

Editorial Remarks: Journal of Clinical Case Studies

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I want to begin by stating that I am excited to be considered an interdisciplinary professional. Along similar lines, The *Journal of Clinical Case Studies* represents this interdisciplinary nature by being a highly inclusive journal. The field of psychotherapy, for example, has a long history of theoreticians “clutching” to single theory approaches that have, unfortunately, oftentimes limited our understanding of human behavior (while setting out to expand our understanding of psychological processes). I am partial to [1] characterization of the “dogmas eat dogma” environment, whereby theoreticians were often blind to alternative ways of viewing behavior and the treatment process. Dating back to Freud, the tendency to focus on a limited themes and issues was often put forth. To cite some psychoanalytic examples, the “Oedipus complex”, “instinct theory”, “attachment theory” all of these core concepts have provided meaningful ways to conceptualize development and psychological processes; however, taken singularly, they are all just “pieces of the proverbial pie”.

In my view, as the field of psychotherapy is maturing, the aim needs to be to *integrate* theories and approaches. And we need to integrate approaches in an *informed way*. Such a stance requires acknowledging the inadequacies of any one system and the valuing the contributions of others [2]. An approach to conceptualizing a patient’s problems, for example, can be drawn for empirically-based models, like cognitive-behavioral therapy (CBT), but it can also allow the integration of clinical case material. One might argue that clinical cases are mainly narrative in nature and, hence, unscientific. But I don’t agree with that contention. In terms of my own research pursuits, for example, I am working with a research team to develop an integrative, multi-component model for conceptualizing and treating social anxiety disorder. The model consists of three (often overlapping) phases and components; namely, 1.) A psychoeducational component, entailing educating the patient about social anxiety disorder,

exposure therapy, possible underlying issues, etc. 2.) A CBT component, that consists of cognitive restructuring (i.e., learning to de-catastrophize and alter cognitive distortions); and 3.) A psychodynamic component, which involves exploring the underlying issues, providing empathic responsiveness, etc. I am citing my own research as an example of a model that could be supported by both empirically-based research and clinical case reports. Both methods, in my opinion, can be considered scientific because the CBT component could be studied via randomized control trials (RCTs), which are mainly quantitative in nature, while the psychodynamic component could be studied via clinical case studies, which could be considered more qualitative in nature. Both methods are legitimate methods because they provide the data needed to support the model. By combining methods, the researcher can gather sufficient data, and generalize the results, while also deriving a thick description-through the clinical case studies-of the data.

One last point is that I am excited to see how neurobiological data will be integrated with psychological data as we further our understanding of human behavior. Neuroaffective science and neuropsychology is offering the “hard science” research findings that I believe are sometimes needed to bolster the psychological findings.

I welcome your feedback and counterpoints.

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