, which has as the focus of

> study the actions, reactions, recollections, and meaning–making of human beings in response to their passage through life (p. 199).

Scepticism toward *any* form of objectivity or 'real' knowledge (existing outside of the co–constructed experience between the analyst and analysand), however, produced a curious and unhelpful paradox in psychoanalysis. If the clinical situation is *merely* a co–construction of different narratives and idiosyncratic experiences, then it is somewhat paradoxical that we need qualified psychoanalysts to perform them (Kline & Sonneberg, 2001):

> If psychoanalysis is nothing more than the co–construction of a narrative, or the literary interpretation of symbols, why do institutes not regard writers and literary critics as the best candidates? [...] If it is a consideration of the central values of the human life, why are not philosophers best qualified to undertake analytic training? *If there is no true knowledge acquired in the analytic process, then what happens to the intense and daily felt reality of the clinical setting?* (p. 242).

There is something to be said about how psychoanalytic practitioners work with patients *truthfully.* Which interpretations are acceptable; which ones are farfetched? What reasoning processes are being employed behind different therapeutic techniques; how do they impact each individual patient and treatment outcome? Amongst many different competing therapeutic modalities – of which psychoanalysis is just one – there remains an overarching responsibility to produce knowledge about clinical work and techniques not in an insular but an open and transparent way that is also accessible to non–psychoanalytic practitioners and researchers, social workers, patients, etc. After all,

knowledge about clinical situations in psychoanalysis is not exempt from examination, whether by psychoanalysts or those outside of our field (Cooper, 1984).

This is an opportunity to utilise the case study as a method suitable for scrutinising and developing clinical practice. Rather than treating case narratives as mere 'anecdotal reports' or 'parables', we should acknowledge the distinctive contributions they bring to empirical research. For example, whilst large–scale outcome measures such as RCTs are well suited to provide information about the effectiveness of therapeutic interventions, they may overlook specific factors that lead to variations between different patients and therapeutic modalities (McLeod & Elliott, 2011). Case studies are ideal for filling this gap: they can 'zoom in' to microscopic detail and thematically analyse differences in the application of therapeutic techniques, patient symptoms and responses, outcomes, assessment, etc. (Onwuegbuzie & Leech, 2005).

Van Nieuwenhove et al.'s (2019) case study about childhood trauma–related interpersonal patterns is a good example of how case studies can inform evidence–based research and practice. Although interpersonal features related to childhood trauma have been studied comparatively to other forms of non–interpersonal traumata, Van Nieuwenhove et al. (2019) found that there are almost no detailed, qualitative descriptions on the nature of different interpersonal patterns. This, however, is particularly crucial for therapeutic progress as therapists will need to find appropriate responses and techniques in each case of childhood trauma. The case of 'Amy' helped Van Nieuwenhove et al. (2019) identify some of the core interpersonal patterns associated with the patient's childhood trauma: non–assertiveness, neediness, domineering/controlling behaviour, frustration and inability to express herself. Drawing from attachment theory, attempts to control and manipulate others were connected with the interaction patterns experienced by 'Amy' in her relationships with primary

caregivers. Identifying these specific interpersonal patterns enabled Van Nieuwenhove et al. (2019) to determine the appropriate therapeutic format (psychodynamic psychotherapy), length (short–term) and relationship (therapist maintained neutral, acknowledging and empowering interactions) that would suit Amy's therapeutic needs. The case study demonstrates how new relational experiences can help trauma patients feel more open and self–confident within and outside the therapy room. These findings are also important in the broader context of empirical research on childhood trauma as they specify the core interpersonal issues arising from early traumatic relationships, and how these traits can be managed within the therapeutic context.

2.4 Concluding comments

By reviewing classic and contemporary criticisms, this paper sought to disentangle some of the misconceptions surrounding knowledge generation practices in psychoanalytic case studies, including:

Table 2. Common case study misconceptions
(1) Subjective experiences are obstacles to good research; (2) Practitioner–researchers in therapeutic contexts cannot have effective relationships with research participants (patients); (3) Therapeutic relationships are generally 'constructed' via suggestibility and scientific judgment; (4) Generalisation is the end–goal for all forms of clinical research.

Psychoanalytic and clinical case studies are unique in the sense that they offer a glimpse of theory 'in action': what was it like to work with patient *x* in clinical scenario *y*? Meta–

subjectivity of this kind has been crucial to Freud's classic psychoanalytic case studies, and it remains to be significant for contemporary case studies, a few of which were discussed in this paper (Dumont and Corsini, 2006; Truijens et al., 2019; Van Nieuwenhove et al. (2019). These case studies were generated by *particularising* – not generalising – significant therapeutic moments, outcomes, and exchanges with specific patients. It is therefore important that we do not discard the significance of context–dependent subjective narratives, which has happened all too often in systematic research (Berg, 2019a).

From a social science perspective, it is also important that we do not equate subjectivity with bias or research fallibility (Onwuegbuzie & Leech, 2005). On the contrary: acknowledging the complexity and variability of subjective experiences will bring us to a richer, more complicated picture of everyday clinical reality (Rabu & McLeod, 2017; Bowie at al., 2019). The complexity of different therapeutic relationships and therapist/patient attitudes is especially important when considering criticisms in which therapists and patients are ascribed specific – often binary – roles or attitudes (e.g., 'scientific judge' or 'expert' vs 'ideological disciple' or 'passive receiver') (Grünbaum, 1984, 1988; Foucault, 1979). For example, although Rabu and McLeod's (2017) study does not discredit the fact that there are problematic therapeutic relationships and case narratives, it points to a far more complicated clinical picture where expertise is often accompanied with feelings of humility and failure.

By comparing early psychoanalytic case studies to contemporary research developments in psychotherapy and social sciences, this paper shows how the case study method improved since Freud's time. Contemporary case study researchers seek to explicitly discuss countertransference reactions and issues in case narratives; clinical case studies are structured more rigorously with components that go beyond

interpretation (e.g., assessment and follow–ups); some case studies include raw data (transcripts, case notes, video recordings) to provide additional evidence; and finally, many case studies are pragmatic and utilise multiple methodologies.

However, the paper identifies several methodological shortcomings that are still relevant for contemporary case study researchers:

Table 3. Further developments for case studies in psychoanalysis and psychotherapy
(1) Providing a reflexive assessment of the therapeutic situation and (counter)transference phenomena; (2) Maintaining explicit interpretive heuristics which describe the case researcher's theoretical frame of reference; (3) Leaving room for alternative interpretations, perspectives and viewpoints; (4) Employing other methods to provide a more complex account of the clinical situation.

We need not lose the qualitatively rich narrative and the distinctive advantages of working with single cases; however, we should consider which investigative techniques will help making our research more complex, transferrable, and comprehensive. Although significant efforts are being made to 'resurrect' the case study (Willemsen et al., 2017; Meganck et al., 2017; Iwakabe & Gazzola, 2009; McLeod, 2016) there is no doubt that new methodological suggestions will create disagreements and hurdles in our field. As psychoanalytic clinicians and researchers, however, we should seek to make the case for the case study – not just by being sceptical or wary of such concepts as 'objectivity' and 'validity', but through detailed, reflexive, and clinically attuned case narratives that can fill the qualitative gaps in evidence–based research and practice. The aim of this paper is to show what we can learn from past case study practices – both good and bad – when engaging with new and recurring sceptics in the future.

Chapter 3: Epistemological Guidelines for Case Studies in Psychotherapy and Psychoanalysis

Abstract

In the fields of psychoanalysis and psychotherapy, case study researchers rarely justify their knowledge claims on formal epistemological grounds. This poses several issues to the case study method. Firstly, without articulating the standards by which our knowledge is being justified, we are potentially enabling the criticism that case studies are mere anecdotal reports and should not be treated as forms of evidence. Secondly, without the guidance of wider epistemological standards for case study research, we risk falling into somewhat arbitrary justifications of other as well as our own cases. This paper seeks to address these issues by examining and developing epistemic practices in psychoanalytic and psychotherapy case studies. Drawing from different social science resources, the paper describes three epistemological concepts appropriate for case study research: retroductive reasoning, analytic generalisation and working hypothesis. Retroductive reasoning was identified as a suitable epistemological concept for case studies that seek to trace causal powers and mechanisms in clinical practice. The case–to–theory logic in analytic generalisation is useful for researchers who wish to generalise from single case observations to theory. Working hypothesis case studies can be used when assessing and revising existing theoretical propositions by testing them in practice with specific patients. Although all three epistemological concepts are embedded in some form of rules or definitions, this information in itself was found to be insufficient from the perspective of a case study researcher wishing to apply epistemological guidelines to research. To attend to this issue, the paper seeks to develop existing rules and guidelines for each epistemological concept. Social science definitions and principles are applied in a psychotherapy and/or psychoanalytic context, and further considerations about canons of evidence are provided. Finally, the paper considers the use of multiple epistemological concepts in systematic case studies.

Keywords: *Clinical Case Studies; Systematic Case Studies; Epistemology; Retroduction; Analytic Generalisation; Working Hypothesis; Psychotherapy; Psychoanalysis*

3.1 Introduction

It is a matter of fact that case studies have contributed to knowledge generation in several fields. For example, Sigmund Freud's case of Dora (1901/1905) has become a classic in the fields of psychoanalysis and clinical psychology, where, despite its negative treatment outcome and short length, Dora's case demonstrated the clinical significance of negative transference. Another key example is Vic Meyer's (1966) case of two patients with compulsive washing rituals, which led to a breakthrough in cognitive behavioural therapy (CBT). Meyer's case introduced the method of exposure and response prevention, which revolutionised the treatment of obsessive–compulsive disorder. John Bowlby's (1952) early cases of children separated from their parents in hospitals demonstrated the effects of maternal deprivation and separation anxiety. The experiences of distress and anguish of just few children became the main theoretical drive behind attachment theory and children–in–hospital research.

Despite the significance of the above cases, literature on theory development from case study research is scarce. In fact, case study researchers rarely justify their knowledge claims on formal epistemological grounds (Easton, 2010). As a broad philosophical field, epistemology is concerned with the belief in and the justification of knowledge, and it answers to the question "*What is knowing and the known?"* (Ferrier, 1854, p. 46). Every researcher will have an implicit or explicit epistemological reasoning attached to their study, which means that epistemology is inevitably personal (Bateson, 1979). However, each individual epistemology is also part of a wider form of 'knowing' that creates overarching epistemic practices within the field of study.

In the fields of psychoanalysis and psychotherapy, case study researchers frequently use implicit forms of epistemological reasoning to arrive at their findings.

However, without articulating the standards by which our knowledge is being justified, we are potentially enabling the criticism that case studies are mere anecdotal reports and should not be treated as forms of evidence (Aveline, 2005). Furthermore, without the guidance of wider epistemological standards for case study research, we risk falling into somewhat arbitrary justifications of other as well as our own cases.

This paper seeks to address the above epistemology issues by examining and developing epistemic practices in psychoanalytic and psychotherapy case studies. Three different epistemological concepts have been identified as relevant to this discussion: *retroductive reasoning*, *analytic generalisation* and *working hypothesis*. The rationale for selecting these three epistemological concepts involved: their compatibility with research in the fields of psychotherapy and psychoanalysis; their ability to provide concrete guidelines and/or canons of evidence for case study findings; and existing psychoanalytic and psychotherapy case studies that utilise (implicitly or explicitly) these epistemological concepts to generate knowledge. The case study examples used in this paper include both clinical (narrative reports written by therapists with a focus on rich descriptions of psychotherapy processes as well as therapist interpretations) and systematic (involving researcher teams and utilising multiple sources of data, such as questionnaires, therapist observations, interviews, statistical findings, etc.) case studies (Willemsen et al., 2017). A separate section at the end of the paper considers the use of multiple epistemological concepts in systematic case studies.

Although all three epistemological concepts are embedded in some form of rules or definitions, this information in itself was found to be insufficient from the perspective of a case study researcher wishing to apply epistemological guidelines to research. To attend to this issue, this paper explicates existing rules and guidelines for each epistemological concept, clarifies how they are relevant for case study research, and

assesses conceptual and research applicability issues. Social science definitions and principles are applied in a psychotherapy and/or psychoanalytic context, and further considerations about canons of evidence are provided. By describing the epistemological diversity of case study research, this paper seeks to show that case studies can be used to develop different kinds of knowledge in a rigorous way.

3.2 Retroductive reasoning

Retroductive reasoning or retroduction is a strategy of inference originating from the philosophical approach of critical realism (CR). The aim of CR is to produce reliable knowledge about the world *as it is* by tracing phenomena to their causal (generative) powers (Bhaskar, 1977). According to social scientist Andrew Sayer (2000), retroduction is a suitable epistemological concept for this task:

> Merely knowing that 'c' has generally been followed by 'e' is not enough: we want to understand the continuous process by which 'c' produced 'e', if it did. *This mode of inference in which events are explained by postulating (and identifying) mechanisms which are capable of producing them is called 'retroduction'* (p. 207).

In order to understand the process of retroductive reasoning, it is important to outline its function within the broader CR epistemology. In the above passage, Sayer clearly differentiates between the process of retroduction and the process of generalisation: instead of producing knowledge about the frequency or regularity of phenomena, retroductive reasoning involves a move backwards from the phenomenon of interest to powers and mechanisms that generated it (Lawson, 1997).

This is a crucial difference, and one that is generally thought of as a realist criticism of the positivist account of causality. Instead of seeking to identify regularly occurring causal relations, CR assumes the existence of a world comprised of multiple complex and different structures that *do not* generate regular patterns or events. For this reason, the process of retroduction seeks to describe what causes change by outlining the powers that "produce", "generate", "create", "determine" or "enable" (Sayer, 1992, p. 104) things to happen within their context (the time and space in which they are exercised). From this point of view, retroduction is considered to be an appropriate form of reasoning for the study of complex social phenomena that involve multiple causal powers (e.g., situations and events involving relationships, discourses, identities, economic activities, kinship, etc.).

In addition, CR acknowledges that our world is largely socially constructed (i.e., we cannot think about the world independently of our ideas and beliefs of it). However, the very premise of retroductive reasoning is that we can arrive at *realistic* and *causally meaningful* interpretations to explain social phenomena. Thus, although CR shares with social constructionism scepticism about scientific descriptions and categories, it nevertheless does not assume that the study of social phenomena is yet another discursive practice in itself. Tracing the way our social and linguistic practices influence and change theories, classifications, and language is therefore part of retroductive reasoning.

Finally, retroduction is not one researcher's job: it is a *meta–process* that requires multiple researchers and studies to obtain sufficient causal explanation of one substantive phenomenon. This serves a two–fold function: firstly, it ensures that no single causal account is being accepted uncritically, and secondly, it encourages a "cut and come

again" disposition (Easton, 2010) by which researchers are able to assess and compare contrasting versions of reality.

Table 4. KEY CONCEPT: Retroductive reasoning
Retroductive reasoning is a strategy of inference that is closely associated with the philosophical approach of critical realism (see table 5). It involves moving backwards from the phenomenon of interest to powers and mechanisms that generated it. The researcher applying retroductive reasoning seeks to describe the causal powers that produce, generate, create, determine or enable things to happen within their context.

Table 5. KEY CONCEPT: Critical realism
Critical realism is a performative epistemology that works against the grain of both positivism and social constructionism. It assumes that there is a real world out there (we behave as if it is real) and explains things by reference to their causal (generative) powers. The end goal is to explain what causes change in complex social phenomena.

3.2.1 Epistemological guidelines for retroductive reasoning

Despite its centrality to CR epistemology, existing descriptions of retroductive reasoning are abstract and often do not entail guidelines for research application. As a result, most of the literature on retroduction involves either metaphysical analyses containing no methodology or empirical reports that refer to retroductive reasoning, and yet stop short when it comes to providing a detailed methodological description (Fletcher, 2017).

In order to demonstrate how retroduction can be used in case studies, I will first compare Sayer's (1992) eight key CR assumptions about the world and our research practices with some of the core features of the case study method. The similarities between CR assumptions and the case study method will provide an epistemological foundation for retroductive reasoning, which is developed in table 7.

Table 6. Critical realist assumptions about the world (Sayer, 1992, p. 5)
(1) The world exists independently of our knowledge of it; (2) Our knowledge of the world is fallible – it is not immune to bias; (3) Knowledge develops neither wholly through a steady accumulation of facts, nor discontinuously through changes in concepts; (4) Natural and social objects have particular causal powers; (5) The world is differentiated and stratified in different structures that may be present everywhere and do not generate regular patterns or events; (6) Social phenomena (actions, texts, institutions) are concept dependent. The goal is not to explain their material effects, but to understand, read and interpret what they mean; (7) Science and knowledge production is a social practice. Knowledge is largely (although not exclusively) linguistic, and the way we communicate our findings is not incidental to what is known and communicated; (8) Social science must be critical of its studied object. In order to explain and understand social phenomena we have to evaluate them critically.

The case study method is attuned to several of Sayer's CR assumptions. According to Yin (2014), case studies are ideal for the study of complex phenomena, especially when the "boundaries between phenomenon and context may not be clearly evident" (p. 17). This corresponds to Sayer's points about the openness and messiness of social realities as seen in assumptions 3 and 5. Furthermore, Flyvbjerg (2006) has argued that, since "human behaviour cannot be meaningfully understood as simply rule–governed acts" (p. 6), it is necessary to use interpretation to develop a realistic and nuanced view of human behaviour. This interpretive element is particularly important for CR assumptions 6 and 7. Finally, it is rare that a single case study would claim that it has generated a full or whole picture of its studied object. Rather, each case will contain unique or different information, thus only ever revealing different elements of reality. CR does not take issue with this: as can be seen in assumptions 7 and 8, there is an implication that the research

process requires multiple researchers, perspectives, and interpretations to arrive at a sufficiently critical explanation.

Following Sayer's key CR assumptions, the process of retroductive reasoning in a case study may present as follows:

Table 7. The process of retroductive reasoning in a case study
Frequently implicit
(1) Carefully conceptualizing the components and influences of the studied object; (2) Considering how (and if) these influences and components interact; (3) Outlining the possible causal mechanisms on the basis of the latter interaction;
Frequently unaddressed – require formal epistemological reasoning
(4) Choosing between rival and/or competing causal accounts; Considering the linguistic and social influences on the case narrative.

As Easton (2010) argues, most case studies will provide a description of a "problem defined situation in great detail" (p. 119) (thus fulfilling component 1 in table 7). This allows the case study researcher to explicate multiple causal powers that *could have* generated the studied phenomenon (components 2 and 3). As such, many case studies are already utilising some form of retroductive reasoning (between components 1–3) implicitly.

However, there is a significant difficulty in going beyond hypothetical causal explanations: how can we assess which causal account (or accounts) explain the studied object or event realistically? Why this particular account over others? How can we avoid causal misattributions? And finally, how can researchers maintain criticality toward their own theoretical and clinical orientations? These questions pertain to components 4 and

5 in table 7, and require a set of explicit epistemological guidelines in order to be formally attended.

3.2.2 Canons of evidence: choosing between competing causal accounts

Since clinical situations are complex and almost always have multiple causal mechanisms, there is an inherent difficulty in formulating and justifying a causal account that is representative (i.e., portraying realistic aspects) of each case. This difficulty is well elucidated by Pocock (2015) who discusses a complex family therapy case: a child with chronic anxiety has a caregiver who appears to be offering high levels of protection even when there are no external threats. The psychotherapist might immediately form a causal hypothesis that goes something like this: "A problem maintained by maladaptive attempts to solve it" (p. 176). Although this causal hypothesis may be correct in principle, Pocock (2015) argues that subscribing to such a hypothesis uncritically means that the researcher did not utilise retroductive reasoning beyond outlining the possible causal mechanisms (component 3 in table 7). Pocock offers the following critical points for consideration:

1) *Does the caregiver's behaviour have an enabling effect on the child's anxiety?* In a family psychotherapy context, assessing this question would involve a careful observation of the caregiver and child's relationship; the child's safety strategies; the caregiver's comforting strategies; social and cultural factors; general family dynamics, etc. It is also anticipated that a retroductive analysis of any clinical hypothesis will involve a number of psychotherapy sessions (i.e., beyond preliminary assessment).

2) *If there is evidence for this causal hypothesis, the theoretical and clinical positions from which this conclusion is made need to be acknowledged.* Pocock's example is based on the clinical model of Brief Strategic Therapy and the theory of dynamic–maturational model of attachment and adaptation. Reasoning strategies implicit to these models need to be explicated.

3) *The researcher should anticipate that this may be just one out of a number of interacting causal powers and influences.* Chronic anxiety is a complex mental phenomenon, which increases the likelihood of multiple causal forces.

Pocock's (2015) example is useful when thinking about retroductive reasoning in clinical practice because it demonstrates the simultaneous existence of two realities: *physical* (currently observable aspects of reality 'as it is' – symptoms or events) and *social* (subjective and interpersonal experiences and exchanges). For example, the physical symptoms of the child's anxiety in the presence of the caregiver may be indicative of their relationship and comforting strategies. Therefore, addressing both physical and social realities without reducing one to the other is essential to retroductive analysis.

However, the example above still does not inform us on how to choose between competing causal accounts; it only informs us of further critical questions in assessing causal hypotheses. According to White (1997), this issue persists because existing definitions of retroduction rely too much on *falsification* and *scepticism* and say too little about *evaluation* and *meaning*: "Retroduction alone does not sufficiently advance the hypothethico–deductive method to make it adequate for the purposes of evaluating the content of [the psychotherapy] encounter. Evaluation is about more than falsification and scepticism, it is about meanings and it is about consequences" (p. 746). Since there are no

explicit canons of evidence with which we can evaluate the standard of retroductive analysis, there is no way to distinguish between a realistic and a naïve retroduction in a meticulous way.

CR has paid surprisingly little attention to this issue. In his work, Bhaskar (1977) suggested the concept of judgmental rationality. It is a process by which the researcher seeks to "select theories which most accurately represent the 'domain of the real' given our existing knowledge" (Hu, 2018, p. 118). Unfortunately, the concept of judgmental rationality has remained ambiguous as no judgment criteria have been explicated. Whilst Bhaskar (1977) implies that some concepts and accounts are better equipped in representing reality than others, he also argues that "there are no general philosophical criteria" which can be "laid down" (Bhaskar, 1977, p. 168) for this assessment. This poses an important question: if there are no criteria of validity, then how can researchers come to an agreement on which account provides a more realistic perspective?

Groff (2000) acknowledges this issue, noting that Bhaskar's inattention to judgmental rationality may be because the "intersubjective agreement itself [...] is the criterion of validity" (p. 417). That is to say, a causal account can be regarded to be true insofar as researchers in a given field agree it to be true. However, one may argue that the very premise of a CR epistemology and retroduction (as an alternative to inductive and deductive reasoning) already implies validity criteria for plausible causal accounts. We have determined, through Sayer's guidelines, what is *not good enough* for retroductive reasoning in social science research:

Table 8. What constitutes a naïve retroductive analysis?
(1) Treating all knowledge about reality as socially constructed; (2) Generating causal explanations for complex social phenomena on the basis of regularity and frequency; (3) Neglecting the context (time and space) in which causal powers operate; (4) Ignoring that there may be multiple causal forces for a single phenomenon; (5) Reducing or failing to differentiate between physical (observable aspects of "reality as it is") and social (subjective) realities; (6) Ignoring the social, theoretical and linguistic processes behind research (lack of criticality); (7) Reducing causal powers to their material effects (as opposed to trying to understand, read, and interpret their meaning).

These criteria can be regarded as epistemological red flags: the more of them are present in a given explanation, the more likely the explanation is epistemologically flawed or naïve. One may compare two causal explanations of the same phenomenon and see which explanation is more fallible (in the sense that it falls prey to naïve retroduction), and which is more realistic (in the sense that it explicitly works through the problematic criteria in table 8). Although some of the criteria still revolve around scepticism of knowledge (criteria 1 and 2 are strongly attuned to CR and its ontological assumptions), most of the criteria imply an evaluation of content, meaning, and consequences of a given retroductive analysis (White, 1997).

3.2.3 Considering the linguistic and social influences: reflexivity

By referring to the epistemological red flags outlined in table 8, we may be able to compare and assess the explanatory power of different causal explanations for one given case. However, this task can become increasingly difficult if these causal explanations are being generated from different theoretical and clinical orientations. The latter will influence not only the reasoning process, but also the language and the methods that are being used to explain the case. This point is made by Kanye (1995) in the context of psychotherapy research:

> Research questions posed from within the parameters delimited by the canons of scientific research tend to be disconnected from psychotherapy and indeed transform it into something else. […] The questions we bring to therapy [are] theory laden, […] our theories construct the phenomena they are designed to explain (p. 38).

One of the main aspects of retroduction is that it seeks to attend not only to changes that are being caused by different structures "out there", but also by our linguistic, methodological and social choices as researchers. Bhaskar (1977) referred to the latter process as reflexivity, with which it is possible to make critical judgments about the research process. According to Belfrage and Hauf (2017), reflexivity starts with the researcher acknowledging their own position in retroductive reasoning: "Retroduction is not some abstract movement of thought taking place far away from the field, but is implemented and experienced by the *corporeal researcher*" (p. 10). This means that the researcher acts as an "acknowledged vehicle": they have a subjective, social, and

theoretical position that will have an impact on the way causal powers and mechanisms are being traced and inferred. From this point of view, retroduction involves not only a temporal movement (studying the effect/event by tracing the conditions and mechanisms that produced it), but also a move between theoretical and empirical work.

Table 9. KEY CONCEPT: Reflexivity
Reflexivity refers to the researcher's awareness of the overarching professional and theoretical principles that govern the research process, as well as the ability to disclose personal epistemic practices within the wider theoretical framework.

In psychotherapy and social work research, there have been two forms of reflexivity: textual and epistemic (Bourdieu & Wacquant, 1992). Textual reflexivity has been defined as the researcher's capacity to disclose their theoretical, social, and value positions; to present a small–scale "autobiography of the research experience" (White, 1997, p. 748). Epistemic reflexivity, on the other hand, refers to the researcher's awareness of the overarching professional and theoretical principles governing their research process. Epistemic reflexivity is generally preferred over textual; for example, Bourdieu (in Bourdieu & Wacquant, 1992) has argued that, since researchers often fail to describe their relation to the studied phenomenon, they should instead focus on describing the wider epistemic principles of their field.

CR is arguably most clear on this epistemological issue: it accepts that any form of data is "fundamentally interpretivist in character" (Easton, 2010, p. 124). However, this does not mean that the researcher should not seek to articulate the degree to which their epistemological reasoning is personal (Bateson, 1979). For example, in psychoanalytic case studies, psychoanalysts often refer to their theoretical frame of reference (Freudian, Object–Relations, Kleinian, etc.), which accounts for their epistemic reflexivity. But as

Willemsen et al. (2017) point out, each clinical and theoretical orientation contains different (and at times conflicting) modes of theorising and practicing. It is therefore important that the researcher articulates their personal epistemic practices (textual reflexivity) within a wider theoretical framework (e.g., which concepts the researcher depends on or deviates from). A high degree of reflexivity enables what Easton (2010) calls the "cut and come again" disposition: researchers can see why a given case study interpreted a clinical scenario in the way that it did. In turn, this allows for a thoughtful consideration of alternative or contrasting interpretations between researchers from different theoretical orientations.

To draw the above epistemic practices closer to psychotherapy case studies, I will discuss the use of retroduction in Wolf and Jandasek's (2017) systematic case study about concurrent treatment of depression in parents and adolescents by following the process of retroductive reasoning outlined in table 7.

Table 10. CASE EXAMPLE: A retroductive analysis of parent and adolescent depression (Wolff & Jandasek, 2017)

(1) Carefully conceptualizing the components and influences of the studied object. Depression is conceptualised from the point of view of parent–adult interactions. The risk of developing depression among children has been closely linked with having depressed parents (between two and four times greater than for children with non–depressed parents).
(2) Considering how (and if) these influences and components interact. The case suggests a *causally bidirectional* relationship between parent and child experiences of depression. Parental depression is hypothesised to (1) contribute to the early onset of adolescent depression, and (2) have a continuous influence on adolescent depression as changes in parents' symptoms can lead to changes in children's symptoms.

(3) Outlining the possible causal mechanisms. Drawing on existing research, the authors propose that parental psychopathology is frequently transmitted to children through *direct* and *indirect* interpersonal processes. Direct processes involve: impaired parent–adolescent communication, higher levels of expressed emotion, poor emotional regulation, and maladaptive coping skills. Indirect transmission may occur due to issues in parents' behavioural modelling (e.g., ineffective coping skills, poor problem–solving ability, cognitive distortions, etc.).

The case of a 34–year–old mother Lynn and her 14–year–old daughter Sophia is used to illustrate the causal interrelatedness of parent–adolescent depression. Lynn demonstrated severe depression and mild suicidality. Her daughter Sophia also reported a long history of depression and symptoms of attention–deficit hyperactivity disorder (ADHD). Both mother and daughter reported that their relationship was conflictual and that they were reactive to each other's behaviours. The case authors identified several direct and indirect interpersonal processes affecting Lynn and Sophia's depressive symptoms. Both engaged in isolative behaviours, emotional outbursts, and maladaptive coping skills. These interpersonal processes were found to trigger Lynn's negative feelings about her parenting abilities, which in turn increased her anxiety and depressive symptoms. Similarly, Sophia reported experiencing increased depressive symptoms, guilt, and suicidal ideation.

(4) Choosing between rival or competing causal accounts. Given the strong influence of parental depression on adolescent symptoms, the study aims to develop a treatment approach that can target *both* parental and adolescent psychopathology. Interpersonal Psychotherapy for adolescents (IPT–A) was cited as a developmentally appropriate approach. However, the authors conclude that IPT–A does not target parental psychopathology, even if the latter may be causal to the adolescent patient's depression. Similarly, cognitive behavioural therapy (CBT) for youth with depression features minimal parental involvement. As such, both therapeutic approaches may overlook the underlying cause of adolescent depression.

The authors propose a novel treatment approach for depression that involves both parents and adolescents. The proposed model for the concurrent treatment of depressed parents and teenagers has a two–fold aim: (1) to address how parental psychopathology affects adolescents in general, and (2) to assess how specific family dynamics affect parental and adolescent depressive symptoms.

Two therapists worked with Lynn and Sophia, both individually and in conjoined sessions. Across several sessions, Lynn's behaviours were found to have a significant impact on her daughter's depressive symptoms. In one of the sessions, Lynn discovered Sophia's inappropriate interactions with a male peer and became so upset she hit her daughter on the arm. Sophia reported feeling "like a disgrace" (p. 21). Both reported an increase in depressive symptoms after this incident.

The impaired interpersonal processes were identified as causal to both Sophia's and Lynn's increasing experiences of depression and anxiety. In subsequent sessions, the treatment focused on re–establishing a positive communication between the mother and daughter. This involved practicing listening and responding to each other, communicating concerns openly, and learning problem–solving skills. Thus, although half of the treatment process focused on improving Lynn and Sophia's depressive symptoms *individually*, the treatment's main aim was to improve the mother and daughter's relationship dynamics *concurrently*.

(5) Considering the linguistic and social influences on the case narrative. The authors note that their treatment protocol requires two therapists working in tandem per case, which may prove to be "logistically challenging in some treatment settings" (p. 24). Although the authors provide no further consideration for this issue, we may assume that the increased number of therapists working on the same parent–adolescent cases could introduce significant theoretical and clinical disparities into the case narrative. It is therefore important to establish clarity over how therapists co–ordinate between their observational data and therapeutic practices.

3.2.4 Recommendations for future research

At this point, a question may arise on whether retroduction can be used outside of CR epistemology. Sayer (2000) is clear that retroductive reasoning can be used in a wide range of research methods and theoretical frameworks. Just like inductive and deductive reasoning, retroduction is a method for data interpretation, and is most appropriate for research that seeks to identify change in complex social phenomena. Although retroduction is deeply embedded in CR epistemology, the researcher does not have to identify with the entire CR paradigm. However, the research should attend to those CR assumptions that are relevant for a formal retroductive analysis (see tables 6 and 7).

Although retroduction is a promising epistemological concept, particularly in areas where the clash between positivism and social constructionism created a research paralysis (Pilgrim & Bentall, 1999), it still suffers from many epistemological drawbacks. If retroduction places a high value on invoking causal language and making causal judgments, then it certainly requires more than just implicit criteria of what is realistic and naïve knowledge. Moreover, there needs to be a clearer connection between retroductive reasoning and social science research; as it stands now, retroduction remains to be a metaphysical concept with no methodological underpinnings. Future direction for retroduction should therefore involve the development of clearer canons of evidence and their applicability to different research methodologies.

3.3 Analytic generalisation

It is generally agreed by case study researchers that generalisation and replicability are *not* at the heart of case study methodology, and that the goal is *not* to produce a

standardised set of results that can be replicated by another researcher. This is because most case studies entail a high number of variables and contextual conditions that make generalisability of data far more difficult than in experimental or survey research.

However, the issue of generalisability has become central to psychotherapy research, and therefore unavoidable for case study researchers. Although case studies were historically crucial for theory development, they are now in the lowest position in the hierarchy of evidence (Aveline, 2005). At the top, we have systematic reviews, meta–analytic reports and randomised controlled trials (RCTs). Whilst this hierarchy and its 'gold–standard' implications for generalisability received a fair share of criticisms (see for example, Shean, 2014; Westen et al., 2004), the fact is that the methodologies at the top have a very clear logic when it comes to producing generalisable knowledge. Case studies, on the other hand, have a far more ambiguous relationship with the process of generalisation.

Increasingly, social scientist Robert Yin (2013, 2014) proposed a different form of generalisation from that used by quantitative methodologies. Whilst case studies do not pursue a sample–to–population logic (as in statistical generalisation), a single case study can generate a more abstract level of ideas and questions that pertain to other individuals and situations outside of the original case. This process is known as analytic generalisation: "a previously developed theory is used as a template with which to compare the empirical results of the case study. If two or more cases are shown to support the same theory, replication may be claimed" (Yin, 2014, p. 31). This means that a single case study, albeit not having any statistical power, can have important theoretical implications for the field.

Table 11. KEY CONCEPT: Analytic generalisation
Analytic generalisation is a strategy of generalising from single cases to theory. It involves case studies that are concerned with questions that are of wider significance to the field. The end goal is to contribute to theory building as well as to be applicable to other cases in the field.

3.3.1 Statistical vs analytic generalisation

Earlier in the paper, I referred to Freud's case of Dora, Meyer's case about compulsive washing rituals, and Bowlby's child case studies as cases that have undoubtedly contributed to theory development. However, I would also go one step further and call these cases *exceptional* in terms of the impact that they continue to have on knowledge generation. For example, the case of Dora is still one of the most read case histories in the field of psychology: in Google Scholar, it appears more than 19,000 times in articles emerging from a variety of disciplines (Longhofer et al., 2017). This kind of knowledge output produced by a single case can be attributed to several factors:

(1) It is the first psychoanalytic case study that describes in detail the significance of transference;
(2) It is a first thorough report of a negative treatment outcome in psychoanalysis;
(3) It is the first case study to break away from the medical case study format by demonstrating the complex and open system dynamics implicit to everyday clinical practice.

All these factors make Freud's Dora a 'first–of–its–kind' classic: psychoanalytic practitioners go back to this particular case because its contents are relevant to many of their own cases. In a similar vein, CBT therapists working with obsessive compulsive disorder often find themselves returning to Meyer's case, whilst nurses and child psychologists still rely on Bowlby's studies of attachment and separation anxiety.

However, powerful 'first–of–its–kind' cases are not that common: a revolutionary exposition of negative transference is not an everyday commodity in clinical research. In fact, most case studies in psychotherapy have little to no intention for generalisability: they describe the treatment process of particular patients (with the intention to teach other clinicians rather than generalise findings) or provide clarification and additional evidence to already existing theories. But even if we are treating particular patients, we still want to know general information about their experiences. This provides us with an expectation of how a clinical scenario might go or which clinical technique should be used.

For this reason, statistical generalisation is frequently used for producing 'ordinary' (average) generalisations. It involves measuring ratios, effects, frequencies, and average values of different parameters of a population based on a random representative sample. In order to choose a representative population, researchers typically use probability methods of sampling, by which every member of population has an equal chance to be included in the study (Polit & Beck, 2010). As such, statistical generalisation follows a sample–to–population logic.

To strengthen a statistical generalisation, researchers perform replication studies, which employ the same conditions to see if the dataset is replicated. The more times a dataset is replicated (and by extension, the statistical findings are replicated), the more

generalisable the results are to the general population. The end goal is to produce knowledge about an average value of the studied phenomenon in a population.

Analytic generalisation differs from statistical generalisation in both process and end–goal. As pointed out earlier, analytic generalisation does not follow a sample–to–population logic. Instead, it involves a case–to–theory logic: "By analytic generalisation is meant the extraction of a more abstract level of ideas from a set of case study findings – ideas that nevertheless can pertain to newer situations other than the case(s) in the original case study" (Yin, 2013, p. 325). A researcher pursuing analytic generalisation will start with an in–depth case study suitable for a higher–order abstraction. This means that the case describes a multitude of variables within its relevant context and provides a rationale of how these variables may be relevant to other instances in the field. It is also important that the case is articulated in a manner that is authentic and credible to the reader (i.e., understandable to the audience of a specific field) (Polit & Beck, 2010).

Instead of running a statistical replication study, analytic generalisation follows the logic of experimental reasoning. A single case is like a single experiment: if the case is unique in relation to the established theory (e.g., by introducing a new phenomenon), it can then be used as a pilot or prototype for other cases. If multiple case studies produce similar results (literal replication) or contrasting results but for predictable reasons (theoretical replication), then there is strong evidence for the original propositions in the first unique case (Rowley, 2002). The end goal is to contribute to theory building as well as to be applicable to other cases in the field (Yin, 2013).

Table 12. Comparing different forms of generalisation	
Statistical generalisation	**Analytic generalisation**
Large sample	Small sample (N=1; multiple cases)
Independence of observations	Interdependence of observations
Sample–to–population	Case–to–theory
Probability sampling	Theoretical sampling
Statistical replication	Experimental replication
Knowledge about an average value of a phenomenon in a population	Knowledge about a theory that pertains to a population

3.3.2 Epistemological guidelines for generalising from "ordinary" case studies

After establishing how analytic generalisation differs from statistical generalisation, is it evident that the problem of producing generalisations from 'ordinary' case studies still remains. By 'ordinary' case studies, I refer to cases that, despite containing important new findings, have limited explanatory power in comparison to the 'first of its kind' classic cases. Paula Heimann's (1950) clinical work on countertransference can be considered an exemplar of an 'ordinary' case study within its timeframe:

Table 13. CASE EXAMPLE: Analytic generalisation of the countertransference concept (Heimann, 1950)
German psychoanalyst Paula Heimann's (1950) clinical work demonstrated that countertransference does not always have to be an obstacle to the therapist's understanding of the patient's situation. Heimann's central suggestion was that patients often project feelings and thoughts that are felt as unbearable onto their therapists. In turn, therapists begin to perceive the patients' projected feelings as their own. Heimann continued to suggest that this projective identification can be assessed

and explored by focusing on the conscious and pre–conscious countertransference feelings toward patients.

In one of her case examples, Heimann described a male patient in his forties who originally sought treatment to resolve his marriage problems. The highly promiscuous patient told Heimann in the third week of analysis that he was going to marry a woman whom he had met very recently. Heimann interpreted the patient's wish to get married as a form of resistance against the analytic task. However, Heimann felt apprehended and worried about her feelings, which struck her as strange and unprofessional.

After an additional analysis of one of the patient's dreams, Heimann came to realise that the patient unconsciously wished to damage her and supress her as the voice of reason: "Out of guilt for his sadistic impulses he was compelled to make reparation, but this reparation was of a masochistic nature, since it necessitated blotting out the voice of reason and caution" (p. 82). It is at this point of analysis that Heimann acknowledged her previous feelings of worry as an unconscious reaction to the patient's sadistic and self–destructive patterns. She concluded that countertransference is an important criterion not only in selecting the relevant interpretations, but also in detecting aspects of patient's personality: "From the point of view I am stressing, the analyst's countertransference is not only part and parcel of the analytic relationship, but it is *the patient's creation*" (*ibid*).

Given the original rigidity of the classic psychoanalytic approach to countertransference, Heimann's arguments were initially met with considerable scepticism. In this sense, her case work had limited explanatory power and required further support from other clinical cases. With the emergence of relational psychotherapy, an increasing amount of clinical case studies across multiple clinical orientations began to incorporate Heimann's arguments about the use of countertransference (see for example, Dalenberg, 2000; Eizirik et al., 1991). This case–based research produced similar conclusions to Heimann's: when therapists are engaged with their feelings toward patients, they often reveal new information about the patient's unconscious processes; build a stronger therapeutic alliance; and provide

relational support for vulnerable patients. Thus, on the basis of several common attributes (identifying and dealing with countertransference and projective identification processes) between many clinical cases, a contemporary theory about countertransference as a viable clinical tool has emerged.

It is now possible to trace back aspects of Heimann's work that led to the analytic generalisation of the countertransference concept since there have been many cases that replicated Heimann's conclusions. However, if generalisable aspects remain largely implicit or undefined, this can make it difficult to establish whether or not a given case is 'representative'. Therefore, we need epistemological guidelines not only for generalising, but also for identifying a 'representative' case study from which the generalisation can be made.

The question of representability is, of course, not exclusive to case studies. As Polit and Beck (2010) argue, this is one of the key limitations to statistical generalisation: "The vast majority of studies with human beings do not involve random samples. [...] In the rare study in which participants are sampled at random, cooperation is rarely perfect, which means that random *sampling* seldom results in random *samples*" (p. 1453). In their view, random sampling is a research ideal that is rarely achieved: since most researchers have an explicit (non–random) accessible population, this makes generalisation onto other populations and settings difficult and messy. Despite this limitation, however, it is important that statistical generalisation has a research ideal or 'norm' (in the forms of random sampling and replication) in the first place. This 'norm' means that there is a concrete set of guidelines, however flawed, that can be undertaken to assess the validity of a given statistical generalisation.

As an epistemological concept, analytic generalisation is still lacking a research ideal or 'norm'. This has been acknowledged by the educational researcher Mary Kennedy

(1979): “What seems to be needed before single case studies will be widely accepted is a set of rules for drawing inferences about the generality of findings from a case study or even from studies of very few cases” (p. 663). She notes that this single weakness of case methodology is enough to discourage many researchers from employing it. As such, Kennedy offers a set of epistemological rules that seek to tackle two problems at once: they outline an ideal research process for analytic generalisation (epistemological guidelines), and they determine the representability of a given case (canons of evidence for a generalisable case). In the review below, I place Kennedy’s rules in a psychotherapy research context.

Table 14. Epistemological rules for analytic generalisation

(1) Examining a wide range of attributes within a single case (or multiple cases). Since patients and mental experiences vary considerably, we must be careful not to confuse idiosyncratic outcomes with generalisable outcomes. Therefore, the researcher must outline specific patient criteria or treatment aspects within the case that they will be generalising from. For example, analytic generalisation from a series of case studies on depression would involve a meticulous outline of such patient criteria as gender, age, the level of disruptions in emotional stability, experiences of depressive states, etc. Any significant differences and variations between the patients should be noted.

(2) Ensuring that there are many common and/or similar attributes between the cases and the population of interest. This helps forming a basis for generalisation. In order to do this, the researcher may rely on existing knowledge about a certain kind of population (e.g., patients with a diagnosis of depression as per DSM–5); they may choose to make assumptions about some of the population’s attributes thus generating a new hypothesis (e.g., patients with a diagnosis of depression have difficulties engaging with psychotherapy due to anxiety over social interactions); or they may be able to define a hypothetical

population based on its shared attributes thus directly generalising to theory (e.g., a population of patients who are not able to form a transference relationship – including but not limited to patients with depression).

(3) Limiting the number of unique attributes between case studies from which the generalisation is being made. This ensures that case generalisability is uninhibited. Kennedy notes that unique attributes are difficult to isolate because the researcher may not be fully aware of them (e.g., a patient may not wish to disclose a traumatic event), however, the researcher must attempt to look for them and separate the unique features from the common ones. It is also acceptable to define unique attributes *post hoc* (which is more preferable than not defining them at all).

(4) The attributes between the cases must be relevant. This point requires the researcher to identify the relevancy of attributes for further generalisation. For example, patient gender may not always be relevant: if the researcher wants to generalise case findings in order to theorise about the connection between negative transference relationships and patients with depression, it is likely that both male and female patient cases will be of relevance to theory (although significant variations between male and female patients may need to be outlined, as per rule 1).

Kennedy's rules, whilst not exhaustive (as she herself notes, they "can be continuously refined by practicing evaluators", p. 664), are clearly important for setting up both research 'norms' and canons of evidence for analytic generalisation from 'ordinary' cases. In particular, the rules that discuss the relevance and similarity of attributes between different cases ensure that the desired analytic generalisation goes beyond a working hypothesis (see section 3.4, '*Working Hypothesis'*). Whilst the latter requires further study, a stable analytic generalisation should be readily applicable to new situations (Yin, 2013). If replication is achieved through common attributes between two or more cases,

then this may serve as powerful evidence for the generalisability of the original case, even if the original findings had limited explanatory power on their own. Thus, the research 'norm' in analytic generalisation can be based on the logic of experimental replication (literal or theoretical), whilst its canons of evidence can be based on the strength of common attributes between the cases.

3.3.3 Recommendations for future research

Unlike retroductive reasoning, the concept of analytic generalisation is not embedded in a philosophical approach that involves concrete epistemological and ontological preconceptions about the world. In this sense, analytic generalisation in itself is not new to the fields of psychotherapy and psychoanalysis and has been implicitly present in the research practices across these two fields. On one hand, its implicit existence is helpful when trying to explicate the relevant epistemological guidelines. On the other, there appears to be a temptation amongst researchers in these fields to remain on implicit epistemic grounds; since analytic generalisations have been made before without formal epistemological reasoning, this can be done again.

As is clear from Heimann's (1950) example, one does not always have to follow 'fixed' epistemological rules to produce generalisable claims. However, it is important that both the logic as well as the intent of analytic generalisation are clear and explicit. This allows other case study researchers to immediately identify the representability of a given case (via concrete generalisable attributes), and to determine how it compares to the attributes found in other cases. Further research direction for analytic generalisation should involve an expansion of criteria for 'representative' cases. Although Kennedy's (1979) rules provide a helpful start, the research process for analytic generalisation

needs to be developed more clearly in the context of psychoanalytic and psychotherapy case studies in which analytic generalisation has been almost exclusively implicit.

3.4 Working hypothesis

Few people debate the value of case studies in preliminary or exploratory research stages. But even in this instance, case studies are often described as being valuable only as a first step in the research process; that, in order to test a hypothesis generated within a case, one must rely on other kinds of research methods that can further assess whether the hypothesis is applicable to a larger population (see for example, Campbell & Stanley, 1966). Once again, this relates to the issue of generalisability: a single case study is seen as insufficient data for testing new or existing theoretical propositions.

Educational psychologist Lee Cronbach (1975) criticised the view that we must rely on generalisable data in order to test theories. All generalisations begin by collecting information from individuals and situations ('local conditions'). However, *the end goal should not always be generalisation*. If a single case contradicts, informs or deviates from the general law, then the researcher ought to stay with it and particularize it. As such, Cronbach proposed a reversal of research priorities: "As results accumulate, a person who seeks understanding will do his best to trace how the uncontrolled factors could have caused local departures from the modal effect. That is, *generalisation comes late, and the exception is taken as seriously as the rule*" (1975, p. 125).

From Cronbach's point of view, there are unique, context–dependent factors in every research situation: "When we give proper weight to local conditions, any generalisation is a working hypothesis, not a conclusion" (1975, p. 125). Given Cronbach's focus on local conditions, testing theories on the basis of generalisability does not make

sense because conditions in each population sample vary and change over time. For this reason, Cronbach suggested that theory testing should be performed through working hypothesis case studies. This involves moving from case to case, "describing and interpreting the [studied] effect anew" (*ibid*) and particularising the unique factors of each case.

In this regard, case studies can offer far more than just preliminary scouting for a research project; they can be used to test whether theories work and how they can be improved or revised. However, Cronbach does not clearly define what a working hypothesis case study is. I will follow the work of Stiles (2003; 2007), Mahrer (1988) and Edelson (1985, 1986) on theory testing case studies in order to define a working hypothesis case study more clearly.

Table 15. KEY CONCEPT: Working hypothesis case study
Case studies that propose important new distinctions, discoveries or revisions to existing theories are called working hypothesis case studies. Although such case studies may involve a falsification of a theoretical proposition, they generally go beyond falsification by outlining new theoretical suggestions or hypotheses based on detailed case observations. The end goal is to revise theories by assessing how (and whether) they translate to practice.

3.4.1 Theory testing in psychotherapy: working hypothesis vs falsification

Theories do not entail specifications or moment–to–moment situations of clinical practice, which means that their validity can vary greatly across different clinical instances. For this reason, Stiles (2003), much like Cronbach, argued that theory testing lies in the particularisation of data rather than its generalisability:

> By simultaneously bringing many observations to bear on a theory, case studies offer both a way to test and an opportunity to improve the theory. [...] For example, Freud's case studies [...] permeated psychoanalytic theory (that is, the theory was altered by them), and the detailed fit between the theory and the cases helped increase confidence in theory (p. 9).

As such, most case studies in psychotherapy and psychoanalysis function as *working* cases: by demonstrating how patients' behaviour manifests in accordance to a theoretical model or changes in response to a clinical technique, *they test how theory works in practice*. If there is a good fit between the theory and the case material, then this increases confidence in theory. The advantage over other research methods here is that different case studies can demonstrate different observations about the same theory: "Each case tells us something new, and new observations are always valuable, whether they confirm previous theory or add something unexpected" (Stiles, 2007, p. 123). If, on the other hand, a case study indicates a new observation that contributes to theory development or revision, then it begins to function as *working hypothesis* case study.

Many authors have argued that case studies are equipped with an important task of *falsification*: a process by which a theoretical proposition is subjected to a series of observations. If one case falsifies the original theoretical proposition, then the theory must be revised or rejected altogether. Karl Popper's famous example of "all swans are white" illustrates this falsification process: just one observation of a black swan falsifies the proposition that all swans are white. Midgley (2006) provides a psychoanalytic example: if a single case demonstrates that patient's neurosis was not caused by sexual abuse in childhood, then a theory suggesting that all neurosis in adulthood is a result of

early sexual abuse (as Freud's seduction theory did) needs to be revised or replaced by a theoretical model that explains both abuse and non–abuse neurosis.

However, Mahrer (1988) argues that there are significant drawbacks to research that is driven toward falsification of existing theories. In his view, disconfirmation of existing psychotherapy theories is nearly impossible: "I know of no established theory of psychotherapy that declared bankruptcy because of research that failed to confirm, disconfirmed, or falsified its theoretical propositions and network of theoretical assumptions; nor is there a logical necessity for that to occur" (p. 694). This is because there is a significant difficulty in moving between *a)* findings from a falsifying case study, to *b)* the specific theoretical proposition that is being falsified, to *c)* the network of theoretical assumptions that make up the overall theory.

Mahrer further argues that theories in the fields of psychoanalysis and psychotherapy are not usually based on straightforward predictions or testable conditions. Therefore, when a falsifying case appears, its findings are generally "constrained to propositions" (p. 695) – they do not target the core theoretical principles that make up the theory in the first place. Even in Midgley's (2006) example of neurosis, it is not clear whether a case of non–abuse neurosis should discredit the entirety of the theory immediately. Instead, this may mean that neurosis has a variety of causes, and sexual abuse is only one of them. Working hypothesis case studies can be used as a resolution to this issue: although they frequently contain a falsification of a theoretical proposition (e.g., falsifying the claim that all neurosis is caused by early sexual abuse), they can also begin outlining new suggestions or hypotheses based on further case observations. Thus, the theory is not refuted in its entirety, but it is being reworked or revised accordingly to case findings.

3.4.2 Epistemological guidelines for working hypothesis case studies

As with the other two epistemological concepts, working hypothesis case studies have no concrete epistemological guidelines or canons of evidence. Whilst most case studies are useful for developing new ideas or reaching a deeper understanding about a phenomenon, this does not mean that they automatically include a justification for a given hypothesis (Midgley, 2006a). The question here is: on what grounds or criteria can we justify an existing theoretical proposition or rule it out and claim that a change in the patient's behaviour was caused by something else (an alternative hypothesis)?

Marshall Edelson notoriously defended case studies by arguing that they can be used to test clinical propositions (Edelson, 1985, 1986). In doing so, Edelson made it very clear that psychoanalysis is "not exempt from ordinary canons of scientific method and reasoning" (1985, p. 571). In his view, case studies must be formulated in an epistemologically sound, rigorous manner in order to be considered as evidence for a given hypothesis. In a series of papers, Edelson explicates the following points (summarised by Midgley, 2006a, p. 134–135):

Table 16. Epistemological guidelines for working hypothesis case studies
(1) The study should clearly and prominently state the hypothesis being tested in the case;
(2) Facts or observations should be clearly separated from interpretations of these observations;
(3) It should be clearly shown how the hypothesis about the case explains or accounts for the observations;
(4) Observations which, if they had occurred, would have been grounds for ejecting the hypothesis should be specified;

(5) Observations that appear to contradict the hypothesis should be reported and clear grounds for dealing with these counter–examples should be given;
(6) Since any set of observations can be explained in different ways, some argument should be given for why the observations are better explained by this hypothesis rather than a particular alternative hypothesis;
(7) Even if the observations can be better explained by this hypothesis rather than a rival one, the study should consider what factors operating in the clinical setting may have resulted in the obtaining of favourable data, even if the hypothesis were false;
(8) The study should make clear to what extent the hypothesis about this case can be generalised to similar cases or treatments.

Edelson's epistemological guidelines tackle two important gaps in theory testing case studies: generating a hypothesis by carefully comparing it to rival hypotheses and counter–examples (points 5, 6, 7), and testing a candidate theory following the new hypothesis (point 8). These points directly address Mahrer's (1988) criticisms about falsifying case studies. In this sense, working hypothesis case studies follow a Kuhnian model: instead of validating or falsifying a theory in its entirety (Popper's research ideal), the working hypothesis model seeks to identify theoretical anomalies and redefine or revise them accordingly to new observations.

3.4.3 Discovery–oriented approach

According to Mahrer (1988), the way out of ineffective affirmation or disconfirmation of psychotherapy laws and axioms is a discovery–oriented approach: "When hypothesis testing is done properly it includes discovery" (p. 696). The difference between falsification and a discovery–oriented approach is that the latter is not concerned about having a predetermined theoretical expectation. Instead, the discovery–oriented

approach is based on the "intention to learn more; to be surprised; to find out what one does not already expect, predict, or hypothesize; to answer a question whose answer provides something one wants to know but might not have expected, predicted, or hypothesized" (*ibid*). This does not mean that a case study based on a discovery–oriented approach does not involve any motivating interest; it should, as per Edelson's guidelines, either state a clear hypothesis or outline which psychotherapeutic condition, operation or consequence will be assessed.

A discovery–oriented approach allows for some flexibility in case study research: whilst some cases are not intended to test hypotheses, they may lead to important clinical discoveries "on the way", which results in working hypotheses and new theoretical propositions. For instance, clinical case studies often demonstrate how effective or ineffective theories, techniques, and diagnostic entities are in practice with particular patients. However, these case studies rarely begin as theory testing cases. Instead, an existing theory or technique is used for treatment, but when found ineffective, it is almost always replaced by an alternative. In this sense, a complete falsification of a theory is unproductive for clinical treatment. This is particularly well documented in Vaskinn et al.'s (2011) clinical case study with a working hypothesis on the treatment of a schizophrenic patient:

Table 17. CASE EXAMPLE: A working hypothesis case on the treatment of a schizophrenic patient (Vaskinn et al., 2011)

(1) Theoretical anomaly/falsification stage. The case describes a patient called Martin who has been diagnosed with paranoid schizophrenia and antisocial personality disorder. Although literature on schizophrenia and violence is inconclusive, previous diagnostic assessment suggested that Martin's violent outbursts are caused by his paranoid schizophrenia. However, the case authors soon found out that Martin's violent behaviour (assaults on staff members and

material damage to the ward) occurred only in the institutional (hospital) setting. As a result, a thorough diagnostic re–examination has been conducted. The antisocial personality diagnosis has been ruled out, and the originally postulated causal link between Martin's schizophrenia and antisocial behaviour has been rejected.

(2) Development of an alternative hypothesis. An alternative hypothesis was necessary in order to (1) address Martin's problematic behaviour in the hospital and to (2) provide an appropriate form of treatment. Upon further observation, the authors found that Martin suffered from an impaired self–view: he lacked self–confidence and was ridden with doubts about his future outside of the hospital. It was particularly at times of rejection, criticism, and failure that Martin would display violent and aggressive behaviour toward the hospital staff members. As such, the authors proposed that Martin's poor self–view contributed to his feelings of inadequacy and caused his violent behaviour.

(3) Testing the hypothesis. The authors suggested that, if Martin's violence was caused by his impaired view of self, then the new treatment must increase Martin's sense of agency. Sense of agency was defined as a personal perception of competency and freedom that enables the individual to make sense of the world and act congruently in response to various situations. The new treatment should therefore seek to increase Martin's sense of ownership to his own behaviour as well as his physical mode of communication (violence).

Narrative therapy was chosen as an appropriate form of treatment to test the new hypothesis: since patients with psychiatric diagnoses often have negative views about themselves and the prospects of their recovery, narrative therapy could be used to change the patient's personal narrative into one that is more productive and positive.

At the beginning of treatment, Martin's sense of self was described as "entangled with delusions and hallucinations [...] he was convinced that his voices were real and that he could escape them" (p. 253). As such, Martin had little awareness of who he was outside psychotic states. Narrative therapy was therefore used to separate Martin's sense of self 'outside' and 'inside' psychosis. Externalising language was used to conceptualise psychosis as *a problem from a distance*. The therapist consciously employed questions and phrases that stressed the division between Martin as a person and his experiences of psychosis as an illness. This narrative approach soon proved to be productive: Martin began to separate himself from his symptoms, which were now seen as external problems that could be observed and thought about from a distance. In addition, Martin no longer saw himself as a "schizophrenic"; instead, he referred to himself as a "person suffering from schizophrenia".

These developments proved to be crucial in deconstructing and reframing Martin's violent reactions. Martin was now able to talk about his anxiety regarding life outside the hospital without resorting to violence. Since Martin's treatment focused on strengthening his sense of agency, the therapist gradually gave Martin more responsibility and control over the treatment process. For example, Martin actively participated in the development of therapeutic strategies (e.g., initiating conversations with designated staff members, choosing time–outs in the open seclusion area, describing experiences of psychosis, etc.).

(4) Implications for other cases. At the beginning of the case, the authors argue that, should narrative treatment prove to be useful, this case could have important implications for psychotherapy of schizophrenic patients since "the psychotherapy of schizophrenia has not fared well, as little scientific evidence of its efficacy could be provided, especially for psychoanalytically oriented interventions" (p. 248).

Given Martin's improvements, the case authors conclude that treatment deadlocks with schizophrenic patients may be overcome by switching from a biomedical approach to a psychotherapeutic narrative treatment (i.e., the strengthening of patients' sense of agency). They stress that the case findings are particularly relevant for the treatment of schizophrenic patients demonstrating aggressive and violent behaviours in hospital wards.

(5) Assessing the findings. Whilst literature on psychotherapy with schizophrenic patients is scarce and pessimistic, Martin was able to actively participate in his treatment plan and become more independent. This ultimately led to Martin's discharge. The case provides a detailed report of Martin's progress during the treatment and follow–up: he learned to take responsibilities for emerging problems, participated in the development of his treatment plan, and gained confidence in his future outside of the hospital. This fulfils the testing of a candidate theory part of the case: since Martin's antipsychotic medication did not affect his self–view or decrease his violent outbursts, the authors could assume that his treatment gains (increased sense of agency) were the results of narrative therapy.

3.4.4 Recommendations for future research

As Mahrer (1988) points out, the quality of evidence in a working hypothesis case study is not based on the magnitude of the discovery (which is more relevant to 'representative' cases in analytic generalisation). This is because discoveries in working hypothesis cases will usually revolve around psychotherapy *conditions* and *operations* rather than core theoretical principles. Even though Vaskinn et al.'s (2011) narrative treatment approach proved to be successful in Martin's case, it would take multiple cases with different patients in order to generalise the implications of this therapeutic intervention. As such,

working hypothesis case authors should not "rush toward general laws, truths, and principles" (Mahrer, 1988, p. 699) as in analytic generalisation.

Whilst Edelson's (1985, 1986) guidelines also stress the particularisation of the case narrative rather than its generalisation, there is still an implication that researchers should consider the extent to which the hypothesis from a single case can be generalised to similar cases (rule 8 in table 16). However, this can be a difficult task, especially for clinical case studies that involve highly particular conditions and operations. Future research should seek to address this epistemological gap, which would also provide a clearer differentiation between a 'representative' case and a working hypothesis case study.

3.5 The use of multiple epistemological concepts in systematic case studies

Thus far this paper has focused on describing how each of the three epistemological concepts contributes to knowledge generation in single case studies. However, case studies often employ (implicitly or explicitly) multiple forms of epistemological reasoning to arrive at their findings.

Systematic case studies are ideal for utilising multiple epistemological frameworks: they gather both qualitative and quantitative data to formalise assessments; they rely on existing clinical, theoretical and research bodies to provide coherent descriptions of the studied object; and finally, they go beyond therapist interpretations and clinical hypotheses by outlining treatment processes and subsequent "course corrections" (Dattillo & Edwards, 2010). These components distinguish the systematic case study as a mixed method approach that is invested in combining two central components of psychotherapy research: *1)* providing detailed qualitative descriptions of

the treatment process and patients' subjective experiences, and *2)* making more general theoretical inferences that are relevant to the broader field of psychotherapy practice and research (Vertue & Haig, 2008; Fishman, 1999, 2013; Iwakabe & Gazzola, 2009).

This means that systematic case study authors are also more likely to provide detailed descriptions of their reasoning processes (although not necessarily in the sense of acknowledging concrete epistemological concepts or frameworks). This is usually done via *clinical reasoning* (decision–making and problem–solving processes) and *case formulation* (identifying mechanisms, processes and symptoms that are causal to patients' behaviours and conditions in order to formulate a guided treatment decision) aspects of the study (Vertue & Haig, 2008). In this way, a single systematic case study can produce a number of knowledge claims, pertinent to several different strands of psychotherapy research.

But the problem of not being explicit enough in justifying one's epistemological reasoning, which I already addressed in earlier sections, continues to remain. The epistemological issues in clinical case studies generally involve not going far enough in: choosing between rival or competing causal accounts (retroductive reasoning); explicitly defining generalisable aspects that make single case studies "representative" (analytic generalisation); and comparing candidate theories to rival hypotheses and counter–examples (working hypothesis). Although these very same issues are also relevant to systematic case studies, the multiplicity of different data sources in the systematic case study method poses yet another overarching problem: not distinguishing between the different forms of epistemological frameworks sufficiently enough (or at all).

For example, a systematic case study may provide a very detailed case formulation, thus contributing to well–informed treatment processes and a positive therapeutic outcome (Vertue & Haig, 2008). However, if all the different epistemological

frameworks remain largely implicit or unacknowledged in the case narrative, the findings will not be easily transferrable to other cases. As such, epistemically complex systematic case studies should be *pragmatically* clear on the different standards and aims with which they are producing their knowledge claims (Fishman & Messer, 2013):

> To understand and cope with the world, we take on different conceptual perspectives as we might put on different pairs of glasses, with each providing a different perspective. [...] *Pragmatic truth lies in the usefulness of the perspective in helping us to solve particular problems and achieve particular goals in today's world* (p. 159).

In order to demonstrate how multiple epistemological concepts can be utilised in systematic case studies, I will discuss Durland's (in press) series of case studies on telephone–based Cognitive Behavioural Therapy (CBT) for depression in Parkinson's Disease (dPD). The study involves four case studies and features all three epistemological concepts discussed in this paper. For this paper's purposes, I will focus on two of the four cases – "Alice" (a responsive case with a positive outcome) and "Ethan" (a non–responsive case with a negative outcome).

It is important to note that I am interested in the reasoning processes used by Durland in his capacity as researcher. Although this overlaps with his role as a clinician, the below discussion focuses on how he produces knowledge claims that are pertinent to psychotherapy research more broadly (i.e., how he moves from a single case to guidelines and recommendations to other researchers).

Table 18. CASE EXAMPLE: Two systematic case studies on telephone–based Cognitive Behavioural Therapy (TH–CBT) for depression in Parkinson's Disease (dPD) utilising multiple epistemological concepts (Durland, in press)

(1) Case description 1: "Alice". Alice is a 70–year old married, domiciled, and retired Caucasian woman living in Central New Jersey. She has been diagnosed with Parkinson's Disease (PD) 9 years prior to intake. Her husband and caretaker, 69–year old Bob, reported a close relationship with Alice, with no significant marital discord. For most of her life, Alice felt happy and energetic, with a full social calendar. Ever since her PD diagnosis, however, she became less comfortable and interested in socialising with people. A year and a half prior to intake, Alice reported feelings of sadness, sensitivity, setbacks, and disappointment. She did not engage with social activities or other people aside her husband, and there were several periods lasting weeks where Alice barely left the house. Alice's depressive symptoms include depressed mood, anhedonia, insomnia, difficulties in concentration, poor appetite and weight loss. Before her PD diagnosis, Alice did not have any psychiatric illness; however, she regularly experienced panic attacks.

(2) Implicit epistemological reasoning processes.

(2.1) Retroductive reasoning. Durland conceptualised Alice's depression as being caused by the stress and functional impairment associated with Parkinson's symptoms. In turn, this contributed to Alice's disengagement with rewarding social activities, such as exercise, socialising, and church involvement: "I saw Alice's depression as *maintained* by a self–reinforcing cycle of negative interpretation of her experiences and further withdrawal from rewarding activities" (p. 19). Drawing on Alice's qualitative expressions in the treatment, Durland was able to identify the negative thoughts and beliefs that reinforced Alice's depressive symptoms, for example: "*It will be embarrassing for my friends to see me in the state I am in"*; "*I can't handle the challenges of being involved at church like I used to*"; and the core belief "*I am fundamentally flawed*" (p. 19).

The latter thought is a crucial part of case formulation and retroductive reasoning. From a CBT perspective, thinking errors and cognitive biases are *causally*

responsible for disruptions in emotional regulation: "These thoughts contributed to Alice's depressive symptoms by lowering her sense of self–efficacy and reducing her engagement in activities that might have improved her mood" (p. 19). However, it is not clear how Durland came to identify Alice's core belief. This can be clarified by drawing on the patient's particular actions or thoughts. It is also important to clarify whether such core beliefs emerged spontaneously or during a self–report questionnaire.

In addition, Alice's husband, Bob, inadvertently reinforced Alice's worries about social activities by compensating for Alice's lack of activity (e.g., by speaking for Alice in social settings) and rewarding her for behavioural avoidance (e.g., by justifying her anxiety at the prospect of interaction).

Durland's qualitative case formulation enabled him to perform a retroductive analysis of Alice's condition (dPD). As per the process of retroductive reasoning in a case study (see table 7), Durland outlined two possible causal mechanisms and their interactions in Alice's dPD condition: *1)* the physical and psychological impact of Parkinson's symptoms, which led Alice to a self–reinforcing cycle of negative self–perception, and *2)* further reinforcement from her husband and caregiver, Bob, who rewarded Alice for behavioural avoidance. As such, there are both physical (PD symptoms) as well as social (Alice's self–perception and her husband's behaviour) causal mechanisms at work.

This retroductive analysis allowed Durland to make the following clinical decisions: encourage Alice's engagement in meaningful social activities and increase Alice's autonomy in social situations (with and without her husband Bob). Both activities were developed to target the underlying causal belief behind Alice's dPD: "*I am fundamentally flawed*" (p. 19).

(2.2) Working hypothesis. At the beginning of treatment (Module 2), Durland began to compare Alice's expected enjoyment of social activities and her actual feelings: "[Alice] had a lunch date with friends, and had been surprised at how

much she enjoyed their company, and that while she experienced some [difficulties] with sufficient volume and following conversation, these issues had been much less significant than she had expected" (p. 21). On this occasion, Alice rated her Expected Pleasure as a 30 and her Actual Enjoyment as a 70. Herein, Durland considered the importance of "Acting In Accordance With Goals And Not Feelings". This is one of the concepts for TH–CBT, which suggests that depressive symptoms often prevent individuals from engaging in various activities, and that this barrier may be overcome by just "getting started" (rather than immediately and fully participating in activities).

Based on the discrepancy between Alice's anticipated and actually experienced feelings, Durland formulated a working hypothesis that Alice would strongly benefit from engaging in various social activities even if she does not "feel like" it. From this point on, Durland and Alice framed "Acting In Accordance With Goals And Not Feelings" as a form of 'experiment': will Alice's expectations match up with her actual mood during social activities?

As per Edelson's criteria of epistemologically sound and rigorous working hypotheses (see table 16), we can also observe that Durland sought to assess whether his hypothesis about the discrepancy between Alice's expected and actual enjoyment was impacted by their (Durland, Alice, and Bob's) interpretations of Alice's feelings. To help with this, Durland revisited the cognitive model with Alice and Bob to discuss how thoughts and interpretations guide feelings: "Alice and Bob seemed to get caught up in the details of the examples and assessing whether they matched Alice's literal experience" (p. 23). In an attempt to demonstrate a more relatable example, Durland provided a hypothetical comparison between Alice's actual mood prior to a lunch date with friends, and what Alice's mood would have been if she knew that she was going to enjoy her lunch with her friends as much as she eventually did. The hypothetical example provided a firmer ground for Alice and Bob's further assessments of Alice's Expected Pleasure and Actual Enjoyment. This is an illustration of how a working hypothesis is used in practice.

In Module 3, both Alice and Bob "expressed a growing confidence in Alice's autonomy" (p. 23) as a result of her active participation in social activities. This outcome supports Durland's working hypothesis: since there have been no other changes in Alice's lifestyle, we can assume that the "Acting In Accordance With Goals And Not Feelings" treatment component has been effective in producing a positive change in Alice's self–perception.

(2.3) Analytic generalisation. Durland continued to emphasise that Alice's worldview was "the most amenable [out of all cases] to that of the TH–CBT program" (p. 139). As a result, Durland was able to explicate three important generalisable attributes from Alice's case study:

- Alice's concrete cognitive style fits well with the clarity and structure of the CBT therapeutic approach;
- Alice has fully accepted her PD diagnosis, and was therefore oriented toward active coping throughout the treatment;
- Alice had a supportive caregiver who helped her with the treatment progress and allowed her to become more autonomous.

Alice's cognitive functioning was rated as relatively poor, particularly in abstract thinking and memory. She struggled to remember information from previous sessions and was often not able to generalise from specific examples to underlying concepts (e.g., when discussing cognitive distortions).

The fact that Alice's mood improved after she began engaging in social activities autonomously (as per Durland's working hypothesis on the benefit of "Acting In Accordance With Goals And Not Feelings") shows that the treatment was successful in restructuring Alice's negative beliefs in spite of her cognitive issues. The three preconditions listed above enabled Alice to perform her homework, and engage with all the different treatment components. This ultimately led to a positive treatment outcome.

In the paper, Durland compared the case of Alice to three other cases, in which patients underwent the same form of treatment (TH–CBT program) for the same condition (dPD). This comparison is crucial for the process of analytic generalisation (see table 10 on p. 28): the case similarity ensures that there are many common attributes, which can be then further generalised to the broader population of patients with dPD. Alice's case implies that Telephone–Based, Clinician–Guided Self–Help Cognitive Behavioural Therapy (TH–CBT) can have a very positive outcome for those patients who have limited cognitive functioning, have accepted their PD diagnosis, and continue to receive psychological support from caregivers or family members.

(3) Case description 2: "Ethan". Ethan is a 73–year old, married, domiciled, and retired Chinese–American man living in New York. He has been diagnosed with Parkinson's Disease 6 years prior to intake. Ethan's wife and caregiver, 73 year–old Fay, reported no significant marital discord. Ethan reported first noticing depressive symptoms in 2007. After a six–month remission, the symptoms returned in 2008 and have been present ever since. Ethan stated being active, upbeat and physically active for most of his life. However, Ethan's PD diagnosis and deteriorating eyesight began to limit his physical, cognitive and emotional capacities. Ethan's symptoms include depressive mood, disturbed sleeping patterns, poor concentration, increased appetite, helplessness and hopelessness. Like Alice, Ethan reported feeling distressed by his PD diagnosis, especially when he spent time with friends and relatives who knew him "from before".

(4) Implicit epistemological reasoning processes.

(4.1) Retroductive reasoning. Unlike Alice, Ethan reported a history of significant psychological difficulties. As such, Durland's case formulation begins with a retroductive assessment of these issues: in 2008, Ethan stated that he felt "sad" about 25% of the time, experienced disturbed sleeping patterns, increased appetite, poor concentration, and hopelessness. Ethan associated most of these symptoms with the physical (functional) impairment of his PD. Ethan was

distressed by his PD symptoms, and found them particularly difficult when he spent time with "friends and others who knew him "before PD" (p. 75). In addition to a PD diagnosis, Ethan was also diagnosed with Major Depression (Moderate, Recurrent), and was taking 75mg Zoloft daily.

Durland conceptualised Ethan's dPD as being caused by "significant functional impairment resulting from PD and other medical conditions (e.g., a cataract, putative celiac disease, lingering musculoskeletal injuries" (p. 76). This led to a disengagement with such rewarding activities as tennis, socialising, and singing. It also contributed to negative predictions of what engagement with these activities would feel like. Ethan's qualitative expressions were particularly important in identifying the causal beliefs behind his dPD. They conveyed similar negative beliefs to Alice's, but also involved severe feelings of guilt about the impact of Ethan's functional impairment on others: *"I am useless"*; *"If I go to the exercise class, it will be unsafe"*; *"I cannot navigate the world anymore"*, and the core belief, *"I am worthless"*. As in Alice's case, it is unclear whether Durland generated this belief on the basis of Ethan's other responses or whether this belief emerged during the treatment/self–report questionnaires.

Durland also noted that Ethan's wife and caregiver, Fay, was actively contributing to Ethan's poor self–view by "overemphasizing his deficits relative to his strengths, frequently communicating her frustration with his functional impairment, and positively reinforcing Ethan's inactivity by taking charge of many activities Ethan was capable of performing" (p. 76–77). Durland outlined two possible causal mechanisms and their interactions in Ethan's dPD condition: *1)* the physical and psychological impact of Parkinson's symptoms and other medical conditions, which led Ethan to a self–reinforcing cycle of negative self–perception and guilt, and *2)* lack of support from Ethan's wife and caregiver, Fay, who reinforced Ethan's poor sense of self–efficacy and overemphasised his deficits. In comparison to the case of Alice, Ethan's case proved to be more complex both in physical as well as social causal mechanisms.

(4.2) Working hypothesis. Durland proposed that Ethan increases his engagement in social activities in a more careful and selective manner: "I [...] proposed that we look for new activities that were feasible for Ethan, and posited that involvement in *meaningful activities*, regardless of details, was likely to improve his mood" (p. 77). Ethan seemed to appreciate this, and offered examples of activities that helped him "forget about" physical pain and low mood.

Like Alice, Ethan also reported several instances in which he had "not felt like participating" in […] activities beforehand, but found them highly rewarding once he was engaged" (p. 77–78). As such, Durland was able to utilise his earlier hypothesis involving the "Acting In Accordance With Goals and Not Feelings" concept, with which he proposed that "one of the most important means of overcoming depression involved pushing through [negative] feelings by engaging in the activity in spite of them" (p. 78). However, both Ethan and Fay had concerns about this: Ethan worried about physically hurting himself and being a burden to others, whilst Fay was concerned about Ethan missing out on beneficial activities due to fatigue.

It is clear that Durland's earlier working hypothesis, which worked well with Alice, had to be adjusted to account for all the different complex issues involved in Ethan's dPD. This included exploring Ethan's past and present pleasurable activities, and assessing how they can be incorporated into the treatment now. In the end, the working hypothesis in Ethan's case involved a moderate engagement in meaningful (emotionally comforting and not overly physical) activities. Durland postulated that this would have a positive effect on Ethan's negative self–view, particularly his underlying causal belief *"I am worthless"*.

At the same time, Durland acknowledged that, unlike Alice, Ethan has not come to terms with his PD diagnosis, and struggled to adapt to a life with multiple medical conditions. Moreover, Ethan's wife, Fay, contributed to Ethan's self–reinforcing cycle of negative self–perception. For example, she considered Ethan's computer work to be "mindless and unhealthy" (p. 79), whereas Ethan felt that doing certain

computer tasks (e.g., monitoring finances or fixing bugs) made him feel useful. These two factors posed barriers to Ethan's treatment process and Durland's working hypothesis.

Indeed, throughout the subsequent sessions, there was little improvement to Ethan's self–perceptions or engagement in social activities. In Module 4, Ethan struggled to understand how a negative thought can be changed based on evidence. He did not believe that he was useful on the basis of his contributions to the household (e.g., keeping track of bills and solving computer and phone problems), even after Fay communicated this. Durland noted that Ethan evaluated his productivity negatively, "in comparison to a younger, PD–free version of himself" (p. 85). By Module 10, it was evident that Ethan and Fay struggled to work together, and that some of the treatment techniques created further conflict between them. Durland conducted two Booster sessions with Ethen and Fay to discuss these issues and to work on a plan to resolve similar conflicts in the future.

(4.3) Analytic generalisation. Just like in the case of Alice, there are several aspects that can be generalised from Ethan's case:

- Ethan's concrete cognitive style posed difficulties in adapting to the TH–CBT program.
- Ethan has not fully accepted his PD diagnosis, and he therefore continuously focused on his "pre–PD self".
- Although Ethan's caregiver often helped him in understanding and engaging with different treatment processes, their different approaches to certain therapeutic techniques also proved to be a cause for conflict.

Ethan's PD symptoms involved deficits in executive functioning, working memory and reinforcement learning, which were particularly challenging for achieving the aims set out in the TH–CBT program. Furthermore, Ethan struggled to internalise and identify cognitive distortions. This meant that Ethan was unable to assess his negative thoughts against salient pieces of evidence (e.g., Ethan being useful to the

household). As such, the underlying causal mechanisms – the impact of Ethan's PD condition and the core belief "*I am fundamentally flawed*" – have remained largely unchallenged.

As could be seen from the earlier retroductive analysis, Durland identified another causal mechanism in Ethan's dPD: the interpersonal exchanges between Ethan and his wife and caregiver Fay. Since Ethan's cognitive deficits had such a significant impact on his engagement with the treatment, Fay's involvement in the treatment was highly important. However, this also inadvertently contributed to a decrease in Ethan's autonomy. Moreover, since Fay expressed critical views about Ethan's activities, Durland "felt more hesitant to risk alienating her by addressing her critical attitude toward Ethan" (p. 107). These significant and pervasive interpersonal issues created yet another barrier to the treatment process.

It is important to note, however, that Ethan was able to put the needs of the group (his family and friends) ahead of his own individual feelings toward the end of the treatment: "Ethan seemed surprised at how much his low mood had impacted his family members, and was able to recognize this impact as a significant "cost" of his negative thoughts" (p. 113).

From an analytic generalisation standpoint, any representative case – whether it is responsive or non–responsive, positive or negative – can be used to generate knowledge about a theory that pertains to a population. Ethan's case provides important implications for the potential barriers faced by PD patients in TH–CBT program. Furthermore, since Ethan's case deviated from the three most important attributes identified in Alice's case (concrete cognitive style, acceptance of PD diagnosis and supportive caregiver), it also provides support for Durland's original analytic generalisation about the compatibility between PD patients like Alice and the therapeutic techniques used in TH–CBT program. This is known as *theoretical replication*: the case produced contrasting results (negative outcome/no response to the working hypothesis) for predictable reasons (Ethan's

incompatible cognitive style, lack of acceptance of PD diagnosis, and interpersonal issues with his wife/caregiver).

3.6 Concluding comments

There have been two predominant views on case studies in the fields of psychoanalysis and psychotherapy. The first view deems case studies as an insufficient methodology for producing clinical evidence or theoretical developments; this puts them in need of corroboration from statistical and/or experimental research. The second, and more popular view amongst psychoanalytic clinicians, is that case studies convey subjective interpretations that cannot be rigorously assessed by any scientific canons. This paper does not position itself with either of these views. Instead, I have argued that case studies are a viable methodology in itself, capable of producing different kinds of knowledge, and that it can – and *should* – respond to the relevant epistemological rules and canons of evidence.

Drawing from different social science resources, this paper described three epistemological concepts appropriate for case study research: retroductive reasoning, analytic generalisation and working hypothesis. It is important to note that, although one case can utilise multiple epistemological frameworks, the three epistemological concepts described in this paper seek to generate different kinds of knowledge. It is therefore crucial that case study researchers know how to choose the relevant epistemological concept for their work, and how to combine different kinds of epistemological frameworks.

Retroductive reasoning is suitable for research endeavours that seek to trace causal powers and mechanisms in complex social phenomena, such as those in clinical

practice. Analytic generalisation can be used to generalise from observations in single case studies to theory. Working hypothesis case studies are particularly useful for assessing and revising existing theoretical propositions by testing them in practice with specific patients. Clear differentiation between these epistemological concepts will allow case study researchers to utilise them more effectively, and, as Easton (2010) argued, to use epistemological frameworks explicitly rather than implicitly (or not at all).

It is also necessary to acknowledge some of the drawbacks and persisting challenges across all three epistemological concepts. Unlike analytic generalisation and working hypothesis, retroductive reasoning is a far more ambitious epistemological concept since it is embedded within the philosophy of CR and its ontological preconceptions about the world. Moreover, the process of retroduction places a high value on the production of causal knowledge, which is less relevant for the other two epistemological concepts. Causally significant findings are, of course, highly desirable for case study research in psychotherapy and psychoanalysis, especially because patients' experiences often involve a number of complex causal powers that cannot be adequately captured by statistical analyses.

However, much of the literature on retroduction remains to be on metaphysical grounds; it tells us what we can know about reality, but not how we can apply realist claims in an empirical way. This problem is partly caused by ambiguous and/or conflicting accounts of CR. For instance, Acher et al. (2016) defined CR "not as an empirical program [...] not even truly a theory [...] rather, a reflexive philosophical stance concerned with providing a philosophically informed account of science". But as White (1997) argued, producing informed and realistic knowledge is much more than just being sceptical. After all, the central premise of both Bhaskar's and Sayer's definitions of retroduction is the production of causal expectations (and Sayer is clear that this can be

done empirically). Archer et al.'s definition seems to undermine this. It is therefore important to explicate clear definitions of retroductive reasoning and its relation to case study methodology.

Since the concepts of analytic generalisation and working hypothesis are not embedded in complex epistemological frameworks (i.e., they do not contain a philosophy about the world and knowledge), they have been used implicitly in psychoanalytic and psychotherapy case studies. The examples provided in this paper – Heimann's (1950) work on countertransference and Vaskinn et al.'s (2011) case on narrative therapy – are cases that fall under these epistemological concepts implicitly, but do not make any explicit epistemological claims. This in itself is problematic because it means that case study researchers who are producing generalisations or hypotheses are less likely to address concrete epistemological guidelines or canons of evidence. In order to attend to these issues, I sought to make the case–to–theory logic developed by Yin (2013) and Kennedy (1979) relevant to the current generalisation issues in psychotherapy research. Similarly, I developed Cronbach's (1975) definition of the working hypothesis case study in relation to theory testing issues in psychoanalysis and psychotherapy. The more explicitly case studies follow the latter epistemological guidelines, the better equipped we will be to assess what is a 'good' working hypothesis or analytic generalisation in the field.

Finally, this paper sought to demonstrate how the use of multiple epistemological concepts allows for rigorous case study research. Systematic case studies are methodologically suitable for this task because they utilise different forms of data and produce a number of knowledge claims, pertinent to several different strands of psychotherapy research. By discussing Durland's (in press) systematic case studies on telephone–based Cognitive Behavioural Therapy (TH–CBT) for depression in Parkinson's

Disease (dPD), I demonstrated how the three epistemological concepts can be used together in case narratives.

The writing of case studies is a creative exercise, and there are no general 'norms' when it comes to conveying clinical material. However, as case study researchers, we have a responsibility to clarify how we arrived at our knowledge claims, and why these claims are important to our field. The impetus of this paper is to make this process easier by providing epistemological guidelines and canons of evidence that can improve the credibility and rigour of case study findings.

Chapter 4: Scientific thinking styles: The different ways of thinking in psychoanalytic case studies

Abstract

Historian and philosopher John Forrester argues that psychoanalysis is characterized by a style of scientific thinking and reasoning that he coins "thinking in cases". Since Freud, case studies have been used as a medium for sharing, demonstrating, discovering, expanding, consolidating and "thinking" psychoanalytic knowledge. In this paper, we seek to clarify and enrich Forrester's idea of thinking in cases. We first attend to issues around the lack of definition for thinking styles, and we propose a more detailed description for what might constitute a scientific thinking style. Second, we outline how thinking in cases differs from other kinds of thinking styles. In doing so, we argue that some of the criticisms directed at case studies are the result of a confusion between statistical and experimental thinking styles and thinking in cases. Finally, we propose that there is more than one way of thinking in cases. We distinguish between cases as exemplars for analytic generalization, cases as exemplars for analogical learning, and cases in the service of empirical generalization. By making these implicit thinking styles explicit, we seek to demonstrate the importance of case studies at all levels of psychoanalysis: clinical, research, training and teaching.

Keywords: *Freudian theory; History of psychoanalysis; Philosophy; Applied psychoanalysis*

4.1 Introduction

In this paper, we will argue and elaborate Cambridge historian and philosopher John Forrester's idea that thinking in cases is a unique style of thinking and doing science, with particular relevance to psychoanalysis. When Freud turned from neurology to psychoanalysis, it was not just a shift in theoretical model, but also a departure from one scientific thinking style to another. Using classic cases by Freud, Stoller and Winnicott, Forrester (1996, 2017) developed the idea that case studies are the medium (or one might say container) par excellence for sharing, demonstrating, discovering, expanding, consolidating and "thinking" psychoanalytic knowledge. After all, psychoanalysis is both "*(1)* a particular method of treating nervous disorders and *(2)* the science of unconscious mental processes" (Freud, 1926, p. 264), and the case study is the format that straddles both sides. Borrowing Thomas Kuhn's (1962) concept of the exemplar, Forrester (2017) was able to outline how case studies lead to practical knowledge and collective scientific labour:

> One learns how to do science not by learning the rules of principles or concepts and then applying them to concrete situations; rather, one learns how to do science by learning how to work with exemplars: extending them, reproducing them, turning a novel situation into a version of a well–understood exemplar (p. 7–8).

The aim of this paper is to clarify and enrich Forrester's "positive epistemology" for psychoanalysis (Mayer, 2017) based on the idea of thinking in cases as a scientific thinking style. A scientific thinking style is not a philosophically defined ways of

reasoning such as induction or deduction, but a philosophically informed account of what scientists actually do. It entails not only cognitive operations relating to methodology and argumentation, but also practices of generating, sharing, relocating, assimilating, transforming and empathizing with knowledge. Although we rely on the philosophical work by Ian Hacking and Alistair Crombie to outline the development of the concepts of scientific thinking and doing, we also seek to examine some of the criticisms posed to the definition of scientific thinking style.

After addressing the concept of scientific thinking style, we seek to draw these philosophical ideas closer to thinking in cases in the field of psychoanalysis. Ever since the inception of psychoanalysis, psychoanalytic case studies have been criticized for a variety of reasons: lack of generalizability, replicability issues and subjective bias, to name a few. We argue that some of these concerns can be productively explored by explicating the process of thinking and doing science in psychoanalytic case studies. We outline how thinking in cases differs from other kinds of thinking styles, such as statistical and experimental thinking styles. Attending to these differences is crucial as it allows to differentiate not only *how* (process) but also *what* (end–goal) knowledge each thinking style seeks to produce.

Furthermore, we propose that there is more than one way of thinking in cases: beyond exemplars for analytic generalization, one can also think in cases as exemplars for analogical learning, and cases as part of a population for empirical generalization. Identifying the various modes of thinking in cases in psychoanalysis allows for a closer inspection of different processes and scientific canons "in action" in classic and contemporary psychoanalytic cases. Given the fact that thinking in cases as a scientific thinking style is not unique to psychoanalysis, psychoanalysis can learn from epistemological and methodological advances in other case–oriented disciplines. For this

reason, our paper draws on the recent work done in the social sciences in relation to the case study method. Hammersley and Gomm (2000) write in the introduction to their important book *Case Study Method* that case studies had been eclipsed as a method of social research in the 1980s. Since then, recognition of the case method has been increasing, and Yin (2014) provides data to substantiate this claim. Interestingly, a similar trend has been noted in psychoanalysis, with increasing numbers of case studies being published in scientific journals (Desmet et al., 2013) in many schools of psychoanalysis (Willemsen et al., 2015). An international team of researchers have brought together these increasing numbers of published case studies in a searchable online archive (https://www.singlecasearchive.com). The invigorating work done by the European Psychoanalytic Federation Working Party on Comparative Clinical Methods (Tuckett, 2008) and the International Psychoanalytical Association (IPA) Project Committee on Clinical Observation and Testing (Bernardi, 2014) confirms the continued interest in developing the case study method. These developments show that the case study is still a relevant epistemic genre, not only in psychoanalysis, but also in social sciences. By clarifying thinking in cases as a scientific thinking style, we hope to push forward our understanding of the value of the psychoanalytic case and to make a contribution to psychoanalysis as a science in clinical, teaching and research contexts.

4.2 What is a scientific thinking style?

Philosopher Ian Hacking (1992, 2012) has argued that there is not one universal science that brings together the social, human and natural sciences. Instead, he has proposed that there is a plurality of sciences that use different styles of thinking, doing, talking, arguing and showing what each science settles to be objective truths. As such, styles of scientific

thinking and doing are practical and active modes of investigating and "finding out". Each thinking style conveys how (not just what) researchers find out about their studied phenomena. In other words, thinking styles have a performative quality: they are ways of doing science.

It is difficult to define what a style of scientific thinking and doing is, because, as Buchdahl (1993) has suggested, "the existence of 'style' […] is never simply representational" (149). According to historian of science Alistair Crombie (1988), thinking styles consist in:

> The various elements that make up an intellectual style in the study and treatment of nature: conceptions of nature and of science, methods of scientific inquiry and demonstration diversified according to the subject matter, evaluations of scientific goals with consequent motivations, and intellectual and moral commitments and expectations generating attitudes to innovation and change (p. 2).

Crombie (1988) identified six thinking styles, and there is no reason to assume that this is an exhaustive list: mathematical postulation and proof, experimental observation and measurement, analogical or hypothetical modelling, taxonomy and classification of natural kinds, statistical analysis of regularities, populations and probabilities, and historical–genetic thinking. These thinking styles are not objective in themselves: they are not "natural" or "given" ways of acquiring truth. Rather, they were developed by humans (and as such, they are grounded in human cognition and cultural history) as a means to conduct investigations or answer to certain scientific standards. For example, before the mid–seventeenth century, there was no real concept of probability and statistics in Europe; nowadays, a statistical thinking style is advocated by Nobel prize–

winning psychologist Daniel Kahneman (2011) as the most reasonable way to take decisions in any field of social life.

An important feature of scientific thinking styles resides in the fact that they introduce new objects, propositions or explanations about their studied phenomena. That is not to say that the studied phenomena do not exist outside the thinking style. Rather, thinking styles introduce new, but fundamentally different ways of representing the phenomena. Each thinking style allows scientists to speak, think and act in a unique way about their object of study. Compare for instance the following meaningful propositions made about a depressed patient in three different scientific thinking styles:

1) Within the statistical thinking style, one can say: "Patient X scores above the clinical cut–off on the Beck Depression Inventory–II." This proposition represents the depression of the patient as a metric and situates that metric within a population (i.e., the sample that was used to statistically infer a cut–off score).

2) Within taxonomy and classification thinking style, one can say: "Patient X can be diagnosed as having a major depression in terms of the Diagnostic and Statistical Manual of Mental Disorders." This proposition represents the depression as belonging to a class that is defined by a number of diagnostic criteria, and situates this class in relation to other classes (e.g. the class of bipolar disorder, the higher order class of affective disorders, etc.).

3) Anticipating the next section in this paper, we would like to add that, within the psychoanalytic thinking in cases style, one can say: "Patient X suffers a core psychic conflict between love versus anger, hostility and ambivalence towards the lost object." This proposition represents the depression as a psychic conflict that

> is situated within the patient's past and current life (e.g. past and current experiences of loss, separation, deprivation and grievance).

Each proposition is only meaningful within its style. For instance, proposition *1)* relies on the application of a specific instrument (questionnaire), according to a specific methodology (standardized test situation), on the basis of specific assumptions (depression is a unidimensional, quantifiable object of study), by a person with specific skills (test administration and test interpretation), in order to show the depression in a specific way (line graph, chart, numerical table), with a particular goal (to determine the severity of a depression) and a certain persuasiveness (e.g. the statistics behind the development of the questionnaire). For someone who operates within the taxonomy and classification thinking style, proposition *1)* is not meaningful (although they might understand the proposition based on previous encounters with the statistical thinking style), and it does not help to make a categorical diagnosis of patient X. In that sense, each thinking style creates its own objects (in this case, depression as a unidimensional construct, as a mental illness or as an expression of a psychic conflict) and is associated with very different research practices. This does not mean, however, that the object is entirely constructed by the style: the experience of depression remains to be very real, but its conceptualization differs in each thinking style.

Hacking (1992, 2012) asserts that styles of scientific thinking and doing are self–authenticating, in a sense that they do not answer to some other, higher or deeper standard of truth and reason than their own:

> There is no higher standard to which [thinking styles] directly answer […] It is our knowledges that are subject to revolution, to mutation, and to several kinds

> of oblivion; it is the content of what we find out, not how we find out, that is refuted (1992, p. 13).

We do not take this to mean that there are no standards of verification, but rather that standards of verification are internal to the style in which they are developed. Scientific thinking styles provide their own in canons of verification that provide *conditions for truth*:

> Each style has become what we think of as a rather timeless canon of objectivity, a standard model of what it is to be reasonable about this or that type of subject matter […] and to be reasonable in this or that domain (Hacking, 1992, p. 10).

Hacking gives the example of significance testing in the statistical thinking style: statistical calculation allows the scientist to estimate a parameter and at the same time estimate the probability of this estimate to be correct. This canon of verification through significance testing is not a reflection of a higher or deeper "meta–canon" for determining the truth; it is an internal standard.

Critics have accused Hacking of epistemic relativism for his claim about the self–authenticating nature of scientific thinking styles, because all epistemic systems (that are encompassed by different thinking styles) could be perceived, in some sense, as equally valid (Kusch, 2010; Sciortino, 2016). This means that the justifiability of a given proposition depends entirely on the respective style of reasoning and its implicit canons of verification. The risk here is that, even if different styles might value each other's claims, there will be "epistemic ambivalence" because the two will have their respective verification canons upon which different truth claims can be judged. There is also the

issue of "epistemic disagreement": as different thinking styles have their own epistemic principles for putting forward relevant propositions (e.g., average income statistics do not express a proposition relevant to the experimental thinking style), the same proposition can be relevant to one domain of reasoning, but not to the other. Thus, there is a broader issue of how we justify and/or compare truth claims put forward by different thinking styles, which has not been sufficiently addressed in Hacking's writings.

The debate about epistemic relativism is still ongoing and we do not claim to be able to resolve this deep philosophical controversy. We do want to point out, however, with Kusch (2010), that Hacking is not referring to the "anything goes" kind of relativism: "once a style of reasoning is in place, its epistemic principles determine whether a meaningful sentence is justified or unjustified, rational or irrational" (p. 167). Let us take the earlier mentioned propositions concerning the depressed patient: *1)* "patient X scores above the clinical cut–off on the Beck Depression Inventory–II"; *2)* "patient X can be diagnosed as having a major depression in terms of the Diagnostic and Statistical Manual of Mental Disorders"; and *3)* "patient X suffers a core psychic conflict between love versus anger, hostility and ambivalence towards the lost object". The validity of these three propositions is not entirely independent as they all relate to the same reality: the depression in patient X. But each proposition is only meaningful in its respective thinking style. Therefore, it might be perfectly possible that proposition *1)* is validated in the statistical thinking style, while propositions *2)* and *3)* are invalidated (or irrelevant) in their respective thinking styles. However, it is not possible that patient X *simultaneously* suffers and does not suffer from a core psychic conflict between love versus anger, hostility and ambivalence towards the lost object.

Although psychoanalysis has been riddled with discussions of its scientific status, little attention has been paid to its underlying scientific thinking style. In this paper, we

build on Forrester's (1996, 2017) insight that psychoanalysis, along with several other disciplines, is characterized by a thinking style that is based on the concept of the case. Case studies have taken up a central place in the development of psychoanalysis, and they remain central despite fierce criticisms (Willemsen et al., 2015). Our aim is to describe the various ways in which the psychoanalytic thinking style "puts the case to work". Herein, we refer to the case study as a broad epistemic genre – *a way of doing science* (Morgan, 2012). This involves not only thinking in (or with) written case studies, but also in cases as teaching examples, cases for supervision, patient cases in clinical practice, etc. In this sense, we seek to describe how the case has been used by psychoanalysts, both classic and contemporary, in their clinical work, their thinking, speaking, presenting and writing about psychoanalysis.

Table 19. KEY CONCEPT: Scientific thinking style
(1) Employed by natural, social and human scientists during processes of knowledge generation; (2) Not a 'natural' or 'given' way of acquiring truth, but developed by humans and therefore grounded in human cognition and cultural history; (3) A practical and active mode of investigating *how* (not just *what*) knowledge is arrived at; (4) A way to introduce, define and investigate objects of study, propositions, laws, and explanations; (5) A set of criteria of what is convincing evidence within the discipline (Hacking's self–authenticating conditions); (6) Displayed in individual thinking processes as well as in discussions, publications, presentations, etc., within the discipline; (7) Stable over time but evolves as a response to changing scientific standards.

4.3 Thinking in cases

Hacking's thesis about the use of different styles of scientific thinking and doing proved to be crucial to John Forrester's work (Mayer, 2017). Forrester, who spent much of his life researching the history and philosophy of psychoanalysis, agreed with Hacking that there is a plurality of sciences, methods and thinking styles. Alongside the list of six thinking styles, Forrester (1996) proposed a seventh: *thinking in cases*. This style of thinking and doing is not unique to psychoanalysis and can be seen "in action" in other disciplines, such as medicine, law, social work, anthropology, management science and psychotherapy. Although these disciplines differ in their studied phenomena and methods of enquiry, they nevertheless share a scientific interest in thinking about their "objects" through cases. For example, every teacher in psychoanalysis knows that it is impossible to explain the idea of psychic conflict without referring to a vignette. It is as if knowledge in each of these disciplines can never fully emancipate from concrete instances. The case–based reasoning in these disciplines can be observed in the following ways (Forrester, 2017):

1) They have a different relation to theory, in the sense that the specificity of the case is central;
2) They reason in analogy by creating complex networks of similar and dissimilar cases;
3) Their theories are aimed at problem–solving (action) rather than constituting parts of a body of knowledge (theory) (p. 128–129).

By describing the features of case–based reasoning, Forrester sketches a "positive epistemology" for psychoanalysis – positive since Forrester starts from the strengths of thinking in cases as a scientific thinking style (Mayer, 2017). Forrester works on the assumption that psychoanalysis will benefit more from a thorough investigation of how the thinking style operates within case–based disciplines and how it can be improved from the inside, rather than to criticize it on the basis of canons of verification that are used in other thinking styles. At the same time, however, Forrester acknowledges the limitations of the case study as a method for knowledge generation. Before we continue the description of thinking in cases, we want to remind the reader of some of the essential criticisms raised against psychoanalytic case studies.

The first, and arguably most common, criticism is that of subjective bias: psychoanalytic case studies are seen as potentially "contaminated" by the psychoanalyst's feelings, values and intersubjective pressures. Such biases may emerge from the psychoanalyst's unresolved transference relationships and/or uncontained countertransference dynamics (Hinshelwood, 2013) as well as "excessive" group loyalties within the field (e.g., generating normative or unexceptional case studies in order to conform to existing psychoanalytic ideas) (Spence, 2001). Psychologist Frank Sulloway went as far as to say that Freud's case histories "blend into the kind of psychoanalytically reconstructed history that helped to create the Freud legend.…Case histories are by no means compelling empirical demonstrations of the correctness of his psychoanalytic views" (1991, p. 521). An even earlier and now classic criticism by the philosopher of science Karl Popper (1962) deemed Freud's psychoanalytic case studies unfalsifiable because they are "able to explain practically everything that happened within the [field]…Whatever happened always confirmed it" (p. 45). This resulted in significant research reservations: how can we use knowledge from unique and highly

contextual single cases for other clinical situations? And more importantly, how can we verify that the knowledge produced in these cases is not simply "confirming the theory" or "creating the Freud legend"?

The second criticism raises concerns about the generalization of case study findings. Observations from single case studies are often thought to be of limited value to the study of broader clinical populations as they "provide no indication as to whether the [conclusions apply] to all other, many other, a few other, or no other human beings" (Janis in Wallerstein and Sampson, 1971, 41). The issue of generalization has become increasingly important for clinical research, thus leading to further questions about the value of single case observations.

Finally, there is an overarching question of what one can learn from reading psychoanalytic case studies: are we learning about the patient and their clinical condition or are we tracing the psychoanalyst's interpretations? In most instances, the case study reader is inevitably learning about both. However, there may very well be instances where the representation of the case subject – the patient – is impossibly intertwined with the case author's – the psychoanalyst's – reasoning and thinking processes. This point is further elucidated by Walsh (2020):

> But if case–study writing entails communicating something of the intimacy of the analytic encounter […] then, irrespective of the particular clinical phenomenon it broaches, the case–*study* is a medium that will necessarily fall short of representing the case–*subject* in its entirety (p. 7–8).

This paper does not aim to solve these shortcomings of the case study method. At most, we try to introduce some new ideas in the debate about objectivity and generalization in

psychoanalytic case studies by drawing on methodological and epistemological advances in the social sciences. With Forrester, we argue that thinking in cases is a separate style. Beyond Forrester, we propose that psychoanalysts, past and present, think in cases in more than one way: we can think not only in cases as exemplars for analytic generalization, but also in cases as exemplars for analogical learning and cases as part of a population for empirical generalization.

4.3.1 Thinking in cases as exemplars for analytic generalization

The first mode of scientific thinking is the most typical for psychoanalysis, and arguably the most controversial: thinking in cases as exemplars for analytic generalization. This thinking style in not unique to psychoanalysis, as it can also be found in neurology, sociology and anthropology. Forrester (1996, 2017) used Kuhn's concept of exemplars to describe how knowledge from psychoanalytic case studies can be reproduced and extended in other cases. Beyond Forrester's account, however, there is little clarification as to how the singularity of the psychoanalytic case can be transformed into generalizable observations relevant for other cases. As such, we will be referring to the more recent work done by philosopher of science Mary Morgan (2014), in which she describes a specific strategy of moving from the particular to the general called the *finding of exemplar representatives*. In order to clarify the generalization process in this mode of thinking in cases, we will discuss Robert Yin's (2014) concept of analytic generalization.

An exemplar representative is "one case study that defines the type and thus its characteristics" (Morgan, 2014, p. 1014). The strategy consists in establishing case–specific knowledge as typical and therefore relevant for the understanding of the type of interest. Morgan refers to the Kula ring as an exemplar representative for the

understanding of gift exchange systems. Malinowski's ethnographic description of the ritual exchange of apparently worthless necklaces and armbands between tribes on the Trobriand Islands has become a central point of reference for thinking about the nature of gift–giving in many different cultures and times. Study of the Kula ring reveals that gift–giving can be a means to forge a social connection and that the act of giving is more important than the object that is given. This knowledge about the type helps to understand practices of gift giving in different contexts, for instance on Christmas day in Western societies.

A closer look at Freud's oeuvre reveals that psychoanalysis is founded through the use of similar exemplars. The way Freud organized his material in *The Interpretation of Dreams* (1900) is very illustrative in this respect: after a first chapter in which he reviewed the literature, he devoted his second chapter to the presentation of his exemplar, the famous dream of Irma's injection. The analysis of the specimen dream ends with the postulation of a crucial insight (Freud, 1900):

> If we adopt the method of interpreting dreams which I have indicated here, we shall find that dreams really have a meaning and are far from being the expression of a fragmentary activity of the brain, as the authorities have claimed. *When the work of interpretation has been completed, we perceive that a dream is the fulfilment of a wish* (p. 121, emphasis added).

In other words, the dream about Irma's injection has offered Freud the possibility to redefine the type to which dreams belong: dreams are not "fragmentary activity of the brain" as the writers Freud discussed in the first chapter had claimed, but are psychologically meaningful phenomena. In the same way as Malinowski's study of the

Kula ring redefined our thinking about various practices of gift–giving, the dream of Irma's injection allowed Freud to reframe our thinking about dreams.

In a letter to Fliess, Freud described the opening chapters of *The Interpretation of Dreams* as follows (Freud, 1950, Letter 114):

> The whole thing is planned on the model of an imaginary walk. First comes the dark wood of the authorities (who cannot see the trees), where there is no clear view and it is easy to go astray. Then there is a cavernous defile through which I lead my readers – my specimen dream with its peculiarities, its details, its indiscretions and its bad jokes – and then, all at once, the high ground and the open prospect and the question: "Which way do you want to go?" (p. 290).

It is clear that Freud intentionally put forward one particular case because this particular case allowed him to open up a new perspective on dreams. He entitled this chapter "An analysis of a specimen dream" [*Die analyse eines Traummusters*]. The German *Muster* means model, example, pattern. The other dreams that are described later on in the book are used to refine and expand the description of the type and to verify it, for instance by supplying cases that defy the type as initially described (e.g. the nightmare).

Freud used the same approach in *The Psychopathology of Everyday Life* (1901), which he introduced by analysing the forgetting of the name of Signorelli. The principles he described on the basis of this *Muster* are then used to understand a wide range of parapraxes. The exemplar allowed Freud to lay out from the start the type (in this case, parapraxes as psychologically meaningful phenomena) in its full richness and complexity. The case is assumed to demonstrate something important about the type. In Figure 1, this

reasoning process is represented graphically: type X is studied by looking at case Y, under the assumption that case–specific features A, B and C are important features of the type.

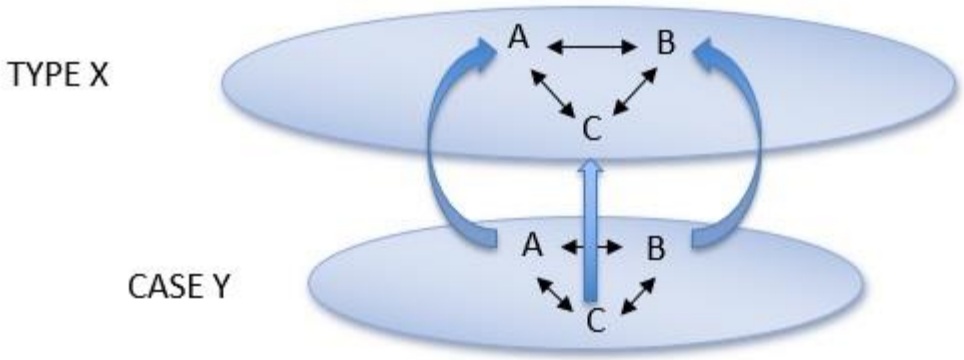

Figure 1. The process of thinking in cases as exemplars for analytic generalization

This reasoning process is what social scientist Robert Yin (2014) calls analytic generalization: "the logic whereby case study findings can extend to situations outside of the original case study, based on the relevance of similar theoretical concepts or principles" (p. 237). In analytic generalization, first an inference is made from an instance (a case) to a hypothesis, a construct or a theory (what we call the type) at a conceptually higher level. Second, this hypothesis, construct or theory can then be applied to other instances (cases) where it seems relevant. Analytic generalization needs to be distinguished from empirical generalization.

In empirical generalization, an inference is made about the features of a population on the basis of a sample from that population (Gomm, Hammersley & Foster, 2000, p. 103). Empirical generalization starts from knowing which population a case belongs to (the case is selected because it belongs to a specific population), and the generalization results in new knowledge about a specific population. For instance, one could be interested in determining whether all dreams are wish fulfilments. We will

return to this in the section on "*Thinking in cases as part of a population for empirical generalization*". Analytic generalization, on the other hand, starts from a theoretically defined situation (the case is defined as a type of…), and the analytic generalization is achieved through corroboration, modification, rejection, expansion or advancement of the theoretical understanding of the type. For instance, with the dream of Irma's injection, Freud demonstrated that the dream is a meaningful psychological phenomenon rather than a disintegrated cerebral activity.

In the case as an exemplar for analytic generalization, the researcher starts from a theoretical or clinical problem and finds a case to investigate the issue. Suitable cases are cases that contain rich data and are clearly linked to the type of interest. The researcher describes the core features of the case, the relations between these core features and the way in which these features are embedded in the complexity of the whole case. By comparing this description with existing theory, it will become clear which theoretical relations can be (dis)confirmed, and which new theoretical relations are revealed in situ.

The Schreber case study (Freud, 1911) is a good example of how Freud built a case into an exemplar. The aim of the Schreber case study is to investigate the clinical phenomenon of paranoia in relation to other forms of psychopathology. Freud did not choose Schreber because he is in any way a typical case of paranoia. In fact, he stresses at one point that Schreber is an "unusual and in itself bewildering" case (1911, p. 18). Freud did not explain why he chose to focus on Schreber (although he does point out that he does not take on paranoid patients for psychoanalysis and therefore has no other option than to work with material from outside the consultation room). The paper is organized in three sections entitled "Case history", "Attempts at interpretation" and "On the mechanism of paranoia". The titles already reveal the process of analytic generalization,

which moves from the particularity of the case over an interpretation of the case, towards a general claim about paranoia. In the third section, Freud came to the conclusion that paranoia is "an independent clinical type" (1911, p. 76) that can be differentiated from schizophrenia. The principle features that Freud found in Schreber are, first, that the mechanism of projection is crucial, and second, that there is a homosexual impulse at the basis of his pathology.

In the final step of his reasoning process, and also in the third paragraph "On the mechanism of paranoia", Freud used Schreber to make a statement about all forms of paranoia (delusions of persecution, erotomania, delusions of jealousy and megalomania):

> it is a remarkable fact that the familiar principal forms of paranoia can all be represented as contradictions of the single proposition: "*I* (a man) *love him* (a man)", and indeed that they exhaust all the possible ways in which such contradictions could be formulated (Freud, 1911, p. 63).

At this point in his reasoning, Freud has moved from the case of Schreber to paranoia as a clinical type and arrived at a conclusion about all forms of paranoia. In other words, the features that he used to define a type (paranoia) on the basis of one in–depth case study, become relevant to many other cases. This reasoning process is similar to what we found in *The Interpretations of Dreams* (the dream of Irma's injection → the dream as a type → various forms of dreams) and in *The Psychopathology of Everyday Life* (the forgetting of the name of Signorelli → forgetting as a type → various forms of parapraxes).

It is important to note that we are not arguing that Freud's conclusions about Schreber are correct, as indeed questions can be raised about the use of an autobiography as the sole source of information and about Freud's method of selecting and interpreting

information from this source. Our point is that his thinking style, which relies on the exemplar, is not revelatory of a predilection for anecdotal evidence on Freud's part, but constitutes a thinking style that is shared with other disciplines and that we now understand better through contemporary work in philosophy of science and the social sciences.

An important limitation of the case as exemplar for analytic generalization lies in the fact that one can end up in a circular mode of thinking. If a type X is studied by looking at case Y, then the features of case Y might get confused with the features of type X. In other words, how can one know whether or not certain features are case specific? This can only be determined by studying more cases. Freud did not constrain his research to just one case. In order to verify his claims about Schreber, he discussed the mechanism of projection in his correspondence with Abraham (1911, 41) and, in relation to homosexuality and paranoia, Freud (1911) wrote:

> Distrusting my own experiences on the subject, I have during the last few years joined with my friends C. G. Jung of Zurich and Sandor Ferenczi of Budapest in investigating upon this single point a number of cases of paranoid disorder which have come under observation. The patients whose histories provided the material for this enquiry included both men and women, and varied in race, occupation, and social standing. Yet we were astonished to find that in all these cases a defence against a homosexual wish was clearly recognizable at the very centre of the conflict which underlay the disease, and that it was in an attempt to master an unconsciously reinforced current of homosexuality that they had all of them come to grief. This was certainly not what we had expected (p. 59).

Two observations can be made here. First, it is striking how Freud presented the Schreber case study as part of a collaborative, international research project involving members from the newly created International Psychoanalytic Association. Pletsch (1982) pointed out the shift in the audience that is addressed by Freud in his case studies: the early case studies (e.g., *Studies on Hysteri*a and the case of Dora) address a medical audience, while later case studies give the impression of a contribution entre nous and were published in the first psychoanalytic periodical, the *Jahrbuch für psychoanalytische und psychopathologische Forschungen*. Second, Freud was aware that one case study does not prove anything, but several case studies conducted by different people can lead to robust knowledge. These other cases act as replications of the original case study. Unfortunately, Freud did not elaborate on the comparison with other cases in the context of the Schreber study.

A contemporary use of the case as an exemplar can be found in the paper by Leuzinger– Bohleber and Teising (2012) on prenatal and genetic diagnostics (PND). They describe the case of a pregnant woman, Mrs F, with a genetically transmitted illness, who discovers that her unborn child will have haemophilia. Mrs F decides to have an abortion, but later has another pregnancy and gives birth to a healthy girl. The research question in this paper is whether this case "can offer a specific and enlightening perspective on this complex and delicate topic [i.e. how people deal with a negative PND]" (p. 294). In order to answer this question, the authors have rich data at their disposal, notably the analyst's report of Mrs F's psychoanalysis and two follow–up interviews 16 years after completion of the treatment. Leuzinger–Bohleber and Teising find that the confrontation with the negative PND triggered an archaic state of mind in Mrs F, characterized by splitting and unconscious phantasies of murder. In the discussion, it becomes clear that the authors think this finding has a broader relevance (analytic generalization): they describe the

decision to have an abortion as potentially traumatic for any woman, as it can trigger the archaic state of mind they found in Mrs F, and they conclude that "all women/couples undergoing late interruptions of pregnancy following PND absolutely need a counterpart to their reactivated archaic inner world in their outside reality – whether in a loving partnership, family, friends, or in the professional medical care during PND" (p. 312). Interestingly, similar to Freud in the Schreber study, Leuzinger–Bohleber and Teising (2012) refer several times to other cases they have studied that supposedly confirm their findings, without discussing these cases in any detail. This confirms the idea that replication of findings is intrinsic to thinking in cases as exemplars, although, unfortunately, these replication studies are barely published (a blemish that marks other sciences as well).

4.3.2 Thinking in cases as exemplars for analogical learning

Thinking in exemplar cases for analytic generalization is not the only mode of thinking in cases. Forrester (1996) seems to allude to this when he briefly mentions the use of the single case for analogical learning, calling it a "*pedagogic* tool that duplicates or repeats an essential element of medical practice" (p. 14, emphasis added). The implication here is that case studies can be used to teach and illustrate situations that are common in clinical practice by offering a vicarious experience of that situation. But Forrester did not further differentiate between the learning and teaching function of cases from the theory–building function of cases. Although one case can be both an exemplar for analytic generalization (providing rich data allowing for an analytic generalization in relation to a type) and an exemplar for analogical learning (providing rich description, detailed experiential accounts and "know–how" knowledge), we argue that these are, in fact, two

different forms of thinking in cases with different processes and end–goals. Whereas thinking in cases as exemplars for analytic generalization involves the process of relocating knowledge about a concrete case into an abstract type, we argue that thinking in cases as exemplars for analogical learning involves the process of re–locating knowledge about one concrete case to another concrete case.

Educational psychologist Robert Stake's book on *The Art of Case Study Research* (1995) is a central resource on the topic of cases as exemplars and their pedagogic qualities. He first notes the importance of having case narratives that are well attuned to human affairs: rich descriptions of relationships, perceptions and emotions rather than objective observables or causal laws. Stake (2010) refers to cultural anthropologist Geertz's concept of "thick description": the case narrative should present a detailed description of the individual or situation and convey an empathic understanding of the latter, including the researcher's interpretations. Herein, Stake (1978) argues, lies the advantage of case studies in comparison to other research methods: "Case studies will often be the preferred method of research because they may be epistemologically in harmony with the reader's experience and thus to that person a natural basis for generalization" (p. 5).

At first glance, Stake's proposition about learning from cases as exemplars seems to be counter–intuitive: on the one hand, he argues that case studies should contain interpersonal and highly contextual data (particularization), and on the other, he suggests that this data can be used to learn something with a broader relevance. For him, the "as if it happened to us" experiential quality of cases allows the readers to engage and recognize similarities between case narratives and their own personal or professional experiences. In other words, the propositional aspects of such case studies capitalize

upon the reader's experience: there is a mental connection with the atmosphere, thoughts, feelings and motivations of the case. Stake (1995) coined this process a naturalistic generalization: "Naturalistic generalisations are conclusions arrived at through personal engagement in life's affairs or by vicarious experience so well constructed that the person feels as if it happened to themselves" (p. 85). However, this process should be described as analogical learning, as it relies on making an analogy rather than a generalization.

This is an important difference from the process of analytic generalization in thinking in cases as exemplars; whereas the latter is focused on extrapolating inferences, hypotheses and findings to *theory*, analogical learning is predominantly used to make *practical decisions* in the consulting room. Furthermore, although analogical learning can teach us something that is common in clinical practice (and so shares an interest in "commonalities" with other ways of scientific thinking), this is not done via statistical patterns of frequency and co–variation. Instead, the focus is on reasoning by analogy and experiential knowing: it went like this before in case *x*, so it is possible that it will go like that again in cases *y* and *z*. For example, a clinician dealing with trauma patients reads a case about transference–related challenges with a patient suffering from traumatic neurosis. The clinician learns about clinical techniques and countertransference reactions that are useful in establishing a therapeutic relation with trauma patients and begins using them with his own patients. One could call this acquiring professional experience: by studying diverse clinical situations, the clinician is able to recognize, through the process of analogical learning, how to act in their own professional practice. Freud was well aware of this quality of the case and how important it is in the training of psychoanalysts. He made the famous comparison between learning psychoanalysis and learning how to play chess: the openings and end games can be studied in books, but the

infinite variety of moves in between can only be learned through a diligent study of games fought out by masters (Freud, 1913).

In Figure 2, this reasoning process is represented graphically: case 1 represents a set of four properties (A, B, C and D) that are defined in a detailed and rich case narrative. Case 2 is similar to case 1 – they share three properties (A, B, C) but there is an unknown fourth property in case 2. Through the process of analogical learning, the reader can infer that, since it was property D in case 1, then it is possible that it will be property D in case 2 as well. Therefore, through the reader's engagement with the rich and experiential narrative of case 1, they can make a practical assumption that case 2 contains a similar pattern or situation.

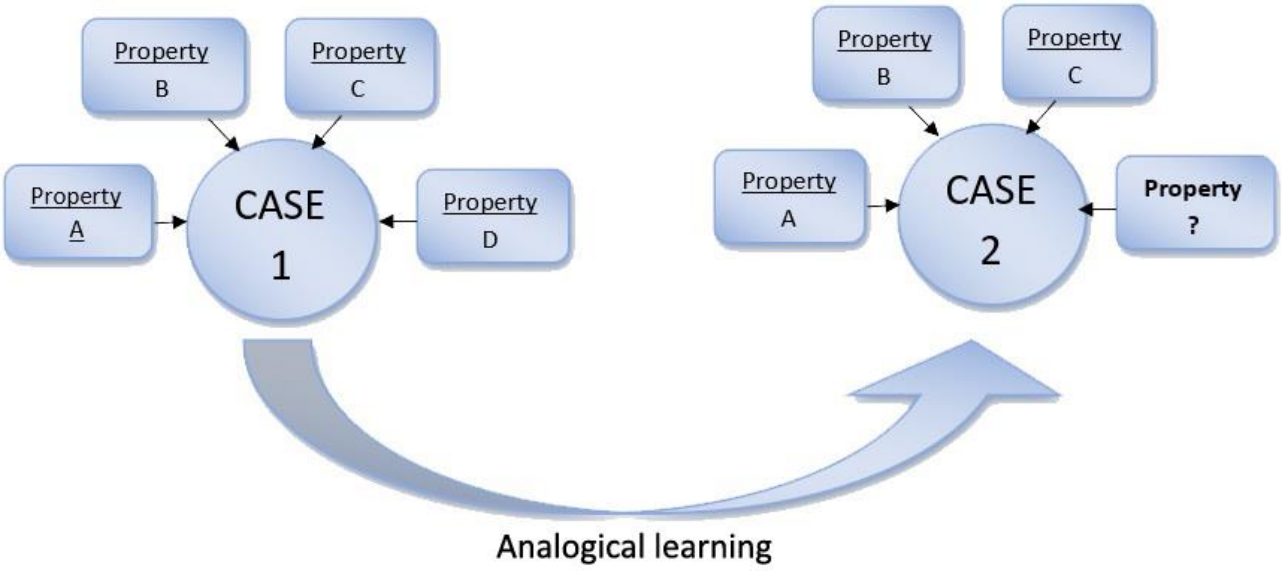

Figure 2. The process of thinking in cases as exemplar for analogical learning

Although this style of thinking does not involve relocating knowledge to a more abstract level (as in analytic generalization), it nevertheless demonstrates a local knowledge transfer: case 1 may demonstrate a powerfully experiential narrative that can be

transferred not just to case 2, but to many other cases. However, this analogical learning will still depend on the particular (not general) nature of case 1: while it describes something that is typical or common to clinical practice (e.g. transference), it is its vicarious experience and "know–how" properties that ultimately make this case transferrable (in a practical rather than theory–building sense) onto other cases.

Recognizing a new situation as a version of a previous situation is not purely a cognitive operation. Stake (1978) argues that naturalistic generalization can only emerge from knowledge that contains "lived experience" and interpretive understanding of "how things are, why they are, how people feel about them, and how these things are likely to be later or in other places" (p. 6). These ideas are not new or exclusive to case methodology. At the turn of the twentieth century, German philosopher Wilhelm Dilthey (1910) argued that there are, essentially, two different ways of doing science: through law–governed explanations (*Erklären*) and through relational understanding of human experiences (*Verstehen*). For Dilthey, the explanatory mode of investigation is well suited for the study of causal connections, physical properties and law–governed regularities. However, he argued that the empiricism of explanatory accounts undermines the uniqueness, subjectivity and meaning of "lived experiences"; that there are important non–quantifiable elements in the study of the human psyche that can be only studied through understanding: "We understand ourselves and others only when we transfer our own lived experience into every kind of expression of our own and other people's lives" (Dilthey in Stake, 1978, p. 5).

This kind of understanding can be linked to the Hungarian–British scientist Michael Polanyi's concept of *tacit knowledge*. Polanyi's basic proposition is that "we can know more than we can tell" (1966, p. 4) – that is, we can learn from experiences,

activities, ideas and skills that are not easily expressible but nevertheless remain central in how we engage with and learn about the world. Tacit knowledge can be described as a "know–how" knowledge: it involves learning from experiences, interpersonally sharable statements, ruminations, metaphors, associations, meanings, ideas and applications. Such knowledge is deeply contextual, which is what makes it difficult to transcribe or verbalize. This difficulty, however, need not be considered as a problem or flaw in thinking in cases as exemplars for analogical learning. It is not always easy to differentiate the subject from the author in psychoanalytic case studies due to the inextricable intimacy of the analytic encounter (Walsh 2020). However, this very intimacy prompts the production of tacit knowledge within the clinical paradigm, thus demonstrating the experiential, "know–how" knowledge of dealing with transference and countertransference dynamics, emotional intensity and forms of unspoken dialogue between patient and analyst. With Walsh (2020), we would like to argue that the thinking in and writing of cases as exemplars for analogical learning is not only "no cause for lament" (p. 19), but also crucial for the study of clinical technique.

Freud was also mindful of the challenges that come with acquiring tacit knowledge, in particular with respect to psychoanalytic technique. In *On 'Wild' Psycho–Analysis* (Freud, 1910a) he writes: "This technique cannot yet be learnt from books, and it certainly cannot be discovered without great sacrifices of time, labour and success. Like other medical techniques, it is to be learnt from those who are already proficient in it" (p. 226). That is one of the reasons to undergo training analysis. In *Analysis Terminable and Interminable* (1937b), Freud wrote:

> It [the training analysis] has accomplished its purpose if it gives the learner a firm conviction of the existence of the unconscious, if it enables him, when repressed material emerges, to perceive in himself things which would otherwise be incredible to him, and if it shows him a first sample of the technique which has proved to be the only effective one in analytic work (p. 248).

In other words, one has to experience how psychoanalysis works on oneself in order to be able to understand it and apply it to others.

This is where Polanyi's tacit knowledge becomes central to Stake's naturalistic generalization: compelling, engaging and realistic case narratives enable the reader to learn from experience. The reader is not learning from facts (explanatory or "know–that" knowledge) but from an everyday perspective of what it is like to work in this or that clinical setting. But even more importantly, conveying tacit knowledge in case narratives is not just about being able to re–tell a clinical story: there is a psychological dimension characteristic of a form of *empathy* (Von Wright 1971). Intentions, feelings and motivations enable the reader's understanding because they point to the meaning and aim of the case, which may be different for each person.

From the perspective of cases as exemplars for analogical learning, a good exemplar will rely on particularized knowledge (Geertz's "thick description"), a relational understanding of human experiences (Dilthey's *Verstehen*) and a practical, "know–how" knowledge (Polanyi's tacit knowledge). These three elements are crucial for the scientific canons (what we have identified as the propositional or persuasive qualities of the case narrative) of thinking in cases as exemplars for analogical learning: "It is the interpretation of the data, of the observations and measurements, that will stand, not as

proof but as persuasion of *one meaning more than another*" (Stake, 2010, p. 25, emphasis added).

Contemporary examples of this mode of thinking in cases can be found in any clinical training: during clinical workshops, intervisions and supervisions, psychoanalysts present a "thick description" of their relational understanding of their work with a patient, not only to better understand this particular patient, but also to develop "know–how" knowledge that can be useful in future clinician situations. The newest addition to this mode of thinking is the Three–Level Model developed in the IPA Project Committee on Clinical Observation and Testing (Bernardi, 2014). It consists in clinical working parties with psychoanalysts from different theoretical strands who discuss selected clinical material in relation to one patient. The focus is on "real analytic practice" rather than "ideal models" (p. 25). The aim is to arrive at a consensus of experts concerning the process of change in that particular patient. The clinical working parties often engage in a mental experiment by imagining different ways in which interpretative strategies from different theoretical orientations may or may not facilitate change in the patient. The Three–Level Model is explicitly not a research method that tries to determine which psychoanalytic theory is most rigorous and compatible with a specific patient population. Rather, clinicians feel that the discussion "helps them get closer to the patient's vantage point […] and this helps to empathically anticipate the way the patient will receive the interpretations" (p. 27).

Similarly, the European Psychoanalytic Federation Working Party on Comparative Clinical Methods (Tuckett, 2008) involves case study discussions in which an analyst presents work in progress to a small group of 8–14 participants. The goal of these meetings is analogical learning: psychoanalysts from different clinical orientations present their work and share each other's approaches to similar and divergent clinical

situations. Clinical assumptions and underlying theoretical models are examined, assessed and discussed in a structured way. The party's overall purpose is to use the "lived experiences" common to each psychoanalytic tradition and training institute to achieve a deeper understanding of what constitutes psychoanalytic clinical work.

4.3.3 Thinking in cases as part of a population for empirical generalization

The third mode of thinking in cases consists in considering cases to be part of a population for empirical generalization. A patient can be assumed to be member of one or more populations, be it a population defined by demographic, clinical or other characteristics. This assumption is very common in the statistical thinking style, but it is less obvious in the case–based disciplines: a legal case, a company or an Amazon tribe can be perfectly legitimate objects of study, without any need to determine, if at all possible, to which populations these cases belong. A similar point has been made by Peter Caws about psychoanalysis as "the science of the idiosyncratic subject" (2003, p. 625) that should avoid any generalization over the population of humans. We will argue, however, that psychoanalytic cases can be considered to be part of a population and that Freud already engaged in this mode of thinking in cases.

In thinking in cases as part of a population, the study of the patient becomes a means to learn about a population of interest. In this mode of thinking, knowledge claims are based on the study of more than one case. Each case is considered to be a variation within a population, and several cases need to be studied to get an understanding of the population characteristics. However, this does not imply that cases are grouped together to form a sample. In this respect, it is important to make the distinction between the mode

of thinking in cases and the statistical thinking style, which also aims to study population characteristics.

The statistical thinking style is based on decontextualization of observations: the object of interest is studied by discarding the context within which this object manifests itself. This decontextualization is a necessary condition for the quantitative estimation of population parameters, such as the average and the standard deviation (in technical terms, this is the assumption of independence of observations). This assumption seems acceptable for features such as bodily weight but is more contentious for psychological features such as personality. Psychoanalysis relies on the case method because this method consists in studying an object within a context where the boundaries between the object and its context are not clearly demarcated. If cases are considered to be part of a population, each case presents a *variation* of the phenomenon of interest within a context, and the interest is not in the average, but in the variation.

Unlike exemplar cases for analytical generalization, cases as part of a population can be used for empirical generalization. Empirical generalization "involves drawing inferences about features of a larger but finite population of cases from the study of a sample drawn from that population" (Gomm et al., 2000, p. 103). It is sometimes conflated with a statistical methodology; however, statistical sampling is just one technique to capture relevant heterogeneity within a population (allowing for empirical generalization). Empirical generalization can also be achieved from a combination of cases about a complexly varying phenomenon (Gomm et al., 2000). Psychoanalytic case studies are ideal for such a comparative exercise: because they do not isolate the phenomenon of interest from its context, case studies yield a large number of potentially relevant observations. If similar observations are made in a number of cases that differ

in their contextual data, one can begin to establish the variability of conditions under which the phenomenon of interest occurs (Iwakabe & Gazzola, 2009).

From first glance, thinking in cases as part of a population may appear similar to exemplar cases for analytic generalization, since both involve studying characteristics that can be relevant to many other cases. However, cases as part of a population are studied on the basis of their membership of a *population of interest*, while cases as exemplars for analytical generalization are studied on the basis of a *conceptual type* they represent. The idea behind cases as part of a population is that each case represents a relevant variation. By comparing one case (or a series of cases) to another, one will discover common themes as well as significant variations (cultural, social, economic, demographic, etc.) between them. Therefore, a good case as part of a population is one that can be situated in and compared with other cases from the population of interest. It should teach us not just about the studied individual, but also about the population the individual belongs to.

In Figure 3, this reasoning process is represented graphically: there is a series of cases (case 1, case 2 and case 3) that are grouped together because they share the same phenomenon. However, each case has a different combination of properties, which may be identical, similar or different from one another. This implies that the phenomenon of interest is occurring under a variety of conditions. Studying the variation presented in these cases will lead to a more robust knowledge about the phenomenon that can be subsequently generalized onto the population of interest.

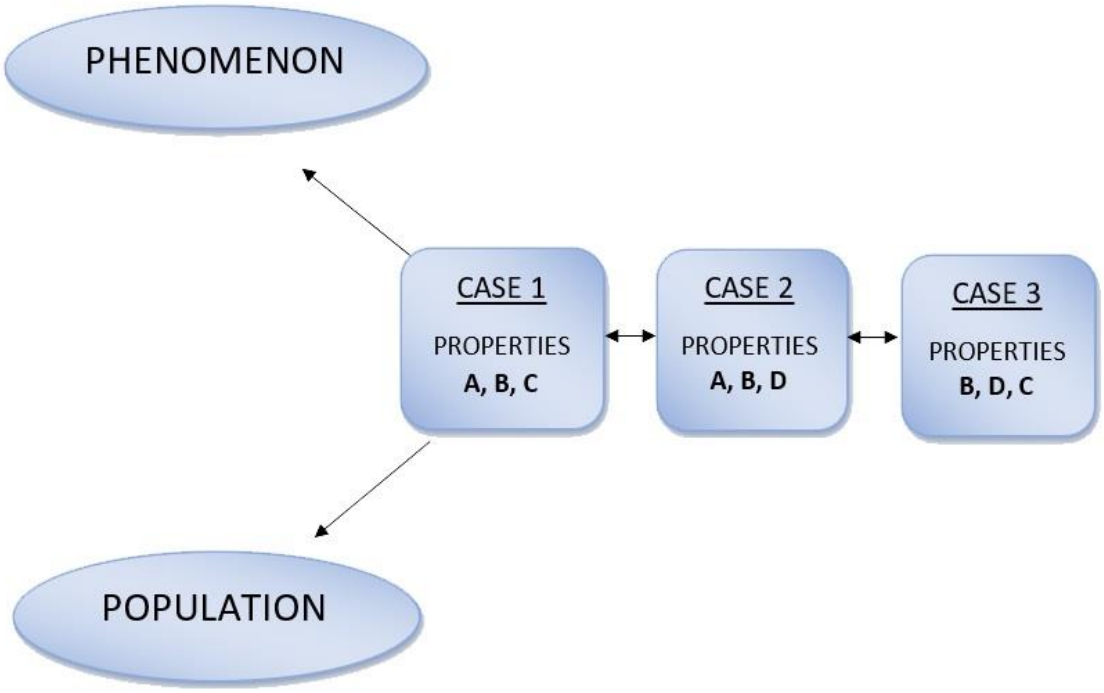

Figure 3. The process of thinking in cases as part of a population for empirical generalization

This form of scientific thinking is being used in the field of psychotherapy research (Iwakabe & Gazzola, 2009) but is also very promising for psychoanalysis (Meganck et al., 2017). Given the long–lasting criticisms of *(1)* lack of generalizability in psychoanalytic case studies, and *(2)* statistically improper generalizations from observations in single case studies, it is important to clarify that the logic of empirical generalization has been acknowledged by Freud and is present in his work, and that it significantly differs from statistical generalization as well as from the previously discussed forms of analytic generalization and analogical learning.

The mode of thinking in cases as part of a population can be found in Freud's *A Child is Being Beaten* (1924). Already on the second page of this article, Freud began to develop an account of beating phantasies by referring to a group of individuals: "The

individuals from whom the data for these analyses were derived were very seldom beaten in their childhood, or were at all events not brought up by the help of the rod" (p. 180). Immediately afterwards, Freud described the difficulty of formulating a hypothesis about beating phantasies because the individuals' responses about the nature of the phantasies were rarely specific and almost always varied from one another. Freud identified that, from all of the cases he refers to in *A Child is Being Beaten*, not one case is representative enough to fully characterize the phenomenon of beating phantasies (note the difference from the Schreber case where he did rely on one case as an exemplar to push forward the hypothesis about paranoia and homosexuality). Therefore, in order to formulate general theoretical claims about beating phantasies, Freud had to use six different cases of individuals with varying circumstances and diagnoses.

The six cases consisted of four female and two male patients, and were described at length diagnostically: two cases of obsessional neurosis (one extremely severe and the other of moderate severity), one case that displayed individual traits of obsessional neurosis, one case of "straightforward hysteria" (p. 183), one case with no clinical diagnosis (could be dismissed as a "psychasthenic") and a sixth case that was left undescribed. Freud's idea behind selecting these cases was to develop a concise theoretical account of beating phantasies by comparing the cases and studying their variations. In other words, Freud was not seeking to create a sample to study group characteristics as in statistical thinking, but to conduct a comparative study in which conditions under which beating phantasies occurred could be outlined.

As such, thinking in cases as part of a population involves working with cases that vary greatly in their situations, context and experiences of the studied phenomenon. Although these cases are not used for generating a sample of cases, measuring average

scores or the frequency of experiences, they are ideal for studying the variations under which the phenomenon occurs. This allows for testing different scientific hypotheses about the population of interest, as well as mapping out the impact and the relevancy of different variations (e.g. in Freud's *A Child is Being Beaten*, gender was the most important variation: the experience of beating phantasies for boys was not analogous to girls' experience). The thinking process involved in cases as part of a population is clearly aimed at generating a robust body of knowledge, in which the validity of scientific conclusions becomes greater the more similarities and variations are studied across a group of patients.

A contemporary illustration of thinking in cases as part of a population can be found in a case comparison study by Dahl et al. (2017) on transference. Their work is re–evaluating a result from an earlier statistical study in which parental countertransference was received positively by patients with high levels of personality pathology and negatively by patients with low levels of personality pathology. Dahl et al.'s study features two patients, Victor and Tim. Both patients were treated by the same therapist, who reported high levels of parental countertransference. From a clinicians' point of view, Victor presented a lower level of psychodynamic functioning than Tim; on self–rated measures, Victor's personality problems were also rated higher than Tim's. Going on the previous statistical generalization, the parental countertransference was to be experienced disparately by Victor and Tim given the difference in their personality pathology levels.

What Dahl et al. find is that both Victor and Tim benefited from the therapist's strong parental countertransference. However, there were important variations in patients' receptivity of countertransference. The authors write the following about

Victor's case: "What strikes us first is that Victor seemingly heard the transference work as an invitation to a new kind of relationship with a benevolent parental figure" (p. 471). Tim, on the other hand, experienced the therapeutic relationship as a continuation of his early parental relations. This is evident from the following expression made by Tim to the therapist: "I assume you want me to, kind of, take hold of my situation and go on with pride or something. But […] I have to know that there is someone I can come and see if the anxiety attack is coming" (p. 472). In the limitations section, the authors note that findings at a case level do not indicate a generalizability. However, their study implies that a different generalization could be made from the one in the earlier statistical study: parental countertransference can be received positively by patients with various pathology levels. Since the study compared only two cases, the authors stress that there is a need for many case studies looking beyond the statistics to provide some of the finer grained details and variations of the transference encounter.

4.4 Concluding comments

By drawing on recent developments and debates in philosophy of science and social sciences, our paper sought to offer a new perspective on the case study method and psychoanalysis as a science. We build on Forrester's idea of thinking in cases as exemplars and differentiate three modes of thinking in cases. We specified how thinking in exemplars for analytic generalization can lead from knowledge of one in–depth case study to knowledge about a type relevant to many other cases; how cases as exemplars for analogical learning produce "know–how" knowledge about vicarious clinical situations; and how cases as part of a population can be used for generalization through

the study of variation within the population. It is important to note that these modes of thinking are not new to psychoanalysis: we demonstrated that the three modes of thinking in cases are implicitly present throughout Freud's oeuvre (not just when he is writing about cases). Moreover, these modes of thinking are not specific to psychoanalysis, as they have been described in relation to other fields such as anthropology, educational psychology, psychotherapy, etc. By making these implicit thinking styles explicit, we hope to contribute to the development and enrichment of what has already been done in psychoanalytic case studies for

over 100 years.

In this paper, we sought to demonstrate not only how Freud and contemporary psychoanalysts think and do psychoanalytic science through case studies, but also how thinking in cases differs from other kinds of scientific thinking styles. Although Forrester (1996) did argue that thinking in cases is a unique thinking style, he did not provide a detailed argument of how it differs from other thinking styles. Throughout all three modes of thinking in cases, we differentiated the reasoning process in Freud's case studies from statistical and experimental thinking styles. We concluded that, out of the three identified modes of thinking in cases, none seeks to arrive at direct replication or statistical generalization. Therefore, applying statistical or experimental canons of verification onto psychoanalytic case studies is not appropriate because the two scientific thinking styles differ in both *how* (process) and *what* (end–goal) knowledge they produce.

It must be made clear, however, that we do not seek to immunize each mode of thinking in cases from criticism. That is to say, we do not believe that Freud's classic case studies (or contemporary psychoanalytic cases, for that matter) and their underlying

modes of thinking should be exempt from scrutiny, even if it derives from other fields and their respective styles of scientific thinking. As pointed out earlier, Hacking's conceptualization of self–authenticating thinking styles leaves much to be desired, and this can be clearly observed in our field. Accusations of self–confirmation and circular (or insular) self–authentication processes have haunted psychoanalysis ever since Freud began writing his classic case studies. As such, we would like to stress that simply describing a thinking style does not establish it as successfully self–authenticating.

In addition, the fact that psychoanalysis is based on what Forrester described as a scientific thinking style does not mean that it is by definition scientific. In fact, one of the criticisms raised against Hacking's theory on scientific thinking styles concerns the lack of clear demarcation criteria to distinguish between scientific and non–scientific reasoning styles (Kusch, 2010; Sciortino, 2016). For instance, according to Wayman (1982), a reasoning style that consists in making analogies between microcosm and macrocosm can be found in India, Greek cosmology and sixteenth–century Europe (e.g., "Man as the image of God", the Vitruvian man, etc.). This would no longer be considered a scientific thinking style. Each thinking style has to develop its own canons of verification that provide conditions for truth, as per Hacking's (1992) definition: "There is no higher standard to which [thinking styles] directly answer" (p. 13). Therefore, a further development to thinking in cases would involve developing such a canon of verification for all three modes of case–based reasoning. Mayer (2017) suggests that such a canon of verification might consist in the integration of the transferential and countertransferential dimension in case writing (reflexive objectivity). Willemsen, Della Rosa and Kegerreis (2017) have suggested a number of guidelines for the writing of case studies.

Finally, we also discussed some of the work done by the European Psychoanalytic Federation Working Party on Comparative Clinical Methods (Tuckett, 2008) and the IPA's Project Committee on Clinical Observation and Testing (Bernardi, 2014). We see all these developments as an attempt to, on the one hand, establish the relevant scientific canons for thinking in cases, and on the other, be conscious of some of the self–authenticating (or self–stabilizing) techniques that have been (or are still) used by psychoanalysts.

Another future direction would be describing thinking in cases as a scientific thinking style at all levels of psychoanalysis: the clinical reasoning process applied by practising psychoanalysts, the learning process of students in psychoanalysis who learn through cases, the didactical approach taken by teachers in psychoanalysis who refer to cases as crucial resources, and the scientific process applied by psychoanalytic researchers who convey their findings in cases. Clearly, "thinking psychoanalysis" entails thinking in cases in every corner of our field. It is therefore important that we seek to understand and develop how we think, speak, present and write in psychoanalytic cases, and how we can do it truthfully.

Chapter 5: Appraising Psychotherapy Case Studies in Practice–Based Evidence: Introducing Case Study Evaluation–tool (CaSE)

Abstract

Systematic case studies are often placed at the low end of evidence–based practice (EBP) due to lack of critical appraisal. This paper seeks to attend to this research gap by introducing a novel *Case Study Evaluation–tool* (CaSE). First, issues around knowledge generation and validity are assessed in both EBP and practice–based evidence (PBE) paradigms. Although systematic case studies are more aligned with PBE, the paper argues for a complementary, third way approach between the two paradigms and their 'exemplary' methodologies: case studies and randomised controlled trials (RCTs). Second, the paper argues that all forms of research can produce 'valid evidence' but the validity itself needs to be assessed against each specific research method and purpose. Existing appraisal tools for qualitative research (JBI, CASP, ETQS) are shown to have limited relevance for the appraisal of systematic case studies through a comparative tool assessment. Third, the paper develops purpose–oriented evaluation criteria for systematic case studies through *CaSE Checklist for Essential Components in Systematic Case Studies* and *CaSE Purpose–based Evaluative Framework for Systematic Case Studies*. The checklist approach aids reviewers in assessing the presence or absence of essential case study components (internal validity). The framework approach aims to assess the effectiveness of each case against its set out research objectives and aims (external validity), based on different systematic case study purposes in psychotherapy. Finally, the paper demonstrates the application of the tool with a case example and notes further research trajectories for the development of CaSE tool.

Keywords: *Systematic case studies; Psychotherapy research; Research appraisal tool; Evidence–based practice; Practice–based evidence; Research validity*

5.1 Introduction

Due to growing demands of evidence–based practice, standardised research assessment and appraisal tools have become common in healthcare and clinical treatment (Hartling et al., 2012; Katrak et al., 2004; Hannes, Lockwood & Pearson, 2010). This allows researchers to *critically appraise* research findings on the basis of their validity, results, and usefulness (Hill & Spittlehouse, 2003). Despite the upsurge of critical appraisal in qualitative research (Williams et al., 2019), there are no assessment or appraisal tools designed for psychotherapy case studies.

Although not without controversies (Mitchels, 2000), case studies remain central to the investigation of psychotherapy processes (Midgley, 2006b; Willemsen et al., 2017). This is particularly true of systematic case studies, the most common form of case study in contemporary psychotherapy research (McLeod & Elliott, 2011; Davison & Lazarus, 2007).

Systematic cases usually involve a team of researchers, who gather data from multiple different sources (e.g., questionnaires, observations by the therapist, interviews, statistical findings, clinical assessment, etc.), and involve a rigorous data triangulation process to assess whether the data from different sources converge (McLeod, 2010a). Since systematic case studies are methodologically pluralistic, they have a greater interest in situating patients within the study of a broader population than clinical case studies (Iwakabe & Gazzola, 2009). Systematic case studies are considered to be an accessible method for developing research evidence–base in psychotherapy (Widdowson, 2011), especially since they correct some of the methodological limitations (e.g., lack of "third party" perspectives and bias in data analysis) inherent to classic

clinical case studies (Iwakabe & Gazzola, 2009). They have been used for the purposes of clinical training (Tuckett, 2008), outcome assessment (Hilliard, 1993), development of clinical techniques (Almond, 2004), and meta–analysis of qualitative findings (Timulak, 2009). All these developments signal a revived interest in the case study method, but also point to the obvious lack of a research assessment tool suitable for case studies in psychotherapy.

Table 20. KEY CONCEPT: Systematic case study
Systematic case study is a systematised alternative to the classical clinical case study. Systematic case studies generally involve a team of researchers, gather data from multiple different sources (questionnaires, observations by the therapist, interviews, statistical findings, etc.), and feature data triangulation processes in order to assess whether the data from different sources converge.

To attend to this research gap, this paper first reviews issues around the conceptualisation of validity within the paradigms of evidence–based practice (EBP) and practice–based evidence (PBE). Although case studies are often positioned at the low end of EBP (Aveline, 2005), the paper suggests that systematic cases are a valuable form of evidence, capable of complementing large–scale studies such as randomised controlled trials (RCTs). However, there remains a difficulty in assessing the quality and relevance of case study findings to broader psychotherapy research.

As a way forward, the paper introduces a novel Case Study Evaluation–tool (CaSE) in the form of *CaSE Purpose–based Evaluative Framework for Systematic Case Studies* and *CaSE Checklist for Essential Components in Systematic Case Studies*. The long–term development of CaSE would contribute to psychotherapy research and practice in three ways:

Table 21. How can *Case Study Evaluation–tool* (CaSE) be used in psychotherapy research and practice?
1. Using CaSE for the assessment of systematic case studies and their relevance to the broader field of psychotherapy research and practice; 2. Using CaSE to evaluate the varying evidential quality of systematic case studies, which is particularly problematic for qualitative meta–analysis and meta–synthesis of published case studies in psychotherapy (Duncan & Sparks, 2019; Iwakabe & Gazzola, 2009; Thorne et al., 2004); 3. Using CaSE to improve the evidential quality, formulation and implications of systematic case studies in psychotherapy.

Given the significance of methodological pluralism and diverse research aims in systematic case studies, CaSE will not seek to prescribe explicit case study writing guidelines, which has already been done by numerous authors (Meganck et al., 2017; Willemsen et al., 2017; McLeod, 2010b). Instead, CaSE will enable the *retrospective* assessment of systematic case study findings and their relevance (or lack thereof) to broader psychotherapy research and practice. However, there is no reason to assume that CaSE cannot be used *prospectively* (i.e., producing systematic case studies in accordance to CaSE evaluative framework, as per point 3 in table 2).

The development of a research assessment or appraisal tool is a lengthy, ongoing process (Long & Godfrey, 2004). It is particularly challenging to develop a comprehensive *purpose–oriented* evaluative framework, suitable for the assessment of diverse methodologies, aims, and outcomes. As such, this paper should be treated as an introduction to the further development of CaSE tool. It will introduce the rationale behind CaSE and lay out its main approach to evidence and evaluation, with further development in mind. A case example from the Single Case Archive (SCA) (https://singlecasearchive.com) will be used to demonstrate the application of the tool

'in action'. The paper notes further research trajectories and discusses some of the limitations around the use of the tool.

5.2 Separating the wheat from the chaff: what is and isn't evidence in psychotherapy (and who gets to decide?)

5.2.1 The common approach: evidence–based practice (EBP)

In the last two decades, psychotherapy has become increasingly centred around the idea of an evidence–based practice (EBP). Initially introduced in medicine, EBP has been defined as "conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients" (Sackett et al., 1996). EBP revolves around *efficacy* research: it seeks to examine whether a specific intervention has a causal (in this case, measurable) effect on clinical populations (Barkham & Mellor–Clark, 2003). From a conceptual standpoint, Sackett and colleagues defined EBP as a paradigm that is inclusive of many methodologies, so long as they contribute toward clinical decision–making process and accumulation of best currently available evidence in any given set of circumstances (Gabbay & le May, 2011). Similarly, the American Psychological Association (APA, 2010) has recently issued calls for evidence–based systematic case studies in order to produce standardised measures for evaluating process and outcome data across different therapeutic modalities.

However, given EBP's focus on establishing cause–and–effect relationships (Rosqvist et al., 2011), it is unsurprising that qualitative research is generally not considered to be 'gold standard' or 'efficacious' within this paradigm (Edwards, 2013; Edwards et al., 2004; Aveline, 2005; Cartwright & Hardie, 2012; Longhofer et al., 2017).

Qualitative methods like systematic case studies maintain an appreciation for context, complexity and meaning making. Therefore, instead of measuring regularly occurring causal relations (as in quantitative studies), the focus is on studying complex social phenomena (e.g., relationships, events, experiences, feelings, etc.) (Erickson, 2012; Maxwell, 2004). Edwards (2013) points out that, although context–based research in systematic case studies is the bedrock of psychotherapy theory and practice, it has also become shrouded by an unfortunate ideological description: "anecdotal" case studies (i.e., unscientific narratives lacking evidence, as opposed to 'gold standard' evidence, a term often used to describe the RCT method and the therapeutic modalities supported by it), leading to a further need for advocacy in and defence of the unique epistemic process involved in case study research (Fishman et al., 2017).

The EBP paradigm prioritises the quantitative approach to causality, most notably through its focus on high generalisability and the ability to deal with bias through randomisation process. These conditions are associated with RCTs but are limited (or, as some argue, impossible) in qualitative research methods such as the case study (Margison et al., 2000).

Table 22. KEY CONCEPT: Evidence–based practice (EBP)
Evidence–based practice (EBP) was introduced in medicine as a conscientious use of current best evidence in clinical–decision making about individual patients. EBP revolves around efficacy research, which assesses whether specific interventions produce causal (measurable) effects on clinical populations. Internal validity and randomisation of samples are crucial to efficacy research. An example of such research is randomised controlled trials (RCTs).

'Evidence' from an EBP standpoint hovers over the epistemological assumption of *procedural objectivity*: knowledge *can* be generated in a standardised, non–erroneous

way, thus producing objective (i.e., with minimised bias) data. This can be achieved by anyone, as long as they are able to perform the methodological procedure (e.g., RCT) appropriately, in a "clearly defined and accepted process that assists with knowledge production" (Douglas, 2004, p. 131). If there is a well–outlined quantitative form for knowledge production, the same outcome should be achieved regardless of who processes or interprets the information. For example, researchers using Cochrane Review assess the strength of evidence using meticulously controlled and scrupulous techniques; in turn, this minimises individual judgment and creates unanimity of outcomes across different groups of people (Gabbay & le May, 2011). The typical process of knowledge generation (through employing RCTs and procedural objectivity) in EBP is demonstrated in figure 4.

Figure 4. Typical knowledge generation process in evidence–based practice (EBP)

In EBP, the concept of validity remains somewhat controversial, with many critics stating that it limits rather than strengthens knowledge generation (Berg & Slaatelid, 2017; Berg, 2019b; Lilienfeld et al., 2013). This is because efficacy research relies on *internal validity*. At a general level, this concept refers to the congruence between the research study and the research findings (i.e., ensuring that the research findings were not influenced by anything *external* to the study, such as confounding variables, methodological errors and bias); at a more specific level, internal validity determines the extent to which a study establishes a reliable causal relationship between an independent variable (e.g., treatment) and independent variable (outcome or effect) (Margison et al., 2000). This approach to validity is demonstrated in figure 5.

Social scientists have argued that there is a trade–off between research rigour and generalisability: the more specific the sample and the more rigorously defined the intervention, the outcome is likely to be less applicable to everyday, routine practice. As such, there remains a tension between employing procedural objectivity which increases the rigour of research outcomes and applying such outcomes to routine psychotherapy practice where scientific standards of evidence are not uniform.

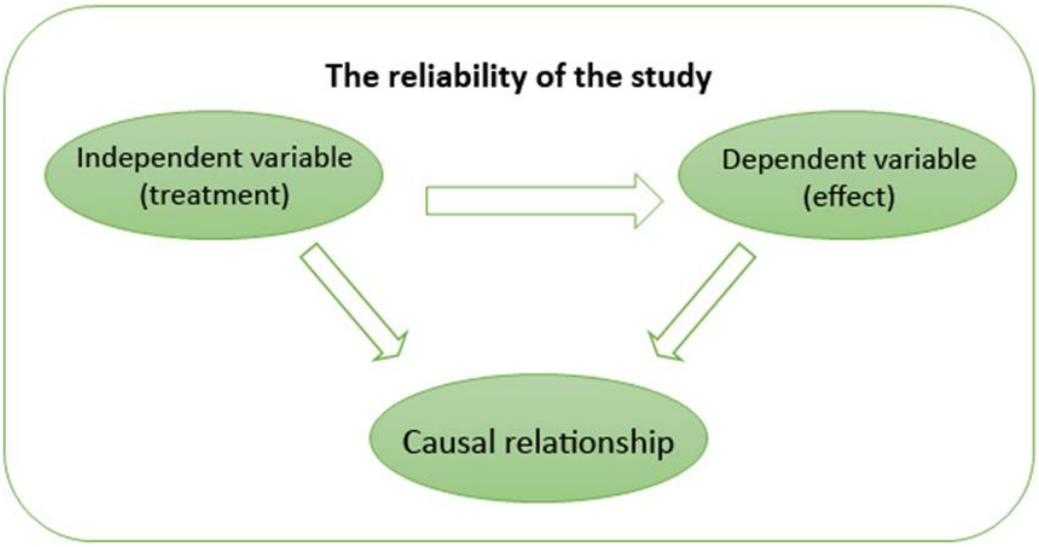

Figure 5. Internal validity

According to McLeod (2002), inability to address questions that are most relevant for practitioners contributed to a deepening research–practice divide in psychotherapy. Studies investigating how practitioners make clinical decisions and the kinds of evidence they refer to show that there is a strong preference for knowledge that is *not* generated procedurally, i.e., knowledge that encompasses concrete clinical situations, experiences, and techniques. A study by Stewart & Chambless (2007) sought to assess how a larger population of clinicians (under APA, from varying clinical schools of thought and independent practices, sample size 591) make treatment decisions in private practice. The study found that large–scale statistical data was not the primary source of information sought by clinicians. The most important influences were identified as past clinical experiences and clinical expertise (M = 5.62). Treatment materials based on clinical case observations and theory (M = 4.72) were used almost as frequently as psychotherapy outcome research findings (M = 4.80) (i.e., evidence–based research). These numbers are likely to fluctuate across different forms of psychotherapy; however, they are indicative of the need for research about routine clinical settings that does not

isolate or generalise the effect of an intervention but examines the variations in psychotherapy processes.

5.2.2 The alternative approach: practice–based evidence (PBE)

In an attempt to dissolve or lessen the research–practice divide, an alternative paradigm of practice–based evidence (PBE) has been suggested (Barkham & Mellor–Clark, 2003; Fox, 2003; Margison et al., 2000; Iwakabe & Gazzola, 2009; Green & Latchford, 2012; Laska et al., 2014). PBE represents a shift in how we think about evidence and knowledge generation in psychotherapy. PBE treats research as a local and contingent process (at least initially), which means it focuses on variations (e.g., in patient symptoms) and complexities (e.g., of clinical setting) in the studied phenomena (Fox, 2003). Moreover, research and theory–building are seen as complementary rather than detached activities from clinical practice. That is to say, PBE seeks to examine how and which treatments can be improved in everyday clinical practice by flagging up clinically salient issues and developing clinical techniques (Barkham & Mellor–Clark, 2003). For this reason, PBE is concerned with the *effectiveness* of research findings: it evaluates how well interventions work in real–world settings (Rosqvist et al., 2011). Although it is not unlikely for RCTs to be used in order to generate practice–informed evidence (Horn & Gassaway, 2007), qualitative methods like the systematic case study are seen as ideal for demonstrating the effectiveness of therapeutic interventions with individual patients (van Hennik, 2020).

Table 23. KEY CONCEPT: Practice–based evidence (PBE)
Practice–based evidence (PBE) was introduced as an alternative paradigm to EBP. PBE focuses on assessing the variations and complexities of treatment in routine clinical

practice. Research in PBE is concerned with the effectiveness of findings by examining how interventions work in real–world settings. External validity and contingency of findings is crucial to effectiveness research. An example of such research is the systematic case study.

PBE's epistemological approach to 'evidence' may be understood through the process of *concordant objectivity* (Douglas, 2004): "Instead of seeking to eliminate individual judgment, … [concordant objectivity] checks to see whether the individual judgments of people in fact do agree" (p. 462). This does not mean that anyone can contribute to the evaluation process like in procedural objectivity, where the main criterion is following a set quantitative protocol or knowing how to operate a specific research design. Concordant objectivity requires that there is a set of competent observers who are closely familiar with the studied phenomenon (e.g., researchers and practitioners who are familiar with depression from a variety of therapeutic approaches).

Systematic case studies are a good example of PBE 'in action': they allow for the examination of detailed unfolding of events in psychotherapy practice, making it the most pragmatic and practice–oriented form of psychotherapy research (Fishman, 1999, 2005). Furthermore, systematic case studies approach evidence and results through concordant objectivity (Douglas, 2004) by involving a team of researchers and rigorous data triangulation processes (McLeod, 2010b). This means that, although systematic case studies remain focused on particular clinical situations and detailed subjective experiences (similar to classic clinical case studies; see Iwakabe & Gazzola, 2009), they still involve a series of validity checks and considerations on how findings from a single systematic case pertain to broader psychotherapy research (Fishman, 2005). The typical process of knowledge generation (through employing systematic case studies and

concordant objectivity) in PBE is demonstrated in figure 6. The figure exemplifies a bidirectional approach to research and practice, which includes the development of research–supported psychological treatments (through systematic reviews of existing evidence) *as well as* the perspectives of clinical practitioners in the research process (through the study of local and contingent patient and/or treatment processes) (Teachman et al., 2012; Westen et al., 2004).

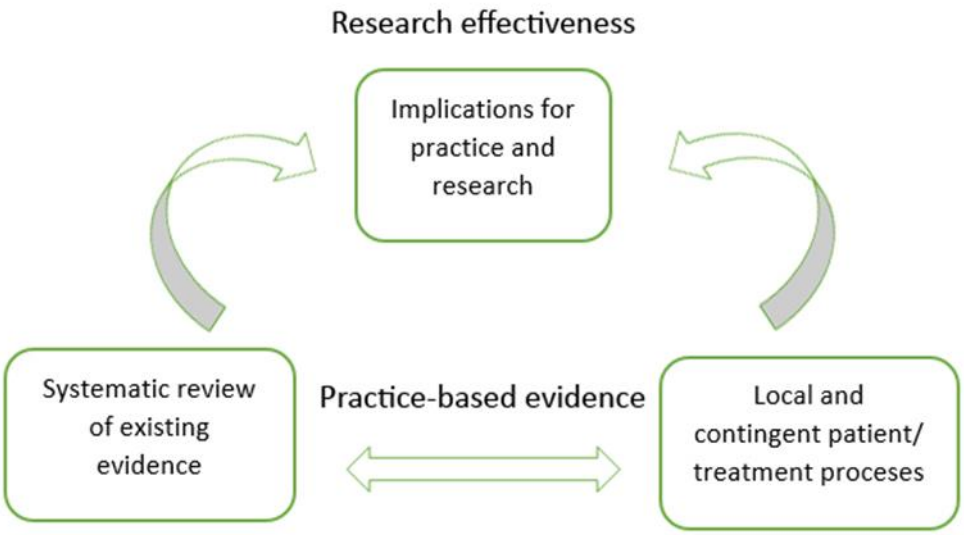

Figure 6. Typical knowledge generation process in practice–based evidence (PBE)

From a PBE standpoint, *external validity* is a desirable research condition: it measures extent to which the impact of interventions apply to real patients and therapists in everyday clinical settings. As such, external validity is not based on the strength of causal relationships between treatment interventions and outcomes (as in internal validity);

instead, the use of specific therapeutic techniques and problem–solving decisions are considered to be important for generalising findings onto routine clinical practice (even if the findings are explicated from a single case study; see Aveline, 2005). This approach to validity is demonstrated in figure 7.

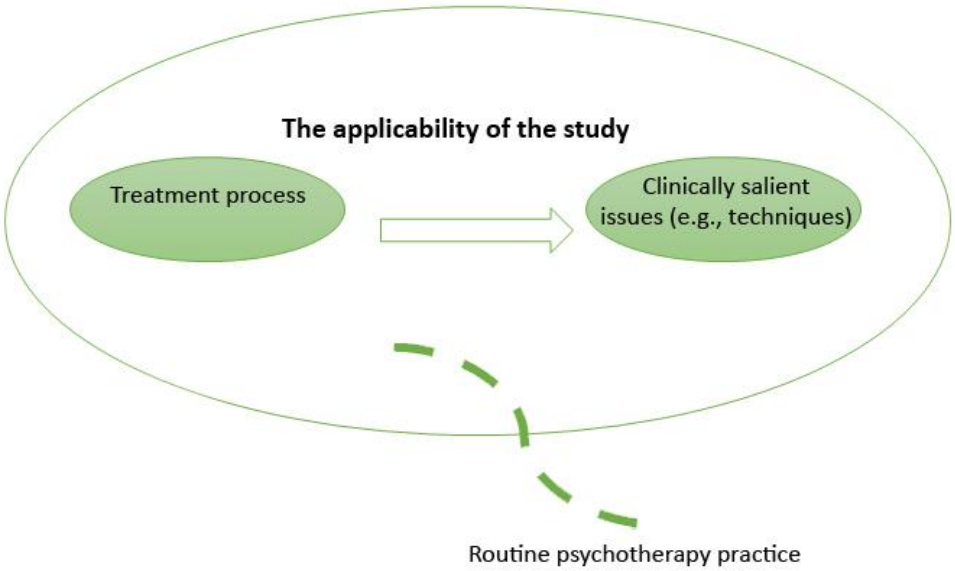

Figure 7. External validity

Since effectiveness research is less focused on limiting the context of the studied phenomenon (indeed, explicating the context is often one of the research aims), there is more potential for confounding factors (e.g., bias and uncontrolled variables) which in turn can reduce the study's internal validity (Barkham & Mellor–Clark, 2003). This is also an important challenge for research appraisal. Douglas (2004) argues that appraising research in terms of its effectiveness may produce significant disagreements or group illusions, since what might work for some practitioners may not work for others: "It cannot guarantee that values are not influencing or supplanting reasoning; the observers may have shared values that cause them to all disregard important aspects of an event" (Douglas, 2004, p. 462). Douglas further proposes that an interactive approach to

objectivity may be employed as a more complex process in debating the evidential quality of a research study: it requires a discussion among observers and evaluators in the form of peer–review, scientific discourse, as well as research appraisal tools and instruments. While these processes of rigour are also applied in EBP, there appears to be much more space for debate, disagreement, and interpretation in PBE's approach to research evaluation, partly because the evaluation criteria themselves are subject of methodological debate and are often employed in different ways by researchers (Williams et al., 2019). This issue will be addressed more explicitly again in relation to CaSE development (section 5.4, '*Developing purpose–oriented evaluation criteria for systematic case studies*').

5.2.3 A third way approach to validity and evidence

The research–practice divide shows us that there may be something significant in establishing complementarity between EBP and PBE rather than treating them as mutually exclusive forms of research (Fishman et al., 2017). For one, EBP is not a sufficient condition for delivering research relevant to practice settings (Bower, 2003). While RCTs can demonstrate that an intervention works on average in a group, clinicians who are facing individual patients need to answer a different question: *how can I make therapy work with this particular case?* (Cartwright & Hardie, 2012). Systematic case studies are ideal for filling this gap: they contain descriptions of microprocesses (e.g., patient symptoms, therapeutic relationships, therapist attitudes) in psychotherapy practice that are often overlooked in large–scale RCTs (Iwakabe & Gazzola, 2009). In particular, systematic case studies describing the use of specific interventions with less

researched psychological conditions (e.g., childhood depression or complex post–traumatic stress disorder) can deepen practitioners' understanding of effective clinical techniques before the results of large–scale outcome studies are disseminated.

Secondly, establishing a working relationship between systematic case studies and RCTs will contribute toward a more pragmatic understanding of validity in psychotherapy research. Indeed, the very tension and so–called trade–off between internal and external validity is based on the assumption that research methods are designed on an either/or basis; either they provide a sufficiently rigorous study design, or they produce findings that can be applied to real–life practice. Jimenez–Buedo & Miller (2010) call this assumption into question: in their view, if a study is not internally valid, then "little, or rather nothing, can be said of the outside world" (p. 302). In this sense, internal validity may be seen as a pre–requisite for any form of applied research and its external validity, but it need not be constrained to the quantitative approach of causality. For example, Levitt et al. (2017) argue that, what is typically conceptualised as internal validity, is, in fact, a much broader construct, involving the assessment of how the research method (whether qualitative or quantitative) is best suited for the research goal, and whether it obtains the relevant conclusions. Similarly, Truijens et al. (2019) suggest that we should think about validity in a broader epistemic sense – not just in terms of psychometric measures, but also in terms of the research design, procedure, goals (research questions), approaches to inquiry (paradigms, epistemological assumptions), etc.

The overarching argument from research cited above is that all forms of research – qualitative and quantitative – can produce 'valid evidence' but the validity itself needs to be assessed against each specific research method and purpose. For example, RCTs are

accompanied with a variety of clearly outlined appraisal tools and instruments such as CASP (Critical Appraisal Skills Programme) that are well suited for the assessment of RCT validity and their implications for EBP. Systematic case studies (or case studies more generally) currently have no appraisal tools in any discipline. The next section evaluates whether existing qualitative research appraisal tools are relevant for systematic case studies in psychotherapy and specifies the missing evaluative criteria.

5.3 The relevance of existing appraisal tools for qualitative research to systematic case studies in psychotherapy

5.3.1 What is a research tool?

Currently, there are several research appraisal tools, checklists, and frameworks for qualitative studies. It is important to note that tools, checklists and frameworks are not equivalent to one another but actually refer to different approaches to appraising the validity of a research study. As such, it is erroneous to assume that all forms of qualitative appraisal feature the same aims and methods (Williams et al., 2019; Hannes et al., 2010).

Generally, research assessment falls into two categories: *checklists* and *frameworks*. Checklist approaches are often contrasted with quantitative research, since the focus is on assessing the internal validity of research (i.e., researcher's independence from the study). This involves the assessment of bias in sampling, participant recruitment, data collection and analysis. Framework approaches to research appraisal, on the other hand, revolve around traditional qualitative concepts such as transparency, reflexivity, dependability, and transferability (Williams et al., 2019). Framework

approaches to appraisal are often challenging to use because they depend on the reviewer's familiarisation and interpretation of the qualitative concepts.

Because of these different approaches, there is some ambiguity in terminology, particularly between *research appraisal instruments* and *research appraisal tools*. These terms are often used interchangeably in appraisal literature (Williams et al., 2019). In this paper, research appraisal tool is defined as a method–specific (i.e., it identifies a specific research method or component) form of appraisal that draws from both checklist and framework approaches. Furthermore, a research appraisal tool seeks to inform decision making in EBP or PBE paradigms and provides explicit definitions of the tool's evaluative framework (thus minimising – but by no means eliminating – the reviewers' interpretation of the tool). This definition will be applied to CaSE.

Table 24. KEY CONCEPT: Research appraisal tool
Research appraisal tool is a method–specific (or a research component–specific) form of appraisal that draws from both checklist and framework approaches. A research appraisal tool will usually provide explicit definitions for its evaluative framework and will be used by researchers who wish to demonstrate the evidential quality of their study to the readers.

In contrast, research appraisal instruments are generally seen as a broader form of appraisal in the sense that they may evaluate a variety of methods (i.e., they are non–method specific or they do not target a particular research component), and are aimed at checking whether the research findings and/or the study design contain specific elements (e.g., the aims of research, the rationale behind design methodology, participant recruitment strategies, etc.).

There is often an implicit difference in audience between appraisal tools and instruments. Research appraisal instruments are often aimed at researchers who want to assess the strength of their study; however, the process of appraisal may not be made explicit in the study itself (besides mentioning that the tool was used to appraise the study). Research appraisal tools are aimed at researchers who wish to explicitly demonstrate the evidential quality of the study to the readers (which is particularly common in RCTs). All forms of appraisal used in the comparative exercise below are defined as 'tools', even though they have different appraisal approaches and aims.

5.3.2 Comparing different qualitative tools

Hannes et al. (2010) identified CASP (Critical Appraisal Skills Programme–tool), JBI (Joanna Briggs Institute–tool), and ETQS (Evaluation Tool for Qualitative Studies) as the most frequently used critical appraisal tools by qualitative researchers. All three tools are available online and are free of charge, which means that any researcher or reviewer can readily utilise CASP, JBI or ETQS evaluative frameworks to their research. Furthermore, all three tools were developed within the context of organisational, institutional or consortium support.

Table 25. CASP (Critical Appraisal Skills Programme–tool)
CASP is part of the Oxford Centre for Triple Value Healthcare enterprise, which seeks to support healthcare systems and achieve optimal outcomes for populations. CASP has a variety of checklists, many of which are aimed at RCTs (e.g., RCT checklist, systematic review checklist, cohort study checklist, etc.).

Table 26. JBI (Joanna Briggs Institute–tool)
JBI was developed by the Joanna Briggs Institute led by Alan Pearson. Like CASP, JBI offers a variety of appraisal checklists (e.g., cross sectional studies, diagnostic test accuracy studies, cohort studies, etc.) that are aimed at improving healthcare research and practice.

Table 27. ETQS (Evaluation Tool for Qualitative Studies)
ETQS was developed at the University of Leeds by Andrew Long in the Department of Health, under the Outcomes for Social Care for Adults (OSCA) Initiative (1997–99). Out of the three tools, ETQS is most attuned to the qualitative research paradigm; it seeks to assess and enhance evidence that is "different" from the common efficacy research in EBP (Long & Godfrey, 2004).

It is important to note that neither of the three tools is specific to systematic case studies or psychotherapy case studies more broadly. This means that using CASP, JBI or ETQS for case study appraisal may come at a cost of overlooking elements and components specific to the systematic case study method.

Based on Hannes et al. (2010) comparative study of qualitative appraisal tools as well as the different evaluation criteria explicated in CASP, JBI and ETQS evaluative frameworks, an assessment was developed to see how well each of the three tools is attuned to the *methodological*, *clinical*, and *theoretical* aspects of systematic case studies in psychotherapy. The latter components were based on case study guidelines featured in the journal of *Pragmatic Case Studies in Psychotherapy* as well as components commonly used by published systematic case studies across a variety of other psychotherapy journals (e.g., *Psychotherapy Research*, *Research In Psychotherapy:*

Psychopathology Process And Outcome, etc.) (see table 28 for detailed descriptions of each component).

The evaluation criteria for each tool in table 28 follows *JBI Critical Appraisal Checklist for Qualitative Research* (published in 2017) and *JBI Critical Appraisal Checklist for Case Reports* (published in 2017); *CASP Qualitative Checklist* (published in 2018); and *ETQS Questionnaire* (first published in 2004 but revised continuously since). Table 29 demonstrates how each tool should be used (i.e., recommended reviewer responses to checklists and questionnaires).

Table 28. Comparing the relevance of JBI (Joanna Briggs Institute), CASP (Critical Appraisal Skills Program) and ETQS (Evaluation Tool for Qualitative Studies) for appraising components specific to systematic case studies			
Systematic case study components	**JBI Evaluation Criteria**	**CASP Evaluation Criteria**	**ETQS Evaluation Criteria**
METHODOLOGICAL COMPONENTS			
Case Context and Method	Congruity between the research methodology and the research question or objectives	Methodological screening questions: Is a qualitative methodology appropriate? Was the research design appropriate to address the aims of the research?	No assessment criteria for the suitability of the case study method
Research Participants (description of patients, therapists, researchers)	Cultural and theoretical context of the researcher; researcher's impact on the research (and vice versa); adequate patient representation	No assessment criteria for the description of researchers and data analysts	How do the authors locate the study within the existing knowledge base? What role does the researcher adopt within the setting? Are the researcher's own position, assumptions, and possible biases outlined?

Research Procedure (data collection and analysis methods)	Congruity between the research methodology and the analysis of data and interpretation of results	Was the recruitment strategy appropriate to the aims of the research? Were the data collected in a way that addressed the research issue? Was the data analysis sufficiently rigorous?	What theoretical framework guides or informs the study? What data collection methods are used to obtain and record data? How were data analyzed?
CLINICAL COMPONENTS			
Case Introduction	Clear description of patient demographics and current clinical condition	No assessment criteria for case description	What are the key characteristics of the sample (events, persons, times and settings)?
Assessment of the Client's Problems, Goals, Strengths, and History (includes many data sources and methods, such as diagnostic tools and questionnaires)	Participants and their voices are clearly represented No assessment criteria for patient's clinical assessment or the use of other methods and data sources No assessment criteria for the formulation and planning of the treatment	No assessment criteria for patient's clinical assessment or the use of other methods and data sources	Within what geographical and care setting is the study carried out? Is sufficient detail given about the setting? No assessment criteria for patient's clinical assessment or the use of other methods and data sources

Course of Therapy and Treatment Plan	Clear description of patient's history, including a timeline of relevant events	No assessment criteria for course of treatment or progress	Over what time period is the study conducted? No assessment criteria for therapeutic progress
THEORETICAL COMPONENTS			
Clinical decision–making (includes assessment of clinical outcomes and theoretical findings)	Research conclusions flow from the analysis and interpretation of the data	Is there a clear statement of findings? (e.g. triangulation, respondent validation, more than one analyst)	Is there sufficient breadth (e.g. contrast of two or more perspective) and depth (e.g. insight into a single perspective)? What are the implications for policy and practice?
Research Limitations	No assessment criteria for research limitations	No assessment criteria for research limitations	Is there evidence of reflexivity? Is adequate evidence provided to support the analysis (validity and reliability)?
Transferability of Findings	No assessment criteria for transferability of findings	How valuable is the research? Consider the findings in relation to current practice or policy, or relevant research–based literature and how findings can be transferred to other populations or other ways in which the research may be used	To what setting and population are the study findings generalizable?

Table 29. Recommended reviewer responses to JBI (Joanna Briggs Institute), CASP (Critical Appraisal Skills Program) and ETQS (Evaluation Tool for Qualitative Studies)

JBI Evaluation Responses	CASP Evaluation Responses	ETQS Evaluation Responses
Checklist: Yes No Unclear Not applicable	*Checklist:* Yes No Can't tell Additional space for comments available	*Open–ended questionnaire:* Comprehensive and detailed responses in relation to the study

5.3.3 Using CASP, JBI and ETQS for systematic case study appraisal

Although JBI, CASP and ETQS were all developed to appraise qualitative research, it is evident from the above comparison that there are significant differences between the three tools. For example, JBI and ETQS are well suited to assess researcher's interpretations (defined as *interpretive validity*, a subcategory of *internal validity;* Hannes et al., 2010): the researcher's ability to portray, understand and reflect on the research participants' experiences, thoughts, viewpoints and intentions. JBI has an explicit requirement for participant voices to be clearly represented, whereas ETQS involves a set of questions about key characteristics of events, persons, times and settings that are relevant to the study. Furthermore, both JBI and ETQS seek to assess the researcher's influence on the research, with ETQS particularly focusing on the evaluation of *reflexivity* (the researcher's personal influence on the interpretation and collection of data). These elements are absent or addressed to a lesser extent in the CASP tool.

The appraisal of transferability of findings (what this paper previously referred to as *external validity*) is addressed only by ETQS and CASP. Both tools have detailed questions about the value of research to practice and policy as well as its transferability to other populations and settings. Methodological research aspects are also extensively addressed by CASP and ETQS, but less so by JBI (which relies predominantly on congruity between research methodology and objectives without any particular assessment criteria for other data sources and/or data collection methods). Finally, the evaluation of theoretical aspects (also known as *theoretical validity*; Hannes et al., 2010) is addressed only by JBI and ETQS; there are no assessment criteria for theoretical framework in CASP.

Given these differences, it is unsurprising that CASP, JBI and ETQS have limited relevance for systematic case studies in psychotherapy. First, it is evident that neither of the three tools has specific evaluative criteria for the clinical component of systematic case studies. Although JBI and ETQS feature some relevant questions about *participants* and their context, the conceptualisation of *patients* (and/or clients) in psychotherapy involves other kinds of data elements (e.g., diagnostic tools and questionnaires as well as therapist observations) that go beyond the usual participant data. Furthermore, much of the clinical data is intertwined with the therapist's clinical decision–making and thinking style (Kaluzeviciute & Willemsen, 2020). As such, there is a need to appraise patient data and therapist interpretations not only on a separate basis, but also as two forms of knowledge that are deeply intertwined in the case narrative.

Secondly, since systematic case studies involve various forms of data, there is a need to appraise how these data converge (or how different methods complement one another in the case context) and how they can be transferred or applied in broader psychotherapy research and practice. These systematic case study components are attended to a degree by CASP (which is particularly attentive of methodological components) and ETQS (particularly specific criteria for research transferability onto policy and practice). These components are not addressed or less explicitly addressed by JBI.

Overall, neither of the tools is attuned to all methodological, theoretical and clinical components of the systematic case study. Specifically, there are no clear evaluation criteria for the description of research teams (i.e. different data analysts and/or clinicians); the suitability of the systematic case study method; the description of

patient's clinical assessment; the use of other methods or data sources; the general data about therapeutic progress).

Finally, there is something to be said about the recommended reviewer responses (table 29). Systematic case studies can vary significantly in their formulation and purpose. The methodological, theoretical, and clinical components outlined in table 28 follow guidelines made by case study journals; however, these are recommendations, not 'set in stone' case templates. For this reason, the straightforward checklist approaches adopted by JBI and CASP may be difficult to use for case study researchers and those reviewing case study research. The ETQS open–ended questionnaire approach suggested by Long and Godfrey (2004) enables a comprehensive, detailed and purpose–oriented assessment, suitable for the evaluation of systematic case studies. That said, there remains a challenge of ensuring that there is less space for the interpretation of evaluative criteria (Williams et al., 2019). The combination of checklist and framework approaches would, therefore, provide a more stable appraisal process across different reviewers.

5.4 Developing purpose–oriented evaluation criteria for systematic case studies

The starting point in developing evaluation criteria for *Case Study Evaluation–tool* (CaSE) is addressing the significance of pluralism in systematic case studies. Unlike RCTs, systematic case studies are pluralistic in the sense that they employ divergent practices in methodological procedures (*research process*), and they may include significantly different research aims and purpose (*the end–goal*) (Kaluzeviciute & Willemsen, 2020). While some systematic case studies will have an explicit intention to conceptualise and situate a single patient's experiences and symptoms within a broader clinical population,

others will focus on the exploration of phenomena as they emerge from the data. It is therefore important that CaSE is positioned within a *purpose–oriented evaluative framework*, suitable for the assessment of what each systematic case is good for (rather than determining an absolute measure of 'good' and 'bad' systematic case studies). This approach to evidence and appraisal is in line with the PBE paradigm. PBE emphasises the study of clinical complexities and variations through local and contingent settings (e.g., single case studies) and promotes methodological pluralism (Barkham & Mellor–Clark, 2003).

5.4.1 CaSE Checklist for Essential Components in Systematic Case Studies

In order to conceptualise purpose–oriented appraisal questions, we must first look at what unites and differentiates systematic case studies in psychotherapy. The commonly used theoretical, clinical and methodological systematic case study components were identified earlier in table 29. These components will be seen as *essential* and common to most systematic case studies in CaSE evaluative criteria. If these essential components are missing in a systematic case study, then it may be implied there is a lack of information, which in turn diminishes the evidential quality of the case. As such, the checklist serves as a tool for checking whether a case study is, indeed, systematic (as opposed to experimental or clinical; see Iwakabe & Gazzola, 2009 for further differentiation between methodologically distinct case study types) and should be used before *CaSE Purpose–based Evaluative Framework for Systematic Case Studie*s (which is designed for the appraisal of different purposes common to systematic case studies).

As noted earlier in the paper, checklist approaches to appraisal are useful when evaluating the presence or absence of specific information in a research study. This approach can be used to appraise essential components in systematic case studies, as shown below. From a pragmatic point view (Levitt et al., 2017; Truijens et al., 2019), *CaSE Checklist for Essential Components in Systematic Case Studies* can be seen as a way to ensure the internal validity of systematic case study: the reviewer is assessing whether sufficient information is provided about the case design, procedure, approaches to inquiry, etc., and whether they are relevant to the researcher's objectives and conclusions.

Table 30. *Case Study Evaluation–tool* (CaSE) Checklist for Essential Components in Systematic Case Studies

Recommended responses: Yes, No, Unclear or Not Applicable

METHODOLOGY

1. The rationale behind choosing the case study method
2. Description of research design and aims
3. Description of research participants, including:
    - 3a. Patients/clients
    - 3b. Therapists, clinical supervisors
    - 3c. Researchers/data analysts (research team)
4. Description of research procedures, including:
    - 4a. Evaluation of existing literature and research
    - 4b. Data collection methods
    - 4c. Data analysis methods
    - 4d. Data triangulation procedures
    - 4e. Research appraisal tools and instruments
5. Description of researchers' reflexivity (awareness of the relationship between the researcher and research study), including:
    - 5a. Research assumptions pertaining to objectives
    - 5b. Research biases pertaining to data analysis
    - 5c. Differentiation between assumptions and views made by different researchers/therapists
6. Description of research limitations, including:
    - 6a. Congruity between research data and research aims and objectives
    - 6b. Research appraisal and validity
7. Relevant ethical information, including:
    - 7a. Patient's informed consent
    - 7b. Anonymisation of specific clinical material

CLINICAL COMPONENTS

8. Description of patient's history, including:
    - 8a. Demographics
    - 8b. Cultural context
    - 8c. Socio–economic context
    - 8d. Interpersonal history (family and other relationships)

9. Description of patient's clinical condition, including:
    - 9a. Current and past diagnosis (with reference to DSM, ICD and other diagnostic manuals)
    - 9b. Current and past symptoms and experiences
    - 9c. Previously received treatment
    - 9d. The use of medication
10. Description of patient's problems through:
    - 10a. Diagnostic tools (therapist's assessment)
    - 10b. Self–report questionnaires (patient's self–assessment)
11. Description of course of therapy and treatment, including:
    - 11a. Therapeutic modality
    - 11b. Therapeutic setting (number of sessions, frequency, private/public practice)
    - 11c. Therapeutic relationship
    - 11d. Timeline of relevant treatment events/sessions
    - 11e. Follow–up information
    - 11f. Treatment outcomes
    - 11g. Complicating factors
12. Description of clinical decision–making and reflexivity (awareness of the relationship between the therapist and the treatment process), including:
    - 12a. Clinical assumptions pertaining to diagnosis
    - 12b. Clinical biases pertaining to therapeutic techniques and interpretations (especially in relation to therapist's therapeutic modality)
13. Description of therapist where relevant, including:
    - 13a. Professional experience
    - 13b. Demographics
    - 13c. Cultural context
    - 13d. Socio–economic context

THEORY

14. Clear description of theoretical references and key concepts
15. Description of how clinical decision–making relates to the chosen theoretical framework
16. Clear statement of theoretical findings
17. Clear description of evidence for and limitations of the chosen theoretical framework, including:

17a. Validity (does the case study attend its research objectives and aims sufficiently? Do researchers use relevant theoretical concepts, clinical techniques and research methods?)

17b. Reliability (does the case study provide sufficient, detailed and reflexive information on how it arrived at its findings?)

18. Description of transferability of findings (relevance to other cases), including:

18a. Transferability to psychotherapy research

18b. Transferability to psychotherapy practice

18c. Relevance to policy in private and/or public healthcare

18d. Relevance to specific clinical population and setting

5.4.2 CaSE Purpose–based Evaluative Framework for Systematic Case Studies

Identifying differences between systematic case studies means identifying the different purposes systematic case studies have in psychotherapy. Based on the earlier work by social scientist Robert Yin (1984, 1993), we can differentiate between *exploratory* (hypothesis generating, indicating a beginning phase of research), *descriptive* (particularising case data as it emerges) and *representative* (a case that is typical of a broader clinical population, referred to as the "explanatory case" by Yin) cases.

Another increasingly significant strand of systematic case studies is *transferable* (aggregating and transferring case study findings) cases. These cases are based on the process of meta–synthesis (Iwakabe & Gazzola, 2009): by examining processes and outcomes in many different case studies dealing with similar clinical issues, researchers can identify common themes and inferences. In this way, single case studies that have relatively little impact on clinical practice, research or health care policy (in the sense that they capture psychotherapy processes rather than produce generalisable claims as in Yin's *representative* case studies) can contribute to the generation of a wider knowledge base in psychotherapy (Iwakabe, 2003, 2005). However, there is an ongoing issue of assessing the evidential quality of such transferable cases. According to Duncan and Sparks (2019), although meta–synthesis and meta–analysis are considered to be 'gold standard' for assessing interventions across disparate studies in psychotherapy, they often contain case studies with significant research limitations, inappropriate interpretations and insufficient information. It is therefore important to have a research appraisal process in place for selecting transferable case studies.

Two other types of systematic case study research include: *critical* (testing and/or confirming existing theories) cases, which are described as an excellent method for falsifying existing theoretical concepts and testing whether therapeutic interventions work in practice with concrete patients (Kaluzeviciute, 2021), and *unique* (going beyond the 'typical' cases and demonstrating deviations) cases (Merriam, 1998). These two systematic case study types are often seen as less valuable for psychotherapy research given that unique/falsificatory findings are difficult to generalise. But it is clear that practitioners and researchers in our field seek out context–specific data, as well as detailed information on the effectiveness of therapeutic techniques in single cases (Stiles, 2007).

Table 31. KEY CONCEPT: Purpose–based systematic case studies

1. **Representative cases** of a broader clinical population (*typicality*);
2. **Descriptive cases** that capture specific psychotherapy processes as they emerge in treatment (*particularity*);
3. **Unique cases** due to unusual variations that go beyond the 'average' population (*deviation*);
4. **Critical cases** that test existing theories (*faslficiation/confirmation*);
5. **Exploratory cases** that indicate a beginning phase of a multiple case study research (*hypothesis generation*);
6. **Transferable cases** that seek to aggregate and transfer case study findings onto other cases (*generalisability*).

Each purpose–based case study contributes to PBE in different ways. *Representative cases* provide qualitatively rich, in–depth data about a clinical phenomenon within its particular context. This offers other clinicians and researchers access to a 'closed world' (Macrill & Iwakabe, 2013) containing a wide range of attributes about a conceptual type (e.g., clinical condition or therapeutic technique). *Descriptive cases* generally seek to

demonstrate a realistic snapshot of therapeutic processes, including complex dynamics in therapeutic relationships, including instances of therapeutic failure (Maggio et al., 2019). Descriptive cases are commonly used in psychotherapy training and supervision. *Unique cases* are relevant for both clinicians and researchers: they often contain novel treatment approaches and/or introduce new diagnostic considerations about patients who deviate from the clinical population. *Critical cases* demonstrate the application of psychological theories 'in action' with particular patients; as such, they are relevant to clinicians, researchers, and policymakers (Macrill & Iwakabe, 2013). *Exploratory cases* bring new insight and observations into clinical practice and research. This is particularly useful when comparing (or introducing) different clinical approaches and techniques (Trad & Raine, 1994). Findings from exploratory cases often include future research suggestions. Finally, *transferable cases* provide one solution to the generalisation issue in psychotherapy research through the previously mentioned process of meta–synthesis. Grouped together, transferable cases can contribute to theory building and development, as well as higher levels of abstraction about a chosen area of psychotherapy research (Iwakabe & Gazzola, 2009).

With this plurality in mind, it is evident that CaSE has a challenging task of appraising research components that are *distinct* across six different types of purpose–based systematic case studies. The purpose–specific evaluative criteria in tables 32.1–32.6 was developed in close consultation with epistemological literature associated with each type of case study, including: Yin's (1984, 1993) work on establishing the typicality of representative cases; Iwakabe and Gazzola's (2009) and Duncan and Sparks' (2019) case selection criteria for meta–synthesis and meta–analysis; Stake's (1995, 2010) research on particularising case narratives; Merriam's (1998) guidelines on distinctive attributes of unique case studies; Kennedy's (1979) epistemological rules for

generalising from case studies; Mahrer's (1988) discovery oriented case study approach; and Edelson's (1986) guidelines for rigorous hypothesis generation in case studies.

Research on epistemic issues in case writing (Kaluzeviciute, 2021) and different forms of scientific thinking in psychoanalytic case studies (Kaluzeviciute & Willemsen, 2020) was also utilised to identify case study components that would help improve therapist clinical decision–making and reflexivity.

For the analysis of more complex research components (e.g., the degree of therapist reflexivity), the purpose–based evaluation will utilise a framework approach, in line with comprehensive and open–ended reviewer responses in ETQS (Evaluation Tool for Qualitative Studies) (Long & Godfrey, 2004) (table 32). That is to say, the evaluation here is not so much about the presence or absence of information (as in the checklist approach) but the degree to which the information helps the case with its unique purpose, whether it is generalisability or typicality. Therefore, although the purpose–oriented evaluation criteria below encompasses comprehensive questions at a considerable level of generality (in the sense that not all components may be required or relevant for each case study), it nevertheless seeks to engage with each type of purpose–based systematic case study on an individual basis (attending to research or clinical components that are unique to each of type of case study).

It is important to note that, as this is an introductory paper to CaSE, the evaluative framework is still preliminary: it involves some of the core questions that pertain to the nature of all six purpose–based systematic case studies. However, there is a need to develop a more comprehensive and detailed CaSE appraisal framework for each purpose–based systematic case study in the future.

Table 32. *Case Study Evaluation–tool* (CaSE) Purpose–based Evaluative Framework for Systematic Case Studies

Recommended responses: Open–ended questionnaire

32.1 REPRESENTATIVE CASES (purpose: *typicality*)

THE STUDIED PHENOMENON

- What is the studied phenomenon or 'conceptual type' (*e.g., clinical condition, therapeutic technique, patient's symptoms*)? There is generally one specific phenomenon.
- Is the studied phenomenon sufficiently distinguished from other kinds of (potentially similar) phenomena?

PATIENT DATA

- Are patient characteristics relevant to the wider clinical population? (*E.g., is there a good match between symptoms and experiences?*)
- What is the rationale for choosing this patient?
- Does the patient present any unique or deviant characteristics? (*E.g., symptoms that are not representative of the studied clinical condition)*

THE CLINICAL DISCOURSE

- Is there a detailed clinical narrative in the form of therapist reflections and observations?
- Does the case move from the particularity of the patient to a more general (theoretically abstract) claim about the studied phenomenon?

RESEARCH

- Is there a sufficient review of literature on the studied phenomenon?
- Does the case refer to other cases and/or studies that replicate their findings?

CASE PURPOSE

- Does the case demonstrate the typical characteristics of the studied phenomenon?
- Does the case provide findings relevant for the broader clinical population?
- Can the case contribute to psychotherapy theory?

32.2 DESCRIPTIVE CASES (purpose: *particularity*)

THE STUDIED PHENOMENON

- What phenomena are studied in the case (*e.g., clinical condition, therapeutic technique, patient's symptoms)*? There can be multiple phenomena.
- Does the case present events and processes common to clinical practice? (*E.g., therapeutic relationship difficulties*)

PATIENT DATA

- Are patient characteristics described in detail, with particular attention to uniqueness, subjectivity and meaning of "lived experiences"?
- Does the case narrative convey interpersonally sharable statements, ruminations, metaphors?
- Is the patient clearly positioned within their cultural and psycho–social context?

THE CLINICAL DISCOURSE

- Does the case convey the process behind therapist's practical decisions in the consulting room?
- Does the case provide "know–how" knowledge on how practitioners can deal with clinically salient issues and situations?
- Does the therapist provide a reflexive account on how their views and theoretical assumptions might impact the therapeutic relationship and clinical decision–making?

RESEARCH

- Does the case include patient's self–assessment? (*E.g., through self–report measures and dialogic exchange)*
- Does the case include excerpts of dialogue between therapist and patient?

CASE PURPOSE

- Does the case provide a relational understanding (with which readers can empathise) of the studied phenomenon?
- Does the case narrative sufficiently portray "real analytic practice" rather than "ideal models"? (*E.g., by demonstrating disparity between clinical theory/research and practice*)
- Can the case contribute to psychotherapy training and practice?

32.3 UNIQUE CASES (purpose: *deviation*)

THE STUDIED PHENOMENON

- What phenomena are studied in the case (*e.g., clinical condition, therapeutic technique, patient's symptoms)*? There can be multiple phenomena.
- Does the case explain how the studied phenomena are different or unique from the established theory/research? (*E.g., the patient's experience of transference is different from the experiences of transference across a broader clinical population*)

PATIENT DATA

- Are patient characteristics described in detail, with particular attention to uniqueness, subjectivity and meaning of "lived experiences"?
- What is the rationale for choosing this patient?

THE CLINICAL DISCOURSE

- Does the case convey a detailed description of therapeutic interventions and their effectiveness?
- Does the therapist provide a reflexive account on how their views and theoretical assumptions might impact clinical decision–making, particularly in terms of their understanding of the uniqueness/deviation in the case?
- Does the case include sufficient considerations as to the cause of the deviation/uniqueness in patient's clinical condition or symptoms?

RESEARCH

- Does the case convey more than one theoretical and/or research perspective? (*E.g., clinical assessment by multiple practitioners or data analysis by multiple researchers*)
- Are there considerations of alternative explanations to the observed deviation/uniqueness of the case? (*E.g., by referring to other published case studies or research*)

CASE PURPOSE

- Does the case provide insight into a novel phenomenon? (*E.g., by describing unique patient symptoms or experiences*)
- Does the case provide novel theoretical knowledge in relation to unique/deviant phenomenon? (*E.g., by developing a new therapeutic technique*)
- Can the case contribute to psychotherapy theory, training and/or practice?

32.4 CRITICAL CASES (purpose: *falsification/confirmation*)

THE STUDIED PHENOMENON

- What is the studied phenomenon in the case (*e.g., clinical condition, therapeutic technique, patient's symptoms)*? There is generally one specific phenomenon.
- Does the case seek to test an existing theory/research about the studied phenomenon? (*E.g., testing the effectiveness of a well–established therapeutic intervention*)

PATIENT DATA

- Are patient characteristics described in detail?
- Is the patient clearly outlined within their cultural and psycho–social context?
- What is the rationale for choosing this patient?

THE CLINICAL DISCOURSE

- Does the case link therapist narrative and observations with the theoretical/research considerations?
- Does the case convey a detailed description of therapeutic interventions and their effectiveness?

RESEARCH

- Does the case convey more than one theoretical and/or research perspective? (*E.g., clinical assessment by multiple practitioners or data analysis by multiple researchers*)
- Does the case show how the theory/research that is being tested accounts for the clinical observations in the case?
- Does the case provide a sufficient explanation on why their chosen theory/research is more appropriate than another?
- If the case falsifies an existing theory/research, are there sufficient sample considerations? (*E.g., the case may be unique and therefore the original theory/research still stands*)

CASE PURPOSE

- Does the case examine an existing theory/research successfully? (*E.g., by showing whether a theory is effective with a specific patient*)
- If the case falsifies an existing theory/research, does it offer any novel suggestions or revisions to the falsified theory/research?
- If the case confirms an existing theory/research, does it rule out alternative explanations for the tested hypothesis? (*E.g., to show that a therapeutic intervention is effective, the positive effects of other variables like medication may need to be ruled out*)

32.5 EXPLORATORY CASES (purpose: *hypothesis generation*)

THE STUDIED PHENOMENON

- What phenomena are studied in the case (*e.g., clinical condition, therapeutic technique, patient's symptoms)*? There can be multiple phenomena.
- Is the case discovery–led, in the sense that it explores data as it emerges?
- Does the case contain new hypotheses about the studied phenomena?

PATIENT DATA

- Are patient characteristics described in detail?
- Is the patient clearly outlined within their cultural and psycho–social context?

THE CLINICAL DISCOURSE

- Does the case link therapist narrative and observations with the theoretical/research considerations?
- Does the case narrative explore the "how" and "what" questions in relation to patient experiences and treatment processes?
- Does the case identify complex processes and mechanisms in the treatment and link them to theory?

RESEARCH

- Is there a sufficient review of literature of the studied phenomenon?
- Does the case convey more than one theoretical and/or research perspective? (*E.g., clinical assessment by multiple practitioners or data analysis by multiple researchers*)
- Does the data converge? Are different/conflicting findings reported?

CASE PURPOSE

- Does the case convey more than one set of outcomes?
- Does the case indicate future research trajectories?
- Can the case contribute to psychotherapy theory, training and/or practice?

32.6 TRANSFERABLE CASES (purpose: *generalisability*)

THE STUDIED PHENOMENON

- What is studied phenomenon (*e.g., clinical condition, therapeutic technique, patient's symptoms*)? There is generally one specific phenomenon.
- Is the studied phenomenon explicitly defined and differentiated from other kinds of (potentially similar) phenomena?

PATIENT DATA

- Are patient characteristics described in detail?
- Is the patient clearly outlined within their cultural and psycho–social context?
- Does the patient present characteristics typical of the studied phenomenon? Is there sufficient information (clinical, theoretical) to link the patient with the studied phenomenon?

THE CLINICAL DISCOURSE

- Is there a detailed clinical narrative in the form of therapist reflections and observations?
- Does the case shed light on specific characteristics of the therapeutic process? (*E.g., the development of therapeutic alliance*)
- Is the case narrative theme–focused? (*E.g., the case identifies specific treatment patterns across different sessions)*
- Is there a clear description of the therapeutic process, usually involving a session–by–session description?

RESEARCH

- Is there a sufficient review of literature on the studied phenomenon?
- Does the case involve a specific therapeutic, theoretical and research framework, and is the framework made explicit by the researchers?
- Is there a clear description of the research process? (*E.g., step–by–step description of data analysis procedures*)

CASE PURPOSE

- Does the case provide information about common or specific psychotherapy processes?
- Can the case be compared to and aggregated with other psychotherapy case studies on the basis of its studied phenomenon and formulation?

5.5 Using CaSE on published systematic case studies in psychotherapy: an example

To illustrate the use of *CaSE Purpose–based Evaluative Framework for Systematic Case Studies*, a case study by Lunn et al. (2016) titled "Psychoanalytic Psychotherapy With a Client With Bulimia Nervosa" was selected from the Single Case Archive (SCA) and analysed in table 33. Based on the core questions associated with the six purpose–based systematic case study types in tables 32.1–32.6, the purpose of Lunn et al.'s (2016) case was identified as *critical* (testing an existing theoretical suggestion).

Sometimes case study authors will explicitly define the purpose of their case in the form of research objectives (as was the case in Lunn et al.'s study); this helps identifying which purpose–based questions are most relevant for the evaluation of the case. However, some case studies will require comprehensive analysis in order to identify their purpose (or multiple purposes). As such, it is recommended that CaSE reviewers first assess the degree and manner in which information about the studied phenomenon, patient data, clinical discourse, and research are presented before deciding on the case purpose.

Although each purpose–based systematic case study will contribute to different strands of psychotherapy (theory, practice, training, etc.) and focus on different forms of data (e.g., theory testing vs extensive clinical descriptions), the overarching aim across all systematic case studies in psychotherapy is to study local and contingent processes, such as variations in patient symptoms and complexities of the clinical setting. The comprehensive framework approach will therefore allow reviewers to assess the degree of *external validity* in systematic case studies (Barkham & Mellor–Clark, 2003).

Furthermore, assessing the case against its purpose will let reviewers determine whether the case achieves its set goals (research objectives and aims). The example below shows that Lunn et al.'s (2016) case is successful in functioning as a critical case as the authors provide relevant, high–quality information about their tested therapeutic conditions.

Finally, is also possible to use CaSE to gather specific type of systematic case studies for one's research, practice, training, etc. For example, a CaSE reviewer might want to identify as many *descriptive* case studies focusing on negative therapeutic relationships as possible for their clinical supervision. The reviewer will therefore only need to refer to CaSE questions in table 32.2 on descriptive cases. If the reviewed cases do not align with the questions in table 32.2, then they are not suitable for the CaSE reviewer who is looking for "know–how" knowledge and detailed clinical narratives.

Table 33. Using *Case Study Evaluation–tool* (CaSE): Lunn et al. (2016)'s case "Psychoanalytic Psychotherapy With a Client With Bulimia Nervosa"

Type of case	The studied phenomenon	Patient data	The clinical discourse	Research	Case purpose
Critical	The studied phenomenon is identified as the treatment of bulimia nervosa. The case tests the need of adapting therapeutic approaches to individual patients on the basis of their specific therapeutic needs and goals rather than providing manualised therapy across the entire clinical population.	A patient was selected from an RCT trial where Cognitive Behavioural Therapy (CBT) was found, on average, more effective than psychoanalytic psychotherapy (PP) However, this patient's symptoms and context indicated that she may benefit from techniques and principles common to PP, which is why she was chosen for this case study. The case involves a lengthy patient description, including previous diagnosis of anorexia nervosa, binge and purge episodes, early object relations, and childhood–rooted trauma. The case provides substantial information on patient's psychological context and demographics but does not contain cultural information (this may have been deemed not relevant).	The case contains a detailed description of therapeutic interventions, such as therapeutic containment, reflection, and acknowledgement of unconscious, split–off, or disavowed aspects of patient's experiences. Therapist observations and clinical decision–making are informed by the theoretical PP principles, particularly in terms of affirming and interpreting patient's experiences. The effectiveness of therapeutic interventions is described as highly positive: patient has stopped binging and purging and was able to develop a closer relationship with her family.	Several theoretical and research perspectives are explored in order to tailor the most suitable approach for the patient, including attachment styles, mentalization, and integrative approaches. One of the authors acted as a therapist, while the two other authors were involved in data analysis; this improved the data triangulation process. Several hypothetical assumptions were made about therapeutic setting and relationship and their suitability for this patient; they are shown to be highly effective and helpful later in the case (e.g., nondirective PP therapy was experienced as more helpful by the patient than directive CBT therapy).	The case demonstrates that insight–oriented, nondirective PP can yield significant successes for patients with bulimia nervosa who also display low reflective functioning and insecure attachments. This case is an important critical follow–up to larger RCT study, which by and large favoured CBT to PP for patients with eating disorders.

5.6 Concluding comments

This paper introduces a novel *Case Study Evaluation–tool* (CaSE) for systematic case studies in psychotherapy. Unlike most appraisal tools in EBP, CaSE is positioned within purpose–oriented evaluation criteria, in line with the PBE paradigm. CaSE enables reviewers to assess what each systematic case is good for (rather than determining an absolute measure of 'good' and 'bad' systematic case studies). In order to explicate a purpose–based evaluative framework, six different systematic case study purposes in psychotherapy have been identified: *representative cases* (purpose: typicality), *descriptive cases* (purpose: particularity), *unique cases* (purpose: deviation), *critical cases* (purpose: falsification/confirmation), *exploratory cases* (purpose: hypothesis generation), and *transferable cases* (purpose: generalisability). Each case was linked with an existing epistemological network, such as Iwakabe and Gazzola's (2009) work on case selection criteria for meta–synthesis. The framework approach includes core questions specific to each purpose–based case study (tables 32.1–32.6). The aim is to assess the external validity and effectiveness of each case study against its set out research objectives and aims. Reviewers are required to perform a comprehensive and open–ended data analysis, as shown in the example in table 33.

Along with *CaSE Purpose–based Evaluative Framework* (table 32), the paper also developed *CaSE Checklist for Essential Components in Systematic Case Studies* (table 30). The checklist approach is meant to aid reviewers in assessing the presence or absence of essential case study components, such as the rationale behind choosing the case study method and description of patient's history. If essential components are missing in a systematic case study, then it may be implied that there is a lack of information, which in turn diminishes the evidential quality of the case. Following broader definitions of

validity set out by Levitt et al. (2017) and Truijens et al. (2019), it could be argued that the checklist approach allows for the assessment of (non–quantitative) internal validity in systematic case studies: does the researcher provide sufficient information about the case study design, rationale, research objectives, epistemological/philosophical paradigms, assessment procedures, data analysis, etc., to account for their research conclusions?

It is important to note that this paper is set as an introduction to CaSE; by extension, it is also set as an introduction to research evaluation and appraisal processes for case study researchers in psychotherapy. As such, it was important to provide a step–by–step epistemological rationale and process behind the development of CaSE evaluative framework and checklist. However, this also means that further research needs to be conducted in order to develop the tool. While *CaSE Purpose–based Evaluative Framework* involves some of the core questions that pertain to the nature of all six purpose–based systematic case studies, there is a need to develop individual and comprehensive CaSE evaluative frameworks for each of the purpose–based systematic case studies in the future. This line of research is likely to enhance CaSE target audience: clinicians interested in reviewing highly–particular clinical narratives will attend to descriptive case study appraisal frameworks; researchers working with qualitative meta–synthesis will find transferable case study appraisal frameworks most relevant to their work; while teachers on psychotherapy and counselling modules may seek out unique case study appraisal frameworks.

Furthermore, although *CaSE Checklist for Essential Components* and *CaSE Purpose–based Evaluative Framework* are presented in a comprehensive, detailed manner, with definitions and examples that would enable reviewers to have a good grasp of the

appraisal process, it is likely that different reviewers may have different interpretations or ideas of what might be "substantial" case study data. This, in part, is due to the methodologically pluralistic nature of the case study genre itself; what is relevant for one case study may not be relevant for another, and vice–versa. To aid with the review process, future research on CaSE should include a comprehensive paper on using the tool. This paper should involve evaluation examples with all six purpose–based systematic case studies, as well as a "search" exercise (using CaSE to assess the relevance of case studies for one's research, practice, training, etc.).

Finally, further research needs to be developed on how (and, indeed, whether) systematic case studies should be reviewed with specific 'grades' or 'assessments' that go beyond the qualitative examination in table 33. This would be particularly significant for the processes of qualitative meta–synthesis and meta–analysis. These research developments will further enhance CaSE tool, and, in turn, enable psychotherapy researchers to appraise their findings within clear, purpose–based evaluative criteria appropriate for systematic case studies.

Chapter 6: Conclusion

6.1 Summary of thesis findings and contributions

This thesis contributes to the discussion of how clinical and systematic case studies, as two methodologically distinct types of case study (Iwakabe & Gazzola, 2009), can be used in psychotherapy and psychoanalytic research. Specifically, the findings explore the significance of capturing qualitatively rich psychological data in therapeutic practice. Although such data is inherently difficult to document given the fact that all qualitative investigations require the active participation of the researcher, which may subsequently introduce researcher bias (e.g., preference and/or allegiance to one's theoretical/therapeutic framework and "narrative smoothing"; see Truijens, 2016; Spence, 1984, 2001; Midgley, 2006a), this thesis argues that, despite these challenges, we cannot omit data containing 'unstandardised' treatment experiences.

For one, standardising (e.g., via statistics or self–report measures) patient responses does not always lead to data that is congruent or reflective of patient's *genuine* (i.e., constitutive of patient's psychic reality; Hanly & Hanly, 2001) reactions to the treatment process. Chapter 2 presents a discussion of case study narratives which demonstrate the importance of detailed phenomenological patient observations as well as showcase some of the issues in translating subjective experiences into quantitative language (Tacq, 2010). For instance, one of the cases discussed in the thesis by Truijens et al. (2019) argues that data standardisation in psychotherapy can become a heavy burden not only for practitioner–researchers developing such standardised measures but patients as well. As respondents to psychometric and survey measures, patients are often asked to express difficult (sometimes traumatic) feelings, attitudes, and

experiences into quantitative language. Subsequently, the quantitative evaluation may miss the mark in tracking the severity and complexity of patient experiences, such as feelings of distress, confusion, fear or provocation felt in response to questionnaire items. This may have a significant impact on treatment process and outcome, which was observed in Truijens et al.'s (2019) case narrative:

> On a broader level, the questionnaires seem to provoke [the patient's] phobic object, which is her overall fear to be ill or crazy. […] [The patient's] phobic object comes into play at the most basic level of scoring, as she worries whether a specific score can be a sign of abnormality. Beyond that she also questions whether her feelings in general indicate abnormality: "*So what number is that, then, that anger? […] And is that acceptable? And, does that fall under the label normal? Like, is that normal, and to what extent?*" (p. 23, emphasis added).

Questions that fall outside standardised measures, such as in the above passage, are significant, as they often point to complex self–assessments, ideas, and feelings experienced by patients during (and beyond) treatment (Desmet et al., 2021). Chapter 2 through to 5 positioned the latter subjective experiences as foundational for psychotherapy practice and research. Instead of perceiving such data as 'irredeemably biased', the thesis findings suggest that subjective data in psychotherapy should instead be treated as micro–processes containing detailed information about patient symptoms, responses, reactions; therapeutic techniques, interventions and outcomes; therapist attitudes, feelings, and interpretations, and other experiences that can inform therapeutic

practice and theory (Onwuegbuzie & Leech, 2005; McLeod & Elliott, 2011). Specifically, micro–processes that attend to the 'singularities' of individual treatment have been identified as significant in tailoring therapeutic interventions to unique patient needs (Desmet et al., 2021). Chapters 2 and 3 explored how therapeutic modalities and techniques are often selected on the basis of detailed case descriptions containing patient's interpersonal patterns, relational experiences, and responses to the therapist (Levine & Faust, 2013; Van Nieuwenhove et al., 2019). The clinical case study by Vaskinn et al. (2011), which was used in the thesis to demonstrate the epistemic significance of hypothesis generation in psychotherapy research, is exemplary of tailoring therapeutic interventions in this manner. The case provides a detailed description of a patient diagnosed with schizophrenia, which led to the identification of significant symptom and behavioural deviations (the patient perceived himself as incapable of existing outside of the hospital care). This allowed the therapists to develop a new treatment plan (narrative therapy focused on developing a more autonomous self–view), leading to positive treatment outcome and, eventually, discharge from the hospital.

Although the findings from Vaskinn et al.'s (2011) case are not necessarily generalisable to the broader population of individuals diagnosed with schizophrenia (as, indeed, the patient's symptoms and experiences were considered to be diagnostically uncommon), this shows that *particularising* patient descriptions and addressing individual treatment needs is significant for both the practice of psychotherapy (treatment outcome) as well as research (developing novel therapeutic techniques based on the singularity and complexity of individual patient experiences). This argument has been central in defending the value of highly particular case study narratives throughout the thesis, especially in relation to some of the misconceptions surrounding case study

research in Chapter 2. This includes the following 'conventional truths' (Flyvbjerg, 2006): subjective experiences are inherently flawed data; therapist–patient relationships are too far removed from researcher–participant relationships; all therapeutic relationships are based on the processes of suggestibility (Grünbaum, 1984) and scientific judgment (Foucault, 1979); and finally, that generalisation (specifically, statistical generalisation) is the end–goal for all forms of clinical research, including case studies. By addressing these critical accounts, thesis Chapters 2 and 3 explored several philosophical systems, including *social constructivism* (which positioned case narratives as forms of classification, judgment, and correction between the psychoanalytic expert and the passive patient), *positivism* (which considered case studies as unscientific anecdotal reports with non–generalisable findings and subjective bias), and *critical realism* (a performative epistemology working against the grain of both positivism and social constructionism, which has been identified as epistemically significant for the case study method in the thesis). To this date, perspectives comparing philosophical and epistemological frameworks with knowledge generation practices in psychotherapy and psychoanalysis have been scarce; as such, the thesis contributes and further extends research at the intersection of epistemology and case study research (Truijens, 2016; Cartwright & Hardie, 2012; Cartwright, 2015).

Similarly, Chapters 2 and 4 consider the importance of practitioner–researcher experiences and perspectives in case narratives. Since case studies are often developed by researchers who simultaneously act as clinical practitioners (psychotherapists, psychologists, psychoanalysts, mental health and social care workers, etc.), clinical and systematic case narratives offer a methodologically unique perspective (Dattillio et al., 2010): they show *how it feels* to be in the session with patients in concrete clinical situations. In this sense, the practitioner–researcher's subjectivity (or, as Hinshelwood

puts it, 'the analyst's mind'; see Hinshelwood, 2019) is seen as a research instrument, necessary for the engagement with the patient's subjectivity (Morrow, 2005). This approach has been integral to classic psychoanalytic case studies: for example, Freud's case of Dora (1901/1905) demonstrates Freud's own difficulty as a psychoanalyst to engage with Dora's transference feelings, which led to the premature ending of the treatment. A closer look at Freud's oeuvre shows that subjective experiences have been integral to Freud's development of *The Interpretation of Dreams* (1900), in which he discussed the concept of a dream as a psychologically meaningful phenomenon (as opposed to the previously posed view of fragmentary brain activity) based on his own dream (now famously known as Irma's injection; see Freud, 1900). Thesis Chapters 2 and 4 can therefore be seen as historical expositions, drawing parallels between Freud's use of subjectivity in his classic (originating) cases, and contemporary psychotherapy and/or social science concepts involving subjectivity, such as Morrow's (2005) 'researcher–as–instrument' and Stake's (1995) naturalistic generalisation.

Beyond Freud, the thesis discussed contemporary case studies in psychoanalysis and psychotherapy more broadly in order to explore issues of 'taboo feelings', namely, countertransference (Rabin, 2003; Sharma & Fowler, 2016). Although these contemporary cases feature a similar dilemma to Freud's work (i.e., the difficulty of working through challenging feelings of love, sexual attraction, hatred, hostility, and ambivalence felt by therapists to their patients), they also include a far more explicit *reflexive* dimension that many found lacking in Freud's classic case studies (Sulloway, 1991; Spence, 1984, 2001). For this reason, Chapter 2 suggests that case narratives should be positioned not only at a *cognitive* level of researcher's thoughts and beliefs but also at an *emotional* level: *what did it feel like to have this particular dialogue or experience this specific moment with the patient?* Emotionally attuned and reflexive case narratives

allow other practitioners working with similar clinical situations identify techniques and theories that may be relevant to their practice (Willemsen et al., 2017). Beyond reflexivity, the thesis also identified several other persisting methodological weaknesses, common to both classic psychoanalytic as well as contemporary clinical case studies: maintaining explicit interpretive heuristics (describing the theoretical and therapeutic frame); leaving room for alternative interpretations, perspectives and viewpoints; and considering employing other methods to provide a more complex account of the clinical situation.

In defending the case study method, and, specifically, case narratives containing qualitatively rich psychological data, the thesis maintained *a methodologically pragmatic stance*. For instance, when considering the current state of the case study method, the thesis proposes a flexible approach toward investigative techniques in line with Fishman's (2000) concept of pragmatic psychology, which has been particularly important for the development of systematic case studies (Iwakabe & Gazzola, 2009). The thesis acknowledges that utilising several methods and forms of data (i.e., beyond therapist interpretations, such as psychometrics, statistics, self–report questionnaires, etc.) in a single case study can improve the validity and rigour of research findings (McLeod & Elliott, 2011; Iwakabe & Gazzola, 2009; McLeod, 2016) as well as epistemic knowledge generation practices (Vertue & Haig, 2008; Fishman, 1999, 2013). These additions to case study research are important and are clearly explicated in the thesis when discussing classic criticisms posed to Freudian case studies.

Similarly, when considering psychotherapy research on a broader scale, Chapters 2, 3, and 5 provide pragmatic suggestions on how clinical and systematic case studies can be combined (or, at the very least, co–exist) with large–scale outcome studies like RCTs. Although RCTs are excellent in establishing what works on average across a larger clinical

population, they are not suitable for identifying deviations (i.e., what goes beyond the statistically average parameters) in treatment processes and outcomes for individual patients (Dattilio et al., 2010; Fishman et al., 2017). This sets a powerful precedent for the argument of pragmatic methodology in psychotherapy: by combining findings from single case studies (e.g., micro–processes containing individual patient responses to therapeutic interventions) and large–scale outcome studies (e.g., macro–processes indicating the average effectiveness of a therapeutic intervention across concrete clinical populations), we can generate more complex clinical and treatment decisions. In this way, systematic and clinical case studies can contribute to the body of evidence in psychotherapy without losing their epistemological roots – qualitatively rich and contextually embedded descriptions revolving around specific patients and clinical phenomena (Mackrill & Iwakabe, 2013).

Although this thesis highlighted the significance of qualitatively rich psychological data and subjective exchanges between therapists and patients, these two components have also been identified as historically problematic for the case study method (Popper, 1959; Grünbaum, 1984, 1988; Gabbard, 1995; Luyten et al., 2006). Critics have rightfully pointed out that clinical interpretations based on personal reasoning are not a sufficient condition for developing causal claims, hypotheses or generalisable case study findings (Bateson, 1979). This has been particularly problematic for psychoanalytic case studies, which, although riddled with scientific controversies, have received relatively little attention regarding their epistemic practices (Forrester, 1996). In an attempt to address this issue, thesis Chapter 3 sought to articulate and develop epistemological standards that could help case study researchers explicitly justify their knowledge claims. Drawing from philosophy of science and the social sciences, the thesis identified three relevant

epistemological concepts for case study research: *retroductive reasoning, analytic generalisatio*n, and *working hypothesis*.

Retroductive reasoning has been implicitly present in both psychoanalytic and psychotherapy case studies: clinicians often go backwards (e.g., through patient's history) to identify some underlying causal mechanism behind their current mental experiences. At the same time, however, no relevant epistemic guidance or canons of evidence have been explicated to choose between different retroductive (and subsequently, causal) accounts. In response to this limitation, the thesis identified epistemological red flags which increase the chances of a naïve retroductive analysis. Such epistemological red flags can be employed when comparing different clinical interpretations of the same case (or the same clinical phenomenon). Retroductive reasoning is especially important for case studies featuring complex mental phenomena and experiences, in which multiple agents and events might causally contribute to patient's condition (Wolff & Jandasek, 2017). In psychoanalytic or psychotherapy research, the use retroduction as an explicitly identified epistemic concept and/or practice has been limited despite the fact that it is commonly used as an implicit reasoning strategy.

Analytic generalisation, although a far more explicated epistemic strategy (Yin, 2013), suffers from a similar lack of epistemological guidance: it is unclear what makes a single case study 'representative' in terms of the data components that could be generalised onto broader theory in psychoanalysis and psychotherapy. The thesis draws on earlier work on from educational research (Kennedy, 1979) on generalisable attributes in single cases, and positions them in a psychotherapy research context. The thesis findings suggest new research 'norms' (analogous to the statistical 'norms' of

random sampling and replication), which could enable researchers to derive analytic generalisations from 'ordinary' (rather than classic or 'first of its kind') cases.

The concept of *working hypothesis* has not been explicated prior to this thesis. Although Cronbach (1975) proposed the idea of studying 'local conditions' rather than focusing on generalisable outcomes, he did not provide a clear explanation of how one can employ working hypothesis case studies in research. Following the work of Stiles (2003; 2007), Mahrer (1988) and Edelson (1985, 1986), Chapter 3 developed this concept further and differentiated between *working cases* (which test how theory works in practice) and *working hypothesis cases* (which go beyond falsification of a theoretical proposition by outlining new theoretical suggestions or hypotheses based on detailed case observations). This epistemic strategy is particularly significant for discovery–oriented research, where researchers may not have explicit intentions to test hypotheses but may have to revise therapeutic interventions or theoretical propositions due to events unfolding in practice (e.g., if a patient is not responding to a specific therapeutic modality or intervention, changes will have to be made to the treatment plan and/or theory) (Vaskinn et al., 2011).

The epistemological work carried out in Chapter 3 was developed with practitioner–researchers in mind; as such, all social science, philosophy and epistemology concepts and frameworks have been translated to psychotherapy and psychoanalytic research contexts, and all three epistemic strategies feature clinical or systematic case study examples. A detailed section on the use of multiple epistemological concepts in systematic case studies has also been included in order to address the audience of pragmatic practitioner–researchers who are interested in developing epistemically rich case studies.

Chapter 4 was developed due to persisting criticisms about the generalisability of case study findings (Janis in Wallerstein & Sampson, 1971). Although the topic of generalisability has been critically reviewed in Chapter 2, which points out some of the overarching shortcomings of generalisability processes in psychology research (Yarkoni, 2019), and Chapter 3, which specifically focuses on the process of analytic generalisation (Yin, 2013), Chapter 4 delves into yet another issue pertaining to generalisation: namely, the *scientific thinking and reasoning style* behind it. The thesis repositions the argument that there is only one form of generalisation – namely, statistical – by discussing Hacking's (1988) and Crombie's (1988) work on different scientific thinking styles, among which statistical thinking is just one.

Chapter 4 is based on Forrester's (1996, 2017) idea of *thinking in cases*: a form of scientific thinking present not only in psychoanalysis but also medicine, law, social work, anthropology, management science and psychotherapy. Forrester argued that thinking in cases has been all too often confused with other thinking styles, like statistical and experimental, leading to misinterpretations of what it actually means to think in *cases as exemplars for analytic generalisation*. The thesis explicates how thinking in cases as exemplars can be observed in Freud's work; beyond Forrester, Chapter 4 also explicates two new forms of scientific thinking: *cases as exemplars for analogical learning* and *cases in the service of empirical generalisation*. Identifying the reasoning processes behind these three different forms of non–statistical generalisation contributes to the scientific discussion of how psychoanalytic (and contemporary psychotherapy) case studies can be used in clinical, teaching, and research contexts. This work lies at the intersection of psychoanalysis, philosophy and social sciences, and as such, it contributes to ongoing methodological debates of what can (or should) be considered a *scientific* thinking style,

which has been a pertinent topic for psychoanalysis as a discipline since its inception (Luyten et al., 2006).

As a natural progression toward the development of the case study method, Chapter 5 introduces a novel *Case Study Evaluation–tool* (CaSE) for systematic case studies in psychotherapy. Currently, there are no appraisal tools the case study method in any given field. This, in part, may be due to the methodological versatility of the case study method: unlike other qualitative (e.g., structured interviews) and quantitative (e.g., RCTs) methods, case studies generally do not have a 'set in stone' methodological template, besides publishing guidelines (e.g., in journals such as *Pragmatic Case Studies in Psychotherapy* and *Psychotherapy Research*) and clinical writing guidelines (Willemsen et al., 2017).

This methodological pluralism and versatility inspired the development of CaSE. The chapter in itself functions as an epistemological exposition, first showcasing the need for a critical appraisal tool in case study research through a discussion of such concepts as 'evidence' and 'validity' in practice–based evidence (PBE) and evidence–based practice (EBP) paradigms. The thesis contains a comparative exercise between existing qualitative research tools (JBI, CASP, ETQS) and the key methodological, theoretical, and clinical components common to systematic case studies. Drawing on the limited applicability of existing tools, *CaSE Purpose–based Evaluative Framework* is developed on the basis of different purposes that systematic case studies have in psychotherapy: *representative cases* (purpose: typicality), *descriptive cases* (purpose: particularity), *unique cases* (purpose: deviation), *critical cases* (purpose: falsification/confirmation), *exploratory cases* (purpose: hypothesis generation), and *transferable cases* (purpose: generalisability). Each purpose has been linked with an existing epistemological network, which enabled the thesis to explicate evaluative criteria specific for each type of case

study. The tool also contains a *CaSE Checklist for Essential Components in Systematic Case Studies*, which is designed to assess the presence or absence of essential systematic case study components.

Although CaSE will need further development, particularly in terms of the framework criteria as well as the qualitative examination outcomes, this is a significant step in further justifying the evidential status of systematic psychotherapy case studies. As such, Chapter 5 contributes to an existing strand of research which seeks to defend and develop the validity and rigour of the case study method in psychoanalysis and psychotherapy (Iwakabe & Gazzola, 2009; Fishman, 1999, 2005; Stiles, 2007; Wedding & Corsini, 2013; Desmet et al., 2013; Willemsen et al., 2015; Meganck et al., 2017; Desmet et al., 2021). CaSE can already be used as a preliminary appraisal measure by practitioner–researchers working in all therapeutic modalities and practice sectors.

6.2 Limitations and future perspectives

The bulk of the work presented in this thesis is concerned with the development (or further systematisation) of clinical and systematic case studies. Although the thesis is clearly maintaining (and defending) the idiographic narrative approach throughout Chapters 2 to 5, it must be acknowledged that some critics would find the overarching pragmatic tone of this work as potentially delegitimising the classic clinical case study method, which has been historically more aligned with therapist interpretations and clinical observations (Iwakabe & Gazzola, 2009; Widdowson, 2011). For example, psychoanalyst Hoffman (2009) argues that systematic empirical research is often at odds with the existential uncertainty, personal values and "consequential uniqueness" found in rich clinical case narratives. This, according to Hoffman, also extends to some of the

epistemic differences: he argues that, although one could use clinical case studies as hypothesis–generating (which is, indeed, one of the key methodological arguments made in Chapter 3), he would instead perceive them as generating "important plausible *possibilities* for practicing analysts to have in mind in their work. The term *hypothesis* encourages the expectation of "testing" that will make greater generalisation possible, and I do not consider that expectation to be warranted" (Hoffman, 2009, p. 1046, emphasis in original).

This criticism extends into ongoing methodological debates about what kind of research (and what kind of research findings) is possible in single case studies. One such heated debate can be observed between Fonagy and Wolpert (2018) in *The British Journal of Psychiatry*, where both parties present dramatically different views on what is a 'good' case history in psychotherapy and psychoanalysis. As a case study researcher, it is not difficult to find oneself at odds between all the different 'sides' concerning the case study method. However, what I have tried to portray in this thesis is that, while qualitatively rich clinical observations are quintessential for the practice and research of psychotherapy, it is also reasonable to not rush toward causal inferences, research hypotheses (or even possibilities, as Hoffman called them) or generalisable findings without a substantially rigorous methodological framework. The latter, however, also needs to be developed in a way that would be relevant for case study research – not as a broad qualitative methodology, not as small–scale experimental analysis, not as a 'secondary' method to large–N studies, but as a methodologically unique form of qualitative research with its own distinct types of case study and forms of evidence. From this point of view, it would be important to develop a second version of *Case Study Evaluation–tool* (CaSE) for the critical appraisal of clinical, methodological, and

theoretical components common to clinical case studies in psychotherapy.

The epistemological work carried out in this research will also require further development. In particular, the thesis identified several application issues for the critical realist concept of retroduction in Chapter 3. Much of the existing literature – including Bhaskar's (1977) and Sayer's (1992) work – remains on philosophical and/or metaphysical grounds: it tells us about the critical realist ontology but does not inform us of any specific epistemological guidelines that would allow researchers to apply retroduction in an empirical way. Although this thesis sought to attend to this issue by differentiating between epistemologically critical and epistemologically naïve retroductive explanations, future research is needed to address broader inconsistencies in the critical realist philosophical system. That is, not all proponents of critical realism see it an empirical program or epistemic strategy (Archer et al., 2016), a stance that goes against Sayer's and Bhaskar's work in which causal expectations are crucial to the application of critical realism (and subsequently, retroduction) in empirical research. Therefore, further research is necessary to demonstrate the 'hands on' application of retroductive reasoning in psychotherapy and psychoanalysis. Herein, Pocock's (2015) article serves as a good example of how retroductive processes can be applied in complex family therapy cases; this needs to be replicated in other therapeutic modalities.

Beyond retroduction, similar issues can be observed in other epistemological concepts discussed in thesis Chapters 3 and 4. Although the epistemic strategies of analytic generalisation and working hypothesis have been implicitly observed in psychoanalytic and psychotherapy case studies, the lack of explicit epistemological considerations for either of these concepts remains problematic. As observed in Chapter 4, although Freud used the case of Schreber (Freud, 1911) as an exemplar for analytic generalisation in order to develop the psychoanalytic theory of paranoia, this in itself

does not justify the theory (especially since it is based on a published autobiography rather than treatment processes). Similarly, it is not clear how exactly we can differentiate between a working hypothesis case study and a 'representative' exemplar case for analytic generalisation. Future research is therefore needed to develop the epistemic guidance for these strategies, and to demonstrate them in contemporary clinical and systematic case studies in psychotherapy. In addition, a broader discussion of scientific (and a clarification of whether they are, indeed, scientific) standards employed in different forms of thinking in cases is needed to ensure that psychoanalytic (and, more broadly, psychotherapy) case studies do not employ *circular* standards of self–authentication and verification (Hacking, 1992, 2012). The dangers of this have been outlined in Chapter 2 through the discussion of psychoanalytic insularity; however, further work is needed to identify such insular attitudes in case study narratives.

Finally, it is important to acknowledge some of the limitations and anticipated criticisms for the *Case Study Evaluation–tool* (CaSE). There are ongoing debates about how one should (and consequently, should not) appraise research findings within the evidence–based practice (Barkham & Mellor–Clark, 2003; Gabbay & le May, 2011; Truijens, 2016). The thesis refers to the concept of procedural objectivity, with which knowledge is generated and appraised in a standardised, non–erroneous way, thus producing objective (i.e., with minimised bias) data. Proponents of procedural appraisal would not find CaSE a convincing tool in the assessment of case study findings for (at least) two reasons.

First, CaSE is embedded in purpose–oriented evaluation criteria. Although Chapter 5 outlines what each purpose is, and what the evaluation criteria for each type of purpose–based case study might be, it is evident that there is still space for interpretation and disagreement about the different kinds of purposes a case study might have in

psychotherapy. This is an issue for all framework–based forms of appraisal (Widdowson, 2011): they rely (although to varying degrees) on the reviewer's interpretation of the tool.

Second, the qualitative analysis exemplifying the use of *CaSE Purpose–based Evaluative Framework for Systematic Case Studies* (table 33) does not contain a clear outcome assessment beyond the qualitative examination (i.e., a specific 'grade'). Although this would be useful for case study researchers utilising meta–synthesis and meta–analysis methods, some case study (and, more broadly, qualitative) researchers find that employing grades (or other quantitative measurements) may constrict the idiographic elements of research (Berg & Slaatelid, 2017; Berg, 2019). These issues must therefore be addressed in consultation and dialogue with other case study researchers in psychotherapy.

As such, I hope that the development of CaSE tool, which began in this doctoral project, will flourish beyond this thesis. It would be fruitful to see this tool develop in collaboration with the Single Case Archive (SCA; https://www.singlecasearchive.com), which has been central to the growth of this project (and, indeed, the development of my role as a case study researcher) as well as like–minded researchers from the Society for Psychotherapy Research (SPR), many of whom are eager to see the resurrection of the case study method in psychotherapy (Meganck et al., 2017; Williamsen et al., 2017; Desmet et al., 2021; Truijens et al., 2019; Krivzov et al., in press). Although the case study method is as old as human history (Flyvbjerg, 2011), it is evident from this thesis, as well as the rapidly expanding lines of research in psychotherapy and social sciences that, in some sense, the journey for the case study method has just begun.

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