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Health psychology and the study of the case: from method to analytic concern

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Abstract

This paper recommends that the study of the case be seen as of primary analytic concern to social scientists, and particularly to health psychologists. Criticism is made of the idea that a case is merely a medical instance or a methodological option. Instead, we argue that health psychologists should re-direct their attention to the 'study of the case' as being central to issues concerning health, illness and healing. There are three reasons for doing this. First, case study is basic to any procedure that involves collecting information about the context in which medicine is practised. Second, communication between health professionals involves presenting the clinical situation of their patients as storied accounts, so that cases are made, not found. Third, there is presentational work by patients, involving communications of (as well as about) suffering and relief. This last feature is basic to how doctors and health psychologists, especially those engaged in clinical work, understand individuals as 'cases'. The paper explores differences between these different forms of case, while emphasising portrayal as a key feature of all of them. In justifying the study of the case on conceptual as well as on clinical and methodological grounds, we highlight the position of health psychology in its attempts both to study and to intervene in health-care contexts. © 2001 Elsevier Science Ltd. All rights reserved.

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Introduction

This paper argues that case study should be central to health-related research, rather than it being a peripheral method used only occasionally, if at all. In particular, we argue that health psychology should be especially attentive to the question of what a case is, how people become cases and what this implies for the application of concepts to health practice. Rather than being, as 'case study', one alternative method of obtaining data, the 'study of the case' invites a re-think of theoretical assumptions about the way that illness is understood, and as something with which professionals engage. To

make this point, we shall argue that the idea of the case, as the term is often used in medical contexts, needs to be understood against the background of practical interventions that health care involves. For this reason, the more familiar notion of case study as a way of understanding social phenomena (e.g. illness) needs to be supplemented by an examination of the way that people become cases in the course of the therapeutic endeavour. It is for that reason that we have chosen to discuss this issue with special reference to health psychology.

Whether case studies should be used in health-related research is an issue that extends well beyond the boundaries of health psychology, embracing medical sociology and anthropology. It might be said that this issue is not a new one for these disciplines, and that the study of patients as cases has already been investigated by researchers using sociological/anthropological

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approaches. From this perspective, the idea of how people become cases *for doctors* illuminates the question of ‘caseness’ as an ontological issue (for patients) as well as a methodological one for social scientists.

However, the special relevance of case study to health psychology lies in the dual relationship that many psychologists have both as researchers and as practitioners who apply their knowledge alongside (in accord with) medicine. Arguably, where sociologists and anthropologists largely study health matters, clinically trained psychologists not only research health problems but assist in the delivery of care in hospitals and in the community, which suggests a particularly close relationship of health psychology to medicine.¹ This development has been based upon the ‘scientist-practitioner’ model widely used in clinical psychology (Hayes, Barlow & Nelson-Gray, 1999), and has progressed with little reference to activities in other social science disciplines, such as medical sociology and anthropology. This is predominantly because the avowed ‘scientific’ approach of psychology is at some variance with these disciplines. However, this approach does serve to facilitate the recognition of psychological contributions within the medical domain.

Employing methodologies such as laboratory-based experiments, quantitative questionnaire data and statistical analysis, it has been possible to achieve widespread recognition in medical circles that psychological factors significantly influence health

¹ There are differences between countries in the training required to qualify as a health psychologist and, in consequence, differences in the role of health psychologists in the relevant health care services. For example, in the USA clinical health psychologists are involved in the treatment and rehabilitation of the physically ill (Belar, 1997), while in the UK *clinical* psychologists working in medical care contexts provide a similar service. In the UK the term ‘health psychologist’ (as opposed to clinical psychologist) is used to describe those having training in the application of psychology to physical illness but who have not received clinical training and who cannot therefore undertake therapy with individual clients. This means that not all ‘health psychologists’ may engage in therapy. They may, however, offer ‘consultancy’ which provision might take the form of an intervention with an individual patient. This is consistent with the recommendations of the final report of the European Federation of Professional Psychologists Association task force on health psychology (Marks et al., 1998). This states that health psychologists require knowledge of, amongst other things, communication skills, counselling skills, assessment and evaluation and psychological interventions aimed at change in individuals and systems. Our paper bears upon all professional relationships of health psychologists with patients, whether these have an explicit therapeutic aim or not. An ethic of care and the aim of relieving suffering underpin all such relationships, and our paper is addressed to these issues.

status. The consequence is that psychology now forms a (relatively small) part of the medical school curriculum, and clinical and health psychologists have been given an increasingly substantial role to play in the promotion of health and care of the sick. (Yardley, 1997, p. 5).

Yardley’s point is made against the background of other critiques of health psychology that see its stand in a natural science perspective to be at odds with more recent understandings of illness, sickness and the patient’s role as constructed experiences (Chamberlain, 2000; Stainton Rogers, 1996; Stam, 1988). These critics point, interestingly, to the consequences for theory that follow from health psychology’s adherence to quantitative methods and quasi-experimentation, viz. that explanations of health and illness remain poorly developed.

In taking health psychology as the subject of our discussion of the case, we recognise that there are different claims about the discipline and its scope, about preferred methods and lines of explanation.¹ These, we think, are impossible to resolve within the bounds of the subject, if only because they concern health psychology’s relationship to medicine and to associated disciplines such as sociology and anthropology. That is why we seek to address these issues in the wider context of social science and medicine, where questions about the case as method, as patient role and as constructed experience have already been addressed. However – and this is the reason for couching the paper in the terms we do – it is especially with regard to health psychology that these issues are brought together into potential conflict.

Why does this situation occur? One answer — offered many times already — is that natural science models and associated measurement techniques fail to provide an adequate understanding of the illness experience. But there is another reason, which goes beyond issues of method and theory to the kinds of practical relationship into which health psychologists are brought in the course of acting as agents of medicine. As either researchers or clinical practitioners, health psychologists must formulate and communicate their experiences (with patients) for other health psychologists and colleagues in associated disciplines. The question then arises whether the preferred assumptions of psychological theorising assist or hinder the development of this practical knowledge. Our belief is that the application of experimental methods to questions of health care militates against the development of knowledge that addresses issues concerning the therapeutic relationship. There is something missing here; an acknowledgement of the need to embrace, in health psychologists’ research, issues that are daily there in their practice.

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