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# The Systematic Case Study Manual

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## Introduction

The case study described in this guide is different from other accounts of clinical activity in one important respect: the primary function of the Systematic Case Study (SCS) is to develop your research skills rather than your clinical skills, though a good SCS can have an immense impact upon clinical understanding and practice. Through case studies, it is possible to see how research skills and clinical skills can complement each other.

Assessing outcome is a part of the culture in the NHS, and a growing emphasis is being placed on being able to answer questions on whether and *how* a client improves as a result of treatment. Systematic case studies can provide valuable information on the effectiveness and mechanisms of change of interventions.

We think that the application of the scientific method to the measurement and description of a therapy case is a crucial step in personal and professional development as clinical psychologists. This is an essential skill which helps us understand what really goes on in therapy, and to think critically and creatively about our practice.

Case studies have been used by clinical psychologists to explore change in clients from the beginning of the profession, and have formed an essential part of the evidence base that we all use every day.

All in all, then, case studies are good news. The NHS wants clinicians to do them. To develop or investigate therapies psychologists need to do them. And to develop your research skills and your clinical practice you need to do them.

## What is a case study?

Case studies have been around in one form or another for a long time. Historically, they have been crucial in a number of developments within psychology (e.g., Freud and Breuer's narrative accounts of patients with 'hysteria' and Watson's 'little Albert'). These were often narrative accounts of a therapeutic intervention, outlining the events and the clinician's understanding of these events.

Clinical Psychology in the UK is largely based upon a scientist practitioner approach, fostering a healthy curiosity in the origin and treatment of psychological problems and a critical evaluation of our own practice. Not surprisingly, single case studies in the form of Single Case Experimental Designs (SCED) are associated with this approach. This design was initially an adaptation of the work of experimental psychologists such as Skinner. SCED became popular in the 1960's when clinicians found that they were useful in evaluating (and developing) behaviour therapy interventions.

***Case Study: a definition***

A case study is: "a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real-life context using multiple sources of evidence" (Robson, *'Real World Research'*, Blackwell, 1993).

The "contemporary phenomenon" is the case, and technically can mean almost anything- e.g. an individual, series of individuals, a group or even an institution. For most SCSs, it is usually taken to mean an individual client.

It is a strategy (or an approach) rather than a method: different methods can be used, quantitative and qualitative, but what they have in common is that they are an attempt to study aspects of an intervention (or sometimes a complex assessment) in one particular case.

It is also empirical, in that it relies on the collection of evidence rather than the therapist giving his or her opinions (with the many obvious flaws that this entails). The data collected varies considerably, however, and the clinician may use multiple methods of evidence or data collection

Finally, it is focused on a phenomenon in context: it is an attempt to understand what happens in real life. Case studies tend to have high external validity, and often produce findings that are of great interest to the clinician.

Within this definition, however, case studies vary tremendously. Different methods can be categorised in many ways, from the aims of that method to the unique aspects of the strategy used. One good starting point is to consider three main strategies, which may be used separately, but are often combined:

- Experimental, in which there is direct prospective manipulation and quantitative data is collected. (This might be, for example, a multiple baseline study of an intervention for a child with a number of obsessional behaviours).

- Quantitative analysis, in which quantitative analysis is carried out on data collected through passive observation – i.e. no direct manipulation is carried out. This may include outcome measures or process measures. (This might be, for example, a course of CBT administered in a routine way but with particular assessments, such as between and in session questionnaires, in place). It might also be an account of a detailed assessment and its interpretation (e.g. a neuropsychological assessment).

- Qualitative analysis, in which qualitative data is studied, usually obtained through passive observation. (This might be, for example, a process study of the content of therapy sessions for a particular client).

## The Systematic Case Study: what are you expected to do?

***Picking a case***

Your SCS should be based upon a client (or sometimes a group) you work with during the first or second placement**. You should discuss your plans with your placement supervisor early in placement to identify clients to approach for consent**. See the appendix for the relevant consent forms. For assistance with the academic elements in the case study, however, you need to talk to your academic tutor. It is expected that you consult your academic tutor at least twice about the case study, once to discuss the design and once to discuss the interpretation of results. This will normally be within tutorials dedicated to SCS support, but tutors may also respond to queries outside the tutorial where this is helpful.

The method you chose will depend upon the nature of the intervention being investigated and your own personal preference. You need to start first with a consideration of what you are exploring and then you need to decide how best to collect the information you require. If you choose to carry out a Single Case Experimental Design, you need to decide on the best design to use, e.g. ABAB or changing criterion design. See your SCD teaching notes.

The most common of the strategies adopted by trainees is to collect information without experimental manipulation. This still requires some thought and planning: it is not enough to simply give out a single questionnaire before and after an intervention. You need to consider how you can capture change in this intervention and how you might evaluate the effect of some of the factors that may influence change. You need to consider issues such as statistical versus clinical significance, and the ability of your assessments to give you the information you desire.

Don't feel you need to pick a case with the best outcome – we often learn the most from cases that are not straightforward. The key is to think about how you will measure change and the process of change. Idiographic tools in particular give great scope for creativity.

Case studies may also be focussed on an **extended assessment**. This may be a detailed neuropsychological assessment, or some other complex assessment process such as that focussed on a diagnosis of autism. To comply within the constraints of the SCS format, the assessment will normally be focussed on a question that the assessment is being used to answer. For example, are the symptoms that this person is reporting best explained by depression or dementia? The assessment is usually described in the order it was conducted, with a focus on the interpretation made at each stage when results are obtained, how this influenced the developing hypotheses, and how it influenced the next stage of assessment.

***Picking a question***

Chances are you will have several clients that you could use in your SCS. So which one to pick, assuming you have their consent? Our advice is to pick an interesting question – a hook – and use that to base both your study and your write up. In this way, your SCS document becomes something of a detective story: you outline the question or the problem, the background, how you investigated, and what you made of what you found. If you choose to focus on a therapy case, which most do, you have enormous scope. Therapy is full of intriguing complexity and we actually know comparatively little about why change occurs. Your question might be specific to that case, but will often have resonance with bigger issues.

So, what might you focus on? The choice is yours:

- *"Why does my client seem to be so much better, and report achieving her goals on idiographic measures, when she shows no change on the nomothetic measures such as the CORE?"*
- *"Is the best way to track the way my client's change to focus on one of the items in a measure rather than the global score? Will doing that throw light on when and why she changed?"*
- *"I've been working with my client on her anxiety, but I wonder if our work has impacted some of her other problems?"*
- *"My client has done really well, but does she feel more empowered at the end of therapy or does she feel that change has been out of her control?"*
- *"Has my therapeutic work helped this child adjust to her chronic illness?"*
- *"My client has made huge progress. Was it something I did in therapy, or was it winning the national lottery?"*

The key: whatever you investigate, whatever answers you find, be prepared to prove your conclusions as best you can so we don't have to take your word for it!

***Selecting measures***

Measures of **outcome** are the first consideration. You need to decide what you should look at in relation to the intervention:

a. an overall measure of wellbeing or a symptom checklist,
b. a measure to track change in a specific problem
c. a measure to track change in a specific behaviour,
d. progress towards the client's personal goals for change.

You also need to think about how you will collect information on the **process** of therapy. There are many ways to do this. There is a trend towards using sessional measures routinely, and these often come in two forms: outcome measures (such as the shorter CORE measures or the Outcome Rating Scale) and therapy alliance measures (such as the Session Rating Scale).

Many other sources of information are available, such as symptom specific measures which may be given every few sessions, diaries collected weekly (measuring such things as number of panic attacks, eating behaviour, pain etc.) or content analysis of clinical notes or tapes of therapy sessions.

Other measures are available that target client perceptions of therapy or the therapist explicitly, such as the Helpful Aspects of Therapy questionnaire and the Agnew Relationship Scale. Some therapies – such as Cognitive Analytic Therapy - have process measures built in.

We would urge you to explore methods that involve gathering quantitative data using idiographic methods, such as personal questionnaires, q-sort or card sorting tasks, and repertory grids. The advantage of these is that they may be more relevant to the needs of the client, though they may be more difficult to interpret.

Idiographic assessment comes in many different forms, but may be grouped into 6 general types:

1. Patient generated questionnaires

   These are questionnaires where the client generates the items, such as Personal Questionnaires and the PSYCHLOPS. Goal attainment scaling follows a similar idea.

2. Patient generated narratives

   This includes any narrative from a client about the therapy, and includes diaries and transcripts from interviews such as the Client Change Interview. This is an excellent approach and involves interviewing your client at the end of therapy about their views on whether they have changed and why.

3. Scales

   This includes all sorts of easy to use scales used by clients to record things such as anxiety – e.g. VAS, SUDS etc. They might be used as part of homework tasks, for example, or incorporated into diaries. The SRS and ORS are types of scale.

4. Counts

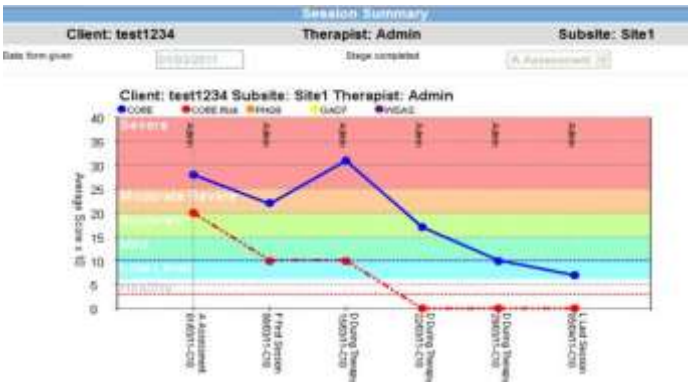
   This includes any count made by the client, for example frequency of a behaviour such as binges, worry episodes etc.

5. Grids

   This includes any grid representing some aspect of a client's belief or feelings, such as a repertory grid.

6. Visual tools

   This covers all visual methods to represent some aspect of the client, such as circles representing some aspect of the self.




The CORE-NET system includes a large number of measures, it graphs data in an accessible and useful way, and it also includes a number of features that you might find helpful. It is possible to track individual items over time, for example, if you find that it reflects a key part of the client's difficulties. Most importantly, the act of measuring change might be part of the therapy itself – something that triggers discussion with your client (and supervisor).

In some cases, for methodological reasons (it answers your question better) or practical (your client doesn't like filling in measures) you may chose to focus largely on analysis of qualitative data (usually session transcripts). If thoughtfully designed, this approach can give rich and relevant answers to clinical or research questions.

Consider at the beginning how to best quality assure your analysis. You need to include details of the method chosen in the method section of the report you write. You also need to think about how you relate the results of your analysis to the case itself. Remember, though, that case studies, like all forms of research, may be carried out well or poorly. A well-conducted, *rigorous* case study will pay due attention to issues such as design and data collection, whatever method has been chosen. Issues of reliability and validity pose specific problems, and there should be attempts to address them.

## SCS write up

Any case study that focuses on an intervention with an individual needs a clear account of the assessment process, patient history, and a formulation devised from the therapeutic model being used. You need to explicitly state the intervention used, and how you attempted to measure change. You need to demonstrate an awareness of the difficulties in doing this, such as alternative explanations for changes. It is particularly important that you demonstrate an understanding of the difference

between statistical and clinical significance, and how to calculate a reliable change index (RCI).

Briefly, we know that all measurement is unreliable to some extent. So, when we are working with someone and their score changes, how do we know whether the difference between two scores from an individual might be a consequence of measurement error or whether it represents a true change? i.e. If you gave a measure out twice, it might be filled in a little differently each time. And if it is a real change, is it an important one? Have we made a real difference for our client?

So, we want to know if an individual's change is:

1) Reliable – is it a real change?

2) Clinically significant – is it a meaningful change?

The Reliable Change Index (RCI) is a useful way of answering that first question. It was initially developed by Jacobson and Truax (1991) and slightly modified later following comments by Christensen and Mendoza. It determines whether a change in pre-post scores is reliable or not.

If a change is reliable, how do we answer question 2? Is the change meaningful? To answer this, we need to look at the change in scores for our client, and consider this in relation to what we know about the scores people typically get on that measure. We can look at the scores a clinical population get on that measure, and can also look at the scores people typically get when they don't have a clinical problem (the 'normal range'). Where are our clients scores in relation to these? There are three ways of considering this and answering that question about whether there has been a clinically significant change. We refer to these three solutions as using three different criteria:

a) **Criterion a**: my client's score at the end of therapy is now outside the clinical range

b) **Criterion b**: my client's score at the end of therapy is now within the range of the non-clinical group

c) **Criterion c**: my client's score at the end of therapy is now closer to the mean of the non-clinical group than it is to the mean of the clinical group.

Which one should you use? It depends on what information you have about the distributions of the clinical and non-clinical populations on the measure you have used. Sometimes this information is surprisingly hard to find! It also depends on the degree to which they overlap, and how conservative you want your judgement to be.

Criterion a is best when there is considerable overlap between distributions as it is more conservative; b and c are best where distributions do not or hardly overlap; c is appropriate if distributions show a modest overlap.

If all you have are some norms for a clinical population, then all you can do is use Criterion a because you don't have the range of scores typical of a non-clinical population – i.e. all you know is whether your clients' score is in the clinical range or not.

The Leeds Reliable Change Indicator provides a user-friendly calculation of scores as well as a visual representation in the form of a 'tramline' display of whether change in scores reported by a client at the end of treatment (in comparison to baseline) is clinically significant. It also determines whether the change is reliable or due to the degree of error of the measuring tool. A trainee developed this software for his SEP.

All SCS reports should include a discussion of relevant literature, relating any findings and observations to a wider context. There should also be an attempt to explore alternative explanations, and a discussion of possible alternative interpretations from different theoretical positions.

There will be great deal of variety in your case studies, depending upon the focus, the client group, and the theoretical orientation. Case studies of Psychodynamic work, for example, will place more emphasis on the interactions between client and therapist. Case studies of a more behavioural intervention may include a detailed discussion of the merits of different choices for the design, such as multiple baselines and alternating treatments.

***Sensitivity to Client's needs***

It is important that a desire to document change is not achieved at excessive cost to the client. It is not acceptable, for example, to ask someone to complete many additional questionnaires with no obvious relevance to them or their problems. Instead, your efforts to analyse the process or outcome of your sessions should be clearly focussed – you should have a rationale for every measure you use – and should be of benefit to your work with the client, either directly, such as documenting change, or indirectly, such as through revealing to you an important aspect of the therapeutic relationship. It is worth bearing in mind too, that you will not be allowed to return after the end of a placement to collect follow up data.

You are required to gain service-user's consent to use their information in the SCS – you should use the participant information sheet and consent form in the appendices to this guide – though there are exceptions, where for example a client's presenting problem makes this problematic. If in doubt, consult your academic tutor. The completed consent form should be placed in the client's file on placement, and the placement supervisor should sign off the Confirmation of Consent form in the appendices, for inclusion in your SCS appendices. **No patient identifiable information should be included in your SCS submission.**

In the event that you decide to write up the case for publication you should check the target journal's author guidelines regarding consent for case studies as soon as possible. On the SCS consent form there is the option to include a line consenting to publication, however some journals may require you to use their own consent form. We also have a general consent for publication form prepared, that we can supply you with on request, email a.m.dorsett@leeds.ac.uk

## What are the Programme Requirements?

The SCS should be a **maximum of 5,000 words**, excluding references and appendices. You may include **up to 8 tables or figures.** It is to be completed in the first year, and must be submitted by the date set early in the second year. The case study should be written using a standard format: introduction, description of case, relevant literature review, method, results, discussion, references, and appendix.

An example format for an SCS:

1. Introduction and description of case.

2. Review of literature on problem and treatment.

3. Outline of therapy (include brief summary of each session in appendices).

4. Method and data collection: measures used, why and when. It can be a good idea to summarise them in a table, such as the one below which presents an overview of the measures used during a 12 session treatment for PTSD.

| Measure used | Reason | Sessions administered |
|---|---|---|
| CORE-OM | Global outcome measure | 1, 5, 12 |
| IESR | PTSD outcome measure | 1, 12 |
| ORS | Session-by-session global outcome measure | Each session |
| SRS | Measure of therapeutic alliance | Each session |
| Personal Questionnaire | Idiographic measure focussing on client's goals | Each session |
| Diary rating of flashbacks | Quick measure of PTSD symptoms | Brought to each session |

5. Results: Summarise main results for outcome measures, process measures etc. Include graphs and tables where appropriate (e.g. graph sessional measures showing change over time). When reporting outcome measures which show a positive change has occurred, always calculate whether they demonstrate statistically significant change and clinically significant change.

6. Discussion: include reflections on possible reasons for any clinically significant change, or absence of change. Implications for personal learning and future clinical practice.

## How will the SCS be assessed?

The SCS has the status of a university examination or essay. The SCS is one of the research assignments, however, so the actual marking process is different from essay marking, and the grades awarded are taken from the outcomes possible after a viva for the thesis. Therefore, the marker can recommend one of the following:

1. Pass
2. Pass subject to minor editorial or presentational corrections (usually typographic errors etc.)
3. Pass subject to correction of minor deficiencies (usually some small sections will need re-writing)
4. Refer with major amendments.
5. Fail, resubmit a different SCS.

Any of the first three categories are a pass, although the second and third options would require you to make changes and have these checked by the marker. You have **six weeks** in which to make these changes. When resubmitting, you are asked to email a cover letter detailing how you have responded to what the marker has asked, together with the revised SCS with the changed/added parts in red. This will enable the marker to check your changes rapidly.

Option four and five counts as a fail of your first submission of the SCS. For a referral, you would need to re-write the parts of the SCS indicated by the marker and resubmit for re-marking as per the guidance above. Option 5 will require a different SCS submission which will be re-examined. In such cases, the marker considers that the report is not redeemable and a new case should be selected. The deadline for submission of a new piece of work is normally six months.

Historically there has also been an emphasis on formative feedback and self-appraisal in the marking of the SCS, and the programme feels that this is an important part of the assessment process. You are therefore asked to assess your

own work using the self-appraisal proforma in the appendix of this document, and submit a copy with the SCS.

The SCS will be allocated to a marker from the programme team who is not your academic tutor and who has not been consulted about the project. They will assess the work using a proforma.

The proformas for you and the internal assessor all follow the same structure:

*1. Focus*

The case study should represent an attempt to explore important aspects of clinical practice. It should arise from and make reference to a wider theoretical framework.

*2. Methodology*

The methodology chosen should enable valid conclusions to be drawn from the study (e.g. were appropriate measures chosen? was an adequate amount of information collected? was the data obtained reliable? what did you do? etc.).

*3. Implementation*

The case study should be carried out professionally. Potential problems should be identified and, if possible dealt with (e.g. was all the data collected, were there avoidable problems?).

*4. Analysis*

Data gathered in the case study should be analysed using appropriate techniques.

*5. Conclusions*

Appropriate conclusions should be drawn from the case study, with salient features correctly reported. Conclusions should place the observations made within a wider theoretical framework.

*6. Communication*

The case study should be clearly presented in a report format.

## Conclusions

We hope that this document covers most of your queries about the case study. Basically, the process of conducting a case study is considered an important part of

your development as a clinician, and a way of developing important research skills. It is a course requirement, but we also hope that you will find thinking about and describing exploring change in a single case, and thinking about the processes involved, useful in your continuing development as a therapist.

## Useful References


The SCD lecture notes are the most useful resource, together with Stephen Morley's book on single-case designs:

Morley, S. (2017). *Single Case Methods in Clinical Psychology: A Practical Guide*. Routledge.

Other references which you may find useful:

Atkins, D. C., Bedics, J. D., McGlinchey, J. B., & Beauchaine, T. P. (2005). Assessing clinical significance: Does it matter which method we use? *Journal of Consulting & Clinical Psychology 73*(5), 982-989.

Barker, C., Pistrang, N., & Elliott, R. (2015). *Research methods in clinical psychology: An introduction for students and practitioners* (3rd ed.). Chichester: Wiley-Blackwell.

Elliott, R. (2002). Hermeneutics Single-Case Efficacy Design. Psychotherapy Research, 12:1, 1-21, DOI: 10.1080/713869614

Jacobson, N., S., Roberts, L. J., Berns, S. B., & McGlinchey, J. B. (1999). Methods for Defining and Determining the Clinical Significance of Treatment Effects: Description, Application, and Alternatives. *Journal of Consulting and Clinical Psychology, 67*, 300-307.

Kazdin, A. E. (2010). *Single case research designs: Methods for clinical and applied settings* (2nd ed.). New York. Oxford University Press.

Kratochwill, T. R., & Levin, J. R. (1992). *Single-case research design and analysis: New directions for psychology and education*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Lambert, M. J., Okiishi, J. C., Finch, A. E., & Johnson, L. D. (1998). Outcome assessment: From conceptualisation to implementation. *Professional Psychology: Research and Practice, 29*, 63-70.

Morley, S. (2007). Single case methodology in psychological therapy. In S. J. E. Lindsey & G. E. Powell (Eds.), *The Handbook of Clinical Adult Psychology* (3rd ed., pp. 821-843). London: Routledge.

Ogles, B. M., Lunnen, K. M., & Bonesteel, K. (2001). Clinical significance: History, application, and current practice. *Clinical Psychology Review, 21*, 421-446.

## Appendices:

Guide to process measures

Participant Information Sheet

Participant consent form

Consent for publication

Confirmation of consent

Self-appraisal marking form

## Guide to process measures

Included here are some measures of therapeutic alliance that may be used if desired in the course of the SCS. Thanks to the authors of the first three listed below, who have given their permission for their measures to appear here. Primary references lists for each measure are reproduced from the following review;

Cahill J, Barkham M, Hardy G, Gilbody S, Richards D, Bower P, et al. A review and critical appraisal of measures of therapist–patient interactions in mental health settings. Health Technol Assess 2008; 12(24).

**Agnew Relationship Measure *(1998, Agnew-Davies, R.)*[1]**

The following can be found at the end of this document:

- client version
- therapist version
- client item means and standard deviations
- therapist item means and standard deviations

Primary references:

Agnew-Davies R, Stiles WB, Hardy GE, Barkham M, Shapiro DA. Alliance structure assessed by the Agnew Relationship Measure (ARM). B J Clini Psychol 1998;37:155–72.

Stiles WB, Agnew-Davies R, Barkham M, Culverwell A, Goldfried MR, Halstead J, et al. Convergent validity of the Agnew Relationship Measure and the Working Alliance Inventory. Psychol Assess 2002;14:209–20.

**California Psychotherapy Alliance Scales *(Marmar, C.R.)***

The following can be found at the end of this document:

- patient short form
- therapist form
- rater, elements within each dimension

[1] *With thanks to Dr Roxanne Agnew-Davies for her permission to use this measure.*

Primary references:

Tichenor V, Hill CE. A comparison of six measures of working alliance. Psychotherapy 1989;26:195–9.

Safran JD, Wallner LK. The relative predictive validity of two therapeutic alliance measures in cognitive therapy. Psychol Assess 1991;3:188–95.

Marmar CR, Gaston L, Gallagher D, Thompson LW. Alliance and outcome in late-life depression. J Nerv Ment Dis 1989;177:464–72.

Gaston L, Marmar CR. The California Psychotherapy Alliance Scales. In Horvath AO, Greenberg LS, editors. The working alliance: theory, research, and practice. Wiley series on personality processes. New York: Wiley; 1994. pp. 85–108.

**Counselor Rating Form (*1975, Barack, A. & LaCrosse, M.B.)* & short form *(Corrigon and Schmidt, 1983)***

Not available online, but can be derived from publications below.

Primary references:

Atkinson DR, Wampold BE. A comparison of the Counselor Rating Form and the Counselor Effectiveness Rating Scale. *Counsel Educ Sup*ervis 1982;22:25–36.

Bachelor A. The Counseling Evaluation Inventory and the Counselor Rating Form: their relationship to perceived improvement and to each other. *Psychol Rep* 1987;61:567–75.

Barak A, Del DM. Differential perceptions of counselor behavior: replication and extension. *J Counsel Psychol* 1977;24:288–92.

Barak A, LaCrosse MB. Multidimensional perception of counselor behavior. J Counsel Psychol 1975;22:471–6.

Corrigan, J. D., & Schmidt, L. D. Development and validation of revisions in the Counselor Rating Form. *Journal of Counseling Psychology,* 1983; 64-75.

Epperson DL, Pecnik JA. Counselor Rating Form – Short Version: further validation and comparison to the long form. *J Counsel Psychol* 1985;1:3–146.

Heesacker M, Heppner PP. Using real-client perceptions to examine psychometric properties of the Counselor Rating Form. *J Counsel Psychol* 1983;2:80–187.

LaCrosse MB. Perceived counselor social influence and counseling outcomes: validity of the Counselor Rating Form*. J Counsel Psychol* 1980;27:320–7.

LaCrosse MB, Barak A. Differential perception of counselor behavior. *J Counsel Psychol* 1976;23:170–2.

Ponterotto JG, Furlong MJ. Evaluating counselor effectiveness: a critical review of rating scale instruments. *J Counsel Psychol* 1985;32:597–616.

Wilson FR, Yager GG. Concurrent and construct validity of three counselor social influence instruments. *Measure Eval Counsel D*ev 1990;23:52–66.

**Working Alliance Inventory *(1986, Horvath, A.)***

Information about this measure is available from the Working Alliance Inventory Homepage . As this measure is not in the public domain, a Limited Copyright Release is required if you wish to use it for research purposes - directions on the website. The author normally does not charge for copyright release of the WAI if it is used in not-for-profit research.

**Outcome Rating Scale (ORS) and Session Rating Scale (SRS)**

The Outcome Rating Scale and Session Rating Scale are two measures designed to be used in each session, to be actively used to guide the therapist's intervention. The measures and related articles can be downloaded here

You will need to register before you can access these two measures; however, registering only involves an e-mail address, organisation and password.

ID: _____ Date: _____

AGNEW RELATIONSHIP MEASURE

Client version

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Below is a list of statements that describe attitudes people might have about their therapy or therapist. Think about the session you just completed and decide the degree to which you agree with each statement. Circle the number indicating your choice.

***1 = Strongly disagree, 2 = Disagree, 3 = Slightly disagree, 4 = Neither agree nor disagree, 5 = Slightly agree, 6 = Agree, 7 = Strongly agree.***

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| | | |
|---|---|---|
| 1. | I feel free to express the things that worry me. | 1 2 3 4 5 6 7 |
| 2. | I feel friendly towards my therapist. | 1 2 3 4 5 6 7 |
| 3. | I am worried about embarrassing myself with my therapist. | 1 2 3 4 5 6 7 |
| 4. | I take the lead when I'm with my therapist. | 1 2 3 4 5 6 7 |
| 5. | I keep some important things to myself, not sharing them with my therapist. | 1 2 3 4 5 6 7 |
| 6. | I have confidence in my therapist and his/her techniques. | 1 2 3 4 5 6 7 |
| 7. | I feel optimistic about my progress. | 1 2 3 4 5 6 7 |
| 8. | I feel I can openly express my thoughts and feelings to my therapist. | 1 2 3 4 5 6 7 |
| 9. | I feel critical or disappointed in my therapist. | 1 2 3 4 5 6 7 |
| 10. | I can discuss personal matters I am ordinarily ashamed or afraid to revel. | 1 2 3 4 5 6 7 |
| 11. | I look to my therapist for solutions to my problems. | 1 2 3 4 5 6 7 |
| 12. | My therapist's professional skills are impressive. | 1 2 3 4 5 6 7 |
| 13. | My therapist accepts me no matter what I say or do. | 1 2 3 4 5 6 7 |
| 14. | My therapist tries to influence me in ways that are not beneficial to me. | 1 2 3 4 5 6 7 |
| | | 1 2 3 4 5 6 7 |

15. My therapist finds it hard to understand me.

1 2 3 4 5 6 7

16. My therapist is warm and friendly with me.

1 2 3 4 5 6 7

17. My therapist does not give me the guidance I would like.

1 2 3 4 5 6 7

18. My therapist is a persuasive person.

1 2 3 4 5 6 7

19. My therapist is supportive.

1 2 3 4 5 6 7

20. My therapist follows his/her own plans, ignoring my views of how to proceed.

1 2 3 4 5 6 7

21. My therapist is confident in him/herself and his/her techniques.

1 2 3 4 5 6 7

22. My therapist seems bored or impatient with me.

1 2 3 4 5 6 7

23. My therapist expects me to take responsibility rather than be dependent on him/her.

1 2 3 4 5 6 7

24. My therapist and I are willing to work hard together.

1 2 3 4 5 6 7

25. I take the lead and my therapist expects it of me.

1 2 3 4 5 6 7

26. My therapist and I agree about how to work together.

1 2 3 4 5 6 7

27. My therapist and I have difficulty working jointly as a partnership.

1 2 3 4 5 6 7

28. My therapist and I are clear about our roles and responsibilities when we meet.

Text of Items on the Agnew Relationship Measure (client version), with items means and standard deviations

| ARM Items | Mean | SD |
|---|---|---|
| 1. I feel free to express the things that worry me. | 6.23 | 1.07 |
| 2. I feel friendly towards my therapist. | 6.17 | 0.95 |
| 3. I am worried about embarrassing myself with my therapist. | 2.86 | 1.87 |
| 4. I take the lead when I'm with my therapist. | 4.29 | 1.35 |
| 5. I keep some important things to myself, not sharing them with my therapist | 2.79 | 1.85 |
| 6. I have confidence in my therapist and his/her techniques. | 5.92 | 1.12 |
| 7. I feel optimistic about my progress. | 5.36 | 1.34 |
| 8. I feel I can openly express my thoughts and feeling to my therapist. | 5.92 | 1.24 |
| 9. I feel critical or disappointed in my therapist. | 1.80 | 1.19 |
| 10. I can discuss personal matters I am normally ashamed or afraid to reveal. | 5.24 | 1.54 |
| 11. I look to my therapist for solutions to my problems. | 4.01 | 1.77 |
| 12. My therapist's professional skills are impressive. | 5.63 | 1.14 |
| 13. My therapist accepts me no matter what I say or do. | 5.83 | 1.20 |
| 14. My therapist tries to influence me in ways that are not beneficial to me. | 1.71 | 1.12 |
| 15. My therapist finds it hard to understand me. | 2.42 | 1.56 |
| 16. My therapist is warm and friendly with me. | 5.99 | 1.07 |
| 17. My therapist does not give me the guidance I would like | 2.49 | 1.56 |
| 18. My therapist is a persuasive person. | 4.12 | 1.48 |
| 19. My therapist is supportive | 5.97 | 1.02 |
| 20. My therapist follows his/her own plans, ignoring my views of how to proceed. | 1.95 | 1.25 |
| 21. My therapist is confident in him/herself and his/her techniques. | 5.66 | 1.21 |
| 22. My therapist seems bored or impatient with me. | 1.88 | 1.27 |
| 23. My therapist expects me to take responsibility rather than be dependent on him/her. | 5.27 | 1.41 |
| 24. My therapist and I are willing to work hard together. | 5.93 | 1.09 |
| 25. I take the lead and my therapist expects it of me. | 4.18 | 1.34 |
| 26. My therapist and I agree about how to work together. | 5.37 | 1.21 |
| 27. My therapist and I have difficulty working jointly as a partnership. | 2.10 | 1.37 |
| 28. My therapist and I are clear about our roles and responsibilities when we meet. | 5.14 | 1.33 |

ID: _____ Date: _____

AGNEW RELATIONSHIP MEASURE

Therapist version

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Circle the number indicating your choice for each item.

***1 = Strongly disagree, 2 = Disagree, 3 = Slightly disagree, 4 = Neither agree nor disagree, 5 = Slightly agree, 6 = Agree, 7 = Strongly agree.***

---

| | | |
|---|---|---|
| 1. | My client feels free to express the things that worry her/him. | 1 2 3 4 5 6 7 |
| 2. | My client is friendly towards me. | 1 2 3 4 5 6 7 |
| 3. | My client is worried about embarrassing her/himself with me. | 1 2 3 4 5 6 7 |
| 4. | My client takes the lead when she/he is with me. | 1 2 3 4 5 6 7 |
| 5. | My client keeps some important things to her/himself, not sharing them with me. | 1 2 3 4 5 6 7 |
| 6. | My client has confidence in me and my techniques. | 1 2 3 4 5 6 7 |
| 7. | My client feels optimistic about her/his progress. | 1 2 3 4 5 6 7 |
| 8. | My client feels she/he can openly express her/his thoughts & feelings to me. | 1 2 3 4 5 6 7 |
| 9. | My client is critical or disappointed in me. | 1 2 3 4 5 6 7 |
| 10. | My client can discuss personal matters she/he is ordinarily ashamed or afraid to reveal. | 1 2 3 4 5 6 7 |
| 11. | My client looks to me for solutions to her/his problems. | 1 2 3 4 5 6 7 |
| 12. | My professional skills are impressive to my client. | 1 2 3 4 5 6 7 |
| 13. | I accept my client no matter what she/he does. | 1 2 3 4 5 6 7 |
| 14. | I try to influence my client in ways that are not beneficial to her/him. | 1 2 3 4 5 6 7 |
| 15. | I find it hard to understand my client. | 1 2 3 4 5 6 7 |
| | | 1 2 3 4 5 6 7 |

16. I feel warm and friendly with my client.

1 2 3 4 5 6 7

17. I do not give my client the guidance she/he would like.

1 2 3 4 5 6 7

18. I feel I am a persuasive person.

1 2 3 4 5 6 7

19. I feel supportive.

1 2 3 4 5 6 7

20. I follow my own plans, ignoring the client's view of how to proceed.

1 2 3 4 5 6 7

21. I feel confident in myself and my techniques.

1 2 3 4 5 6 7

22. I feel bored or impatient with my client.

1 2 3 4 5 6 7

23. I expect my client to take responsibility rather than be dependent on me.

1 2 3 4 5 6 7

24. My client and I are willing to work hard together.

1 2 3 4 5 6 7

25. My client takes the lead, and I expect it of her/him.

1 2 3 4 5 6 7

26. My client and I agree about how to work together.

1 2 3 4 5 6 7

27. My client and I have difficulty working jointly as a partnership.

1 2 3 4 5 6 7

28. My client and I are clear about our roles and responsibilities when we meet.

Text of Items on the Agnew Relationship Measure (therapist version), with items means and standard deviations

| ARM Items | Mean | SD |
|---|---|---|
| 1. My client feels free to express the things that worry him/her. | 5.69 | 0.98 |
| 2. My client is friendly towards me. | 5.70 | 0.82 |
| 3. My client is worried about embarrassing him/herself with me. | 3.71 | 1.63 |
| 4. My client takes the lead when he/she is with me. | 5.19 | 1.13 |
| 5. My client keeps some important things to him/herself, not sharing them with me. | 3.39 | 1.54 |
| 6. My client has confidence in my techniques and me. | 4.96 | 1.09 |
| 7. My client feels optimistic about his/her progress. | 4.62 | 1.31 |
| 8. My client feels he/she can openly express his/her thoughts and feelings to me. | 5.20 | 1.24 |
| 9. My client is critical or disappointed in me. | 2.89 | 1.30 |
| 10. My client can discuss personal matters he/she is normally ashamed or afraid to reveal. | 5.24 | 1.19 |
| 11. My client looks to me for solutions to his/her problems. | 4.79 | 1.13 |
| 12. My professional skills are impressive to my client. | 4.73 | 1.08 |
| 13. I accept my client no matter what he/she does. | 5.41 | 1.22 |
| 14. I try to influence my client in ways that are not beneficial to him/her. | 1.70 | 1.12 |
| 15. I find it hard to understand my client. | 3.37 | 1.60 |
| 16. I feel warm and friendly with my client. | 5.52 | 1.02 |
| 17. I do not give my client the guidance he/she would like. | 3.31 | 1.44 |
| 18. I feel I am a persuasive person. | 4.59 | 1.16 |
| 19. I feel supportive. | 5.48 | 0.93 |
| 20. I follow my own plans, ignoring my client's view of how to proceed. | 2.54 | 1.23 |
| 21. I feel confident in my techniques and myself. | 4.86 | 1.23 |
| 22. I feel bored or impatient with my client. | 2.60 | 1.57 |
| 23. I expect my client to take responsibility rather than be dependent on me. | 4.98 | 1.05 |
| 24. My client and I are willing to work hard together. | 5.27 | 1.01 |
| 25. My client takes the lead and I expect it of him/her. | 4.79 | 1.08 |
| 26. My client and I agree about how to work together. | 4.98 | 1.18 |
| 27. My client and I have difficulty working jointly as a partnership. | 3.22 | 1.69 |
| 28. My client and I are clear about our roles and responsibilities when we meet. | 4.93 | 1.39 |

**Elements within each dimension**

*A. Patient working capacity – positive contribution*

1. Patient self-discloses thoughts and feelings
2. Patient self-observes behaviours
3. Patient explores own contribution to problems
4. Patient experiences strong emotions
5. Patient works actively with therapist's comments
6. Patient deepens exploration of salient themes

*B. Patient work capacity – negative contribution*

1. Patient conveys an expectation of an easy cure without work on his/her part
2. Patient acts in hostile, attacking and critical manner towards therapist
3. Patient seems mistrustful and suspicious of therapist
4. Patient engages in power struggle, attempting to control the session
5. Patient defies therapist's efforts to promote self-understanding
6. Patient holds therapist at arm's length with flood of words

*C. Patient commitment*

1. Patient is confident that efforts will lead to change
2. Patient is willing to make sacrifices, for example time and money
3. Patient views therapy as important
4. Patient has confidence in therapy and therapist
5. Patient participates in therapy despite painful moments
6. Patient is committed to go through process to completion

*D. Working strategy consensus*

1. Therapy proceeds in accordance with patient's ideas of helpful change process

2. Patient and therapist work together in a joint struggle

3. Patient and therapist agree about the kind of changes to make

4. Patient and therapist share same sense about how to proceed

5. Patient and therapist agree on salient themes

6. Therapist rigidly applies techniques

*E. Therapist understanding and involvement*

1. Therapist is understanding of patient's suffering and subjective world

2. Patient demonstrates non-judgemental acceptance and positive regard

3. Patient demonstrates commitment to help and confidence in treatment

4. Patient does not misuse treatment to serve own needs

5. Patient demonstrates tact and timing of intervention

6. Patient facilitates work on salient themes

CALIFORNIA PSYCHOTHERAPY ALLIANCE SCALES - SHORT FORM

PATIENT VERSION

Directions: Below is a list of questions that describe attitudes people might have about their therapy or therapist. Think about the session you just completed and decide the degree to which each question best describes your experience. Circle the number indicating your choice.

1 = Not at all, 2 = A little bit, 3 = Somewhat, 4 = Moderately, 5 = Quite a bit, 6 = Quite a lot, 7 = Very much so.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Did you feel that even if you might have moments of doubt, confusion, or mistrust, that overall therapy is worthwhile? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. When important things came to mind, how often did find yourself keeping them to yourself rather than sharing them with your therapist? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Did you feel accepted and respected by your therapist for who you are? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. How much did you hold back your feelings during this session? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Did you feel that you were working together with your therapist, that the two of you were joined in a struggle to overcome your problems? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 6. During this session, how dedicated was your therapist to helping you overcome your difficulties? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. How much did you resent the time, cost, or other demands of your therapy? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. Did you feel that your therapist understood what you hoped to get out of this session? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. How much did you find yourself thinking that therapy was not the best way to get help with your problems? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. Did the treatment you received in this session match with your ideas about what helps people in therapy? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. Did you have the impression that you were unable to deepen your understanding of what is bothering you? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 12. How much did your therapist help you gain a deeper understanding of your problems? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Patient ID _____ Date _____

*CALIFORNIA PSYCHOTHERAPY ALLIANCE SCALES*

*THERAPIST VERSION*

*<u>Directions:</u> Using the 7-point scale provided below, indicate the degree to which each item describes what happened in therapy with this patient over the last month.*

*1 = Not at all; 2 = A little bit; 3 = Somewhat; 4 = Moderately;*

*5 = Quite a bit; 6 = Quite a lot; 7 = Very much so.*

| | |
|---|---|
| *1. Patient self-disclosed thoughts and feelings.* | *1 2 3 4 5 6 7* |
| *2. Patient self-observed behaviours.* | *1 2 3 4 5 6 7* |
| *3. Patient explored own contribution to problems.* | *1 2 3 4 5 6 7* |
| *4. Patient experienced strong and modulated emotions.* | *1 2 3 4 5 6 7* |
| *5. Patient worked actively with my comments.* | *1 2 3 4 5 6 7* |
| *6. Patient deepened exploration of salient themes.* | *1 2 3 4 5 6 7* |
| *7. Patient was confident that efforts will lead to change.* | *1 2 3 4 5 6 7* |
| *8. Patient was willing to make sacrifices, i.e., time.* | *1 2 3 4 5 6 7* |
| *9. Patient viewed therapy as important.* | *1 2 3 4 5 6 7* |
| *10. Patient had confidence in therapy/therapist.* | *1 2 3 4 5 6 7* |

11. *Patient participated in therapy despite painful moments.* *1 2 3 4 5 6 7*

12. *Patient was committed to go through process to completion.* *1 2 3 4 5 6 7*

13. *Therapy proceeded in accord with the patient's ideas of helpful change processes.* *1 2 3 4 5 6 7*

14. *The patient and I worked in a joint struggle.* *1 2 3 4 5 6 7*

15. *The patient and I agreed about the kind of changes to make.* *1 2 3 4 5 6 7*

16. *The patient and I shared the same sense about how to proceed.* *1 2 3 4 5 6 7*

17. *The patient and I agreed on salient themes.* *1 2 3 4 5 6 7*

18. *My interventions were guided by one model.* *1 2 3 4 5 6 7*

19. *I was able to understand the patient's suffering and subjective world.* *1 2 3 4 5 6 7*

20. *I could remain non-judgmental; regard the patient positively.* *1 2 3 4 5 6 7*

21. *I felt committed to help the patient, and had confidence in therapy.* *1 2 3 4 5 6 7*

22. *At times I had difficulties keeping the patient's best interests as my chief concern.* *1 2 3 4 5 6 7*

23. *My interventions were tactful and well-timed.* *1 2 3 4 5 6 7*

24. *My interventions facilitated the patient's work on salient themes.* *1 2 3 4 5 6 7*

This is an invitation to take part in a case study.

***What is the purpose of the case study?***
The aim is for me, *(trainee name)*, to develop my research skills and clinical practice. It is an exercise to better understand what goes on in therapy *(/the assessment process)*, to think critically and creatively about my practice *(/the assessment process)* and to be aware of how I affect my clients. The case study will form part of my academic assessment on the Doctorate in Clinical Psychology Programme at the University of Leeds.

***Do I have to take part?***
It is up to you to decide whether to take part or not. If you decide to participate you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part, but then change your mind, you are free to withdraw at any point during our work together *(/the assessment process)* without giving a reason. A decision to withdraw or not to take part will not affect your health care in any way. If you are interested in taking part I will answer any questions you may have.

***What will I have to do if I take part?***
You don't have to do anything extra, as the study is simply an account of what happens in our sessions *(/the assessment process)* and my thoughts.

***Are there any possible advantages of taking part?***
There are no personal advantages in taking part. Case studies can provide valuable information on how therapy *(/the assessment process)* works, especially when a number of case studies are taken together.

***What happens to the information about me and to the case study?***
When the information you provide is written up, identifying details such as your name, location and the service will be changed. Every effort will be made to ensure your anonymity by altering information about you as much as possible without losing the details that are clinically relevant. Complete anonymity cannot be guaranteed, and there is a small chance someone may be able to identify you. However, the only people to see the anonymised case study will be the academic tutors on the Clinical Psychology Programme and the external examiner, and they are bound by the same strict professional code of confidentiality that I am.

*Anonymised case studies may, on occasion, with your consent be written up for publication in an academic journal, with the same safeguards to anonymity as described above. – delete or retain as relevant*

***Need further information or have any concerns?***
If you would like further information about the project then please ask me in sessions or contact me at the address below. If you have concerns and would like to speak to someone independent of the project, please contact *(academic tutor name)*, academic tutor for the Clinical Psychology Programme, using the same contact details.

*(Trainee name),* Clinical Psychology Programme, Leeds Institute of Health Sciences, Level 10, Worsley Building, Clarendon Way, Leeds. LS2 9NL Tel: 0113 343 2732

**UNIVERSITY OF LEEDS**

Doctor of Clinical Psychology Programme

Participant Consent Form for the Systematic Case Study

**Case study**

Please delete as applicable

| | |
|---|---|
| I have read the participant information sheet. | Y/N |
| I have had the opportunity to discuss the case study with my therapist and have had any questions answered satisfactorily. | Y/N |
| I understand that taking part in this case study (or not) will not have any effect upon the healthcare I receive. | Y/N |
| I understand that I am free to withdraw at any point during my work *(/the assessment process)* with *(trainee name)* without giving a reason, and in the case of withdrawal the therapist will not write a case study about me | Y/N |
| I agree to take part in this case study. | Y/N |

| | |
|---|---|
| Participant name: | Trainee clinical psychologist name: |
| ……. | ……. |
| Signature…… | Signature…… |
| Date……. | Date…… |

**UNIVERSITY OF LEEDS**

Doctor of Clinical Psychology Programme

Participant Consent Form for the possible publication of the Systematic Case Study

**Please place one copy of this consent form in the client's file on placement and give the other copy to the client.**

**Possible publication** *(Trainees - include this page if there is any possibility you may want to publish)*

*Please tick either:*

☐ I agree to the non-identifiable case study being submitted to an academic journal in the event of being written up for publication, without further consent being sought.

*Or*

☐ In the event of being written up for publication I would like to be sent a copy of the article and to confirm my consent prior to submission to an academic journal. The timeframe, were this to happen, would likely be within 12 months. In this case I agree to being telephoned by this clinical department to confirm the address to which to send it.
*(ensure supervisor consents to making this contact if required)*

*Or*

☐ I do not agree to the case study being written up for publication.

| | |
|---|---|
| Name of participant……. | Name of trainee clinical psychologist…… |
| Signature…… | Signature…… |
| Date……. | Date…… |

**UNIVERSITY OF LEEDS**

Doctor of Clinical Psychology Programme

## Confirmation of Consent Form for the Systematic Case Study

**Please place one copy of this consent form in the client's file on placement and give the other copy to the client.**

(*Please insert trainee name)*_____ has received written consent from the relevant client for their anonymous inclusion in the SCS report.

The client consent form should be held in the client's file on placement.

Supervisor signature……

Name……...

Date……...

Trainees – Please ask your clinical supervisor to sign this off to show that you have received written consent from the relevant client for their inclusion in your SCS. The client consent form should remain in your client's file on placement, and this confirmation of consent form should be included in the appendices of your SCS.

| | |
|---|---|
| Student ID Number | |
| Title/topic | |

| **Section 1: Focus** | 1 Strongly disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| The Case Study explores a relevant aspect of clinical practice | ☐ | ☐ | ☐ | ☐ | ☐ |
| The report is placed within the wider theoretical literature relating to the clinical problem and intervention | ☐ | ☐ | ☐ | ☐ | ☐ |
| The report is placed within the wider theoretical literature relating to the research method | ☐ | ☐ | ☐ | ☐ | ☐ |
| The report contains a critical appraisal of the literature discussed | ☐ | ☐ | ☐ | ☐ | ☐ |
| The Case Study was undertaken with clearly defined aims. | ☐ | ☐ | ☐ | ☐ | ☐ |

***Comments:***

| **Section 2: Clinical Intervention** | 1 Strongly disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| The formulation was comprehensive and linked to theory | ☐ | ☐ | ☐ | ☐ | ☐ |
| The intervention was appropriate for the client's needs | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alternative interventions were considered | ☐ | ☐ | ☐ | ☐ | ☐ |
| Strengths and weaknesses of different interventions were adequately discussed | ☐ | ☐ | ☐ | ☐ | ☐ |
| Efforts were taken to identify and solve potential problems in the intervention | ☐ | ☐ | ☐ | ☐ | ☐ |

***Comments:***

| **Section 3: Research Method** | 1 Strongly disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| The design was appropriate for the aims of the Case Study | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alternative designs were considered | ☐ | ☐ | ☐ | ☐ | ☐ |
| Strengths and weaknesses of different designs were adequately discussed | ☐ | ☐ | ☐ | ☐ | ☐ |
| The instruments chosen allowed for the collection of an adequate amount of relevant data | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alternative instruments were considered | ☐ | ☐ | ☐ | ☐ | ☐ |
| Strengths and weaknesses of different instruments were adequately discussed | ☐ | ☐ | ☐ | ☐ | ☐ |
| Efforts were taken to assess the reliability and validity of the data obtained | ☐ | ☐ | ☐ | ☐ | ☐ |
| The researcher showed a good understanding of the method used | ☐ | ☐ | ☐ | ☐ | ☐ |

***Comments:***

| **Section 4: Implementation of Research Method** | 1 Strongly disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| The study was conducted with due consideration for ethics, in a sensitive and professional manner | ☐ | ☐ | ☐ | ☐ | ☐ |
| Efforts were taken to identify and solve potential problems in data collection | ☐ | ☐ | ☐ | ☐ | ☐ |
| An adequate amount of data was collected | ☐ | ☐ | ☐ | ☐ | ☐ |
| The data analysis was appropriate for this study | ☐ | ☐ | ☐ | ☐ | ☐ |
| The researcher demonstrated an understanding of the meaning of changes/processes observed (e.g. the distinction between statistically and clinically significant change) | ☐ | ☐ | ☐ | ☐ | ☐ |

***Comments:***

| **Section 5: Conclusions** | 1 Strongly disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| The conclusions were justified by the results | ☐ | ☐ | ☐ | ☐ | ☐ |
| Alternative causes for processes or changes observed in the Case were adequately explored | ☐ | ☐ | ☐ | ☐ | ☐ |
| The implications of the findings for personal development were adequately discussed | ☐ | ☐ | ☐ | ☐ | ☐ |
| The implications of the findings for the intervention with the client were adequately discussed | ☐ | ☐ | ☐ | ☐ | ☐ |
| The findings of this study were placed in the wider context of relevant literature | ☐ | ☐ | ☐ | ☐ | ☐ |
| The researcher shows an understanding of the limitations of the study, and ways in which it might have been improved | ☐ | ☐ | ☐ | ☐ | ☐ |

***Comments:***

| **Section 6: Communication** | 1 Strongly disagree | 2 Disagree | 3 Undecided | 4 Agree | 5 Strongly Agree |
|---|---|---|---|---|---|
| The report was written in a clear and accessible grammatical style | ☐ | ☐ | ☐ | ☐ | ☐ |
| The report was well structured (e.g. with good use of headings, table and graphs) | ☐ | ☐ | ☐ | ☐ | ☐ |
| The main points were presented in a logical and focused fashion | ☐ | ☐ | ☐ | ☐ | ☐ |

***Comments:***

## Section 7: Overall mark

Marking the SCS is the responsibility of a member of staff at the university. In this section, however, you are asked to summarise your impressions of the quality of your work:

| Fail | Refer with major amendments | Pass subject to correction of minor deficiencies | Pass subject to editorial or presentational corrections | Pass |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

***Overall comments, including (where applicable) minor deficiencies, editorial or presentational corrections, or reasons for referral or failure:***

Date . . . . . .

**Please include this self-appraisal form in the appendices of your SCS.**
**Thank you very much for your time.**