Concept Mapping: A Supervision Strategy for Introducing Case Conceptualization Skills to Novice Therapists

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Case conceptualization, a term synonymous with case formulation, is an essential psychotherapy skill. Novice therapists enter into the practice of psychotherapy with limited case conceptualization skills. Hence, an important goal when supervising novice therapists is to effectively teach these skills. Concept mapping facilitates case conceptualization skills through the process of methodically creating graphic representations of clients’ problems and dynamic relationships between these problems. This article introduces a highly structured and practical 4-stage approach to supervision that effectively introduces case formulation skills to novice therapists using concept mapping. It is assumed that concept maps, when shared with clients, function as an intervention to facilitate insight and change.

Keywords: supervision, concept mapping, case conceptualization, case formulation

Concept Mapping in Supervision: A Four-Stage Process

We have developed a four-stage supervision process that focuses on concept mapping. This process is described in the following paragraphs.

Stage I occurs during an initial psychotherapy session, with the novice therapist and client collaboratively generating a problem grid (see Table 1). To construct this grid, the therapist inquires about the client’s problems and then lists them in the first column of a four-column grid, with corresponding behaviors, feelings, and thoughts listed in the remaining three columns.
Joe’s Problem Grid, Including Associated Behaviors, Feelings, and Thoughts

<table>
<thead>
<tr>
<th>Problem</th>
<th>Behaviors</th>
<th>Feelings</th>
<th>Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>• Withdraw from wife, other family members, and friends.</td>
<td>• Impatient</td>
<td>• “My life sucks.”</td>
</tr>
<tr>
<td></td>
<td>• Withdraw from hobbies, social, and recreational activities.</td>
<td>• Restless</td>
<td>• “Nothing works out.”</td>
</tr>
<tr>
<td></td>
<td>• Unhappy, Tense</td>
<td></td>
<td>• “I’m tired of this.”</td>
</tr>
<tr>
<td>Anger, aggression</td>
<td>• Become visibly angry.</td>
<td>• Annoyed</td>
<td>• “Sometimes I just need to blow off steam.”</td>
</tr>
<tr>
<td></td>
<td>• Raise voice.</td>
<td>• Frustrated</td>
<td>• “People piss me off.”</td>
</tr>
<tr>
<td></td>
<td>• Slam doors.</td>
<td>• Angry</td>
<td></td>
</tr>
<tr>
<td>Heavy alcohol use</td>
<td>• Drink alcohol and pass out every night while watching television.</td>
<td>• Tense until drinking begins</td>
<td>• “I don’t have a drinking problem.”</td>
</tr>
<tr>
<td></td>
<td>• Urges and cravings prior to smoking</td>
<td>• Relief after first drink</td>
<td>• “I drink to relax.”</td>
</tr>
<tr>
<td>Cigarette smoking</td>
<td>• Continue to smoke 2 packs of cigarettes per day, despite the fact that wife has asked him to stop on many occasions.</td>
<td>• Relief while smoking and for some time afterwards</td>
<td>• “I wish people would just get off my back about smoking.”</td>
</tr>
<tr>
<td></td>
<td>• “I’ll quit when I’m good and ready.”</td>
<td></td>
<td>• “I’ll quit when I’m good and ready.”</td>
</tr>
<tr>
<td>Marital problems</td>
<td>• Anger, aggression towards wife.</td>
<td>• Angry that his wife is critical of him</td>
<td>• “My wife doesn’t understand me.”</td>
</tr>
<tr>
<td></td>
<td>• Raise voice at wife.</td>
<td>• Furious when wife threatens to leave</td>
<td>• “My marriage sucks.”</td>
</tr>
<tr>
<td></td>
<td>• Refuse to stop drinking, smoking.</td>
<td></td>
<td>• “My wife is always on me about something.”</td>
</tr>
</tbody>
</table>

Although this process may at first appear to be mechanical, it is actually a dynamic exchange between therapist and client wherein the therapist helps the client identify specific problematic behaviors and learn the subtle differences between thoughts and feelings. In addition to providing data for the case conceptualization, this process has the potential to strengthen the therapeutic alliance, as therapist and client work together to establish a shared view of the client’s problems.

To illustrate, consider a hypothetical client named “Joe” who has just begun therapy. Like most psychotherapy clients, Joe has multiple problems. He is a depressed, angry, heavy drinker, and cigarette smoker with severe marital problems. Joe and his therapist spend most of a session completing the problem grid. Joe has an avoidant insecure attachment style, evident by his faulty thinking. A psychodynamic therapist might hypothesize that Joe’s dysfunctional behaviors are a result of transference and simple. I drink to relax and get away.

Ther: So your thought is, “My wife doesn’t understand me.” I’ll write that in the “thoughts” column. What emotion do you feel when you have that thought?

Joe: I’m angry. I’m angry that she always criticizes me. [Based on Joe’s input over the remainder of the session the therapist continues to enter Joe’s behaviors, thoughts, and feelings into the remaining columns of the problem grid.]

During Stage II the therapist reviews the problem grid and uses information contained in it to construct a concept map as homework (see Figure 1). In doing so the following guidelines are followed: (a) the concept map is constructed soon after the problem grid is compiled, while its contents are still fresh in the therapist’s mind; (b) the client’s name is placed in a circle at the center of the concept map and the client’s main problems are plotted in rectangles around that circle; (c) the client’s behaviors, feelings, and thoughts are then plotted in circles around the problems associated with them; (d) the plotting is done so that related problems are in close proximity to each other; and (e) arrows are used to indicate dynamic relationships between problems, behaviors, feelings, and thoughts.

During this stage the therapist generates hypotheses about the client’s functioning and thus begins the process of case conceptualization. This process is designed to be transtheoretical (i.e., transcending any particular theory). As an example of a transtheoretical case conceptualization the therapist might conclude: “Joe tends to create vicious cycles in which he gets depressed and then uses alcohol to relieve depression, resulting in worse depression.” If preferred, this process also provides an opportunity for the therapist to generate specific theoretical explanations for problematic behavior. For example, a cognitive–behavioral therapist might hypothesize that Joe’s dysfunctional behaviors are a result of faulty thinking. A psychodynamic therapist might hypothesize that Joe has an avoidant insecure attachment style, evident by his...
distancing himself from his wife and isolating himself during times of stress.

The volume of material in the problem grid and concept map is determined by various factors including the number, complexity, and severity of problems the client presents. Some concept maps will have many rectangles and circles while others will have just a few. It is important to note that not all information on the problem grid is included in the concept map. Only information most pertinent to the case conceptualization is included, and it is understood that there are no right or wrong ways to construct the concept map. It is also understood that the concept map may change as the client presents new information in future sessions. These understandings help to alleviate novice therapists’ anxiety about completing the concept map “correctly.”

In Stage III, therapist and supervisor meet to review the concept map. As the therapist presents the concept map, completed as homework, the supervisor considers the therapist’s thought processes and helps the therapist develop and strengthen case conceptualization skills. In this stage the supervisor asks the essential question: “What are the client’s various problems and how are they related to one another?” The supervisor explains that the listing of problems, behaviors, feelings, and thoughts is a surface-level process, while examination of the dynamics between these is a deeper-level process. For example, Joe’s cigarette smoking is a surface-level problem. At a deeper, more dynamic level, Joe’s cigarette smoking might be viewed as a compensatory strategy for emotion regulation.

It is during Stage III that the supervisor has an opportunity to teach deeper-level case conceptualization skills, consistent with the supervisor’s own therapeutic framework. For example, a cognitive–behavioral supervisor might focus on the impact of Joe’s thoughts and beliefs on his subsequent emotions and behaviors. A psychodynamic supervisor might point out how Joe’s reactions to his wife and to life stressors relate to his attachment style. The following is an excerpt from the conversation between Joe’s therapist and the supervisor during this stage.

Ther: I’m not exactly sure how to map Joe’s marital problems, his drinking, and his smoking. He doesn’t see drinking or smoking as primary problems. He actually thinks his marital problems are his wife’s fault. I do believe that his drinking and smoking are related to problems in his marriage.

Sup: I agree. How can we make these connections more evident on this concept map?

Ther: Well, I already drew arrows connecting Joe’s drinking and smoking to his marital problems, because he knows his wife doesn’t like those behaviors. But I guess his irritated thoughts about his wife probably contribute to his anger, which in turn leads to more problems in his marriage. [The therapist draws arrows pointing from Joe’s anger and aggression to his mar-

Figure 1. Concept mapping with a hypothetical client, Joe, whose problems include depression, chronic anger, marital problems, cigarette smoking, and excessive alcohol use.
pist, as they review the concept map.

Sup: I like what you’ve done there. On the surface it appears that Joe’s drinking and cigarette smoking are important problems. Actually, on a deeper level, his difficulty with emotion regulation might be considered his most important problem. When you next meet with Joe you can encourage him to reflect on all of these connections. Perhaps he will agree that many of his problems are related to the central theme of mood dysregulation.

It is also during Stage III that supervisors have an opportunity to assess, evaluate, and provide feedback to therapists on a regular basis regarding their case conceptualization skills. Recently the American Psychological Association (APA) Council of Representatives approved guidelines for clinical supervision in health service psychology (APA, 2014). These guidelines state, “Supervisors aspire to provide feedback that is direct, clear, and timely, behaviorally anchored, responsive to supervisees’ reactions, and mindful of the impact on the supervisory relationship” (p. 20). By integrating concept mapping into supervision as described above, therapists engage in a structured method of conceptualizing clients (concept mapping, completed as homework). This homework provides data that can be reviewed by a supervisor who is in a position to provide direct, clear, timely feedback in response to the therapist’s case conceptualization skills. For example, supervisors might assess the extent to which therapists progress from surface-level to deeper-level conceptualizations.

Stage IV of this concept mapping process takes place between therapist and client in the next therapy session, as the therapist presents the concept map to the client and they discuss it. This discussion serves the following purposes: (a) it establishes a collaborative tone and conveys the message that both therapist and client are equally important to the therapeutic process; (b) it demonstrates that the therapist will work hard for the client, as evidenced by the therapist’s preparation for the session; (c) it provides the therapist with an opportunity to further understand and expand the case conceptualization, based on client feedback; (d) it ensures that both therapist and client have similar views of the patient’s problems; (e) it potentially strengthens the therapeutic alliance; (f) it enables the client to understand the therapist’s thought processes and thus become better socialized to the dynamics of therapy; (g) it gives the therapist an opportunity to teach important concepts like the distinction between thoughts and feelings; and (h) it facilitates the client’s insight about his/her own problems.

The following is an excerpt from Joe’s session with his therapist, as they review the concept map.

Ther: Yeah. She thinks my drinking and smoking are causing our problems but I think she’s causing the problems with her nagging and griping at me.

Ther: Okay, so let’s look at this concept map together. You can see that thoughts like “I wish my wife would get off my back!” may be contributing to your anger, which then contributes to your marital problems, as you told me. At the same time, it seems that drinking until you pass out and smoking are both habits your wife doesn’t like, and that might also be contributing to the problems in your marriage.

Joe: I guess I didn’t realize both of those things could be true, but when I see it drawn out like this, it makes sense.

In this exchange, Joe responds to his therapist’s conceptualization in a positive, collaborative manner. Obviously this will not always be the case. When the client disagrees with the therapist’s conceptualization the two work together to restructure the concept map so both can agree.

Summary and Conclusions

In this article, we have introduced concept mapping as the active ingredient of a four-stage model of supervision. Concept mapping provides a structured and practical approach to supervising novice therapists. Consistent with an assumption of the integrative developmental model of supervision (Stoltenberg & McNeill, 2010), we have observed that novice therapists appreciate this structured approach to supervision. Consistent with Mayfield et al. (1999), we have also observed that novice therapists initially conceptualize clients with surface-level concepts. As they gain experience and receive effective supervision, they increasingly conceptualize client problems at deeper levels.

We believe that concept mapping, when integrated into supervision, benefits both therapists and clients. Accordingly, we propose the following questions for empirically testing concept mapping as part of the four-stage process described in this article: (a) Do novice therapists view concept mapping as helpful in acquiring case conceptualization skills? (b) Does concept mapping facilitate surface, deep, or both levels of case conceptualization in novice therapists? (c) Does the collaborative nature of concept mapping facilitate the therapeutic alliance? (d) Does concept mapping facilitate client insight? (e) Conducted early in therapy, does concept mapping improve commitment to therapy (e.g., by reducing the likelihood of early dropout)? (f) Does concept mapping facilitate client behavior change? As these questions are addressed in research, strengths and weaknesses of concept mapping in supervision will be uncovered.

References


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