Chalkboard Case Conceptualization: A Method for Integrating Clinical Data

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Learning to obtain, evaluate, and synthesize information about clients (i.e., case conceptualization) are essential competencies for therapists. We have presented a theory-driven and flexible clinical supervision method (Chalkboard Case Conceptualization, CCC) for teaching supervisees to synthesize clinical data into an integrative understanding of the client, assimilate clinical theory and empirical findings into clinical practice, and foster supervisees' cognitive reasoning in a clinical context. A client example is used to illustrate the CCC process and implementation. Adaptations of CCC for individual, group, and family therapy, and for training supervisors to conceptualize their supervisees are offered. Strengths and limitations are discussed along with suggestions for future research on the CCC method.

Keywords: clinical supervision, case conceptualization, professional competencies, therapist training

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In an effort to ensure that tomorrow's mental health professionals are well equipped to provide services consistent with the standards upheld by the profession (Falender & Shafranske, 2004), graduate programs have increasingly adopted a competency-based stance toward training (e.g., Fuertes, Spokane, & Holloway, 2012). To this end, models have been introduced that identify the specific skills required for effective practice. In particular, Rodolfa et al.'s (2005) Competencies Cube has been instrumental in elucidating the foundational and functional competencies of a practicing psychologist, as well as laying groundwork for Fouad et al.'s (2009) Competency Benchmarks, which further explicate the essential components and behavioral anchors of each competency. Although these competency frameworks constitute important advancements, theory-based methods that facilitate achieving the skills undergirding these competencies have yet to be developed (Falender, Burnes, & Ellis, 2013).

The lack of practical tools to guide trainees' competency development has significant implications for clinical supervision, as it is the primary vehicle through which many clinical competencies are attained (Watkins, 2012). For example, trainees learn to formulate clinical case conceptualizations primarily within the supervision context (Bernard & Goodyear, 2013). Learning to obtain, evaluate, and make sense of information about clients and their presenting issues (i.e., case conceptualization) is a critical set of skills that therapists need to learn (e.g., Bernard & Goodyear, 2013; Eells, 2007; Etringer, Hillerbrand, & Claiborn, 1995; Fuertes et al., 2012; Ingram, 2006; Meier, 1999, 2003). Hence, competency in case conceptualization is a component of and included in one of the six Functional Competency Domains (i.e., assessment/diagnosis/case-conceptualization, Rodolfa et al., 2005). Moreover, both Fouad et al. (2009) and Rodolfa et al. infuse competencies in case conceptualization (aka case formulation) throughout the other competency domains, identifying these competencies in 11 behavioral markers of the Competency Benchmarks. To wit, the Competency Benchmarks (Fouad et al., 2009) specify the need for trainees to learn to formulate appropriate hypotheses (p. S11), and systematically gather theoretical, empirical, and clinical data to guide their case conceptualizations (pp. S18–S19). In light of the importance of case conceptualization skills for competent clinical practice and the dearth of available methods to facilitate their achievement, the purpose of this article is to answer a call for more theory-driven supervision interventions (e.g., Barnes, 2004; Ellis, 2010). Specifically, we offer a theoretically based framework for training supervisees to formulate integrative case conceptualizations, thereby articulating a method for synthesizing theoretical, empirical, assessment, and clinical data.

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Integrative Case Conceptualization

Integrative case conceptualization typically involves several components including: (a) gaining an understanding of the client's issues, characteristics, cultural context, and history (e.g., Loganbill & Stoltenberg, 1983; Stevens & Morris, 1995); (b) differentiating a diagnosis or discriminating among the most significant concerns (e.g., Etringer et al., 1995; Meier, 1999, 2003); (c) comprehending how the client's salient issues and context affect the client's functioning (e.g., Ingram, 2006; Stoltenberg & McNeill, 2010); and (d) synthesizing the available data to obtain a meaningful understanding of the client, group, or family (e.g., Amundson, 1988; Biggs, 1988; Eells, 2007; Ellis, 1988; Holloway, 1988). These conceptualization skills also involve covert processes that occur during therapy sessions (e.g., in-session reactions, interactions, and processes; identifying patterns within and across sessions, e.g., Bernard, 1979; Herschell, Kolko, Baumann, & Davis, 2010; Ingram, 2006; Meier, 1999, 2003).

Discussions of therapists acquiring case conceptualization skills often incorporate conceptual development (e.g., Holloway & Wampold, 1986; Holloway & Wolleat, 1980) or cognitive development (e.g., Biggs, 1988; Blocher, 1983; Borders, 1989; Ellis, 1988). Conceptual development is defined as a hierarchy of conceptual complexity from simplistic, concrete, and dichotomous thinking to complex, abstract, and relativistic thinking processes (e.g., Harvey, Hunt, & Schroder, 1961; Holloway & Wampold, 1986; Hunt, 1978). Alternatively, cognitive development, a more comprehensive construct, refers to the sequential growth of increasing levels of cognitive complexity in combination with a qualitatively more integrative and synergistic understanding of oneself, one's experiences, and one's environment (e.g., Kramer, 1983; Kramer & Woodruff, 1986; Piaget & Inhelder, 1969; Rigazio-DiGilio, Daniels, & Ivey, 1997). Thus, cognitive development moves beyond the definition of conceptual development, by elucidating the qualitatively different process through which individuals at the various cognitive stages apply and integrate their developing knowledge base. Cognitive development theories have been specifically applied to supervisees' case conceptualization skill development and competence (Rigazio-DiGilio & Anderson, 1995; Rigazio-DiGilio et al., 1997). Overall, research suggests that a therapist's ability to integrate client data successfully (case conceptualization) is directly related to his or her cognitive developmental level (e.g., Etringer et al., 1995; Fong, Borders, Ethington, & Pitts, 1997; Ronnestad & Skovholt, 2003).

A therapist's ability to synthesize clinical data competently and formulate integrative case conceptualizations effectively is implicit in most theories of therapist training and development (e.g., Holloway, 1995; Shaughnessy & Carey, 1996; Ronnestad & Skovholt, 2003; Stoltenberg & McNeill, 2010). Indeed, most textbooks on clinical training (e.g., Teyber & McClure, 2011) and supervision (e.g., Bernard & Goodyear, 2013; Cohen, 2004; Falender & Shafranske, 2004) mention case conceptualization and refer to integrating clinical data at a descriptive level; however, these concepts are rarely defined or explained. Hence, few resources exist that delineate or explicate the process by which therapists obtain the competencies needed for synthesizing clinical data and formulating integrative case conceptualizations (e.g., Eells, 2007; Ingram, 2006; Meier, 2003; Murdock, 1991; Stevens & Morris, 1995; Young & Borders, 1999). Also, little has been published in the therapist training and clinical supervision literature that provides a theoretical basis for these skills (e.g., Ellis & Ladany, 1997; Etringer et al., 1995), leaving therapists, as well as clinical trainers, in a quandary. We lack both a coherent and theory-based method for synthesizing clinical data, and formulating integrative case conceptualization, as well as a cogent framework to understand the complex skills and processes underlying this competency.

Lacking the tools needed to facilitate the development of case conceptualization skills, therapists may not be systematically taught or equipped to synthesize clinical data, formulate integrative case conceptualizations, make differential diagnoses (e.g., American Psychiatric Association, 2000, 2004, 2013), develop effective treatment plans (e.g., Ingram, 2006), and promote effective clinical practice. Thus, supervisors, supervisees, and clients stand to benefit from a coherent training method that accounts for the relation between supervisees' cognitive development and integrative case conceptualization skills, and can be readily applied across diverse training and clinical contexts. Chalkboard Case Conceptualization (CCC) provides a theory-grounded method for clinical supervisors to better assess their supervisee's cognitive competencies vis-à-vis the supervisee's ability to formulate integrative case conceptualizations. Doing so enhances supervisors' ability to teach and guide their supervisees to develop conceptual clinical skills, based on the supervisee's individualized needs and skill sets. Specifically, we propose that cognitive development theory (e.g., Biggs, 1988; Blocher, 1983; Ellis, 1988; Kramer, 1983; Piaget & Inhelder, 1969; Rigazio-DiGilio et al., 1997) provides the theoretical basis for understanding how and why integrative case conceptualization is important, and offers guidance in delineating the methods through which therapists can be taught to synthesize clinical data and formulate integrative case conceptualizations.

Cognitive Development

Integrative case conceptualization is a vital part of a therapist's cognitive and conceptual development (Blocher, 1983; Fong et al., 1997; Granello, 2000, 2010; Holloway & Wampold, 1986; Ronnestad & Skovholt, 2003). In fact, advanced conceptual skills have been shown to be predictors of essential clinical skills (e.g., empathy, Lyons & Hazler, 2002; Stoppard & Miller, 1985), as well as accurate and parsimonious case conceptualization abilities (Martin, Slemon, Hiebert, Hallberg, & Cummings, 1989). Thus, the supervisee's capacity for integrative case conceptualizations serves as an indicator of his or her conceptual and cognitive developmental levels (e.g., Bernard & Goodyear, 2013; Stoltenberg & McNeill, 2010). Accordingly, the CCC method integrates and applies Piaget's theory of cognitive development (Piaget & Inhelder, 1969) and Systematic Cognitive Developmental Supervision (SCDS: Rigazio-DiGilio & Anderson, 1995; Rigazio-DiGilio et al., 1997) to provide a theory-based approach for teaching supervisees integrative case conceptualization competencies. These theoretical frameworks were chosen because they offer a comprehensive and empirically established understanding of the development of cognitive skills and processes (e.g., Biggs, 1988; Blocher, 1983; Ellis, 1988).

Piaget's Theory of Cognitive Development

Piaget (e.g., Piaget & Inhelder, 1969) delineated four stages of cognitive development: sensory motor, preoperational, concrete operational, and formal operational. Of particular interest for clinical supervision are Piaget's third and fourth stages (Loganbill, Hardy, & Delworth, 1982; Stoltenberg & McNeill, 2010). Specifically, supervisees at the third stage (i.e., concrete operational) are able to engage in basic clinical reasoning (e.g., organizing client material) but are unable to arrive at a nuanced and multifaceted understanding of clients' presenting issues as they remain singularly focused on categorical thinking about clients and finding the right way to intervene. Alternatively, supervisees at the fourth stage of cognitive development (i.e., formal operational) demonstrate relativistic thought (knowledge is interdependent, is not absolute, and varies along continuums; Perry, 1970) while also exhibiting a tendency toward confirmatory bias and convergent thinking (i.e., incompatible data are typically ignored, distorted, or modified to eliminate contradictions). Some evidence suggested that supervisors often need to intervene strategically to help the supervisee master problem solving that requires formal operational thought processes (e.g., Granello, 2000, 2010). Specifically, supervisors can support their supervisees in engaging in formal operational clinical reasoning by teaching supervisees (a) to solve problems more efficiently and effectively; (b) to think about clients and themselves along continuums; (c) to think scientifically by differentiating observations from inferences (Pepinsky & Pepinsky, 1954) and formulating multiple theory-based hypotheses about clients; and (d) to conceptualize a client from multiple theoretical perspectives (e.g., Ronnestad & Skovholt, 2003).

Since its inception, Piaget's cognitive development theory was expanded to incorporate a fifth, postformal operational stage: dialectic synthesis (dialectical thought; e.g., Kramer, 1983, 2000). The dialectic synthesis stage of cognitive development is characterized by integration, the interdependence of knowledge, efforts to disconfirm hypotheses (vs. confirm), divergent thinking, and the ability to organize and synthesize inconsistent and contradictory data into a meaningful whole while preserving the inconsistencies without distortion. Essentially, the hallmark of the dialectic synthesis stage is cognitive flexibility (Kramer, 2000). A therapist in this stage is a problem solver who knows how to ask the essential questions (vs. focusing on solving the problem), is subject to fewer biases, and can conceptualize a client from multiple incompatible theoretical perspectives simultaneously. The supervisor can stimulate and promote dialectic synthesis thinking by challenging the supervisee to identify interdependencies among client characteristics (e.g., symptoms, diversity and cultural background, history, strengths, etc.), use creatively the available client data as a means to synthesize inconsistent client information (e.g., using metaphors; Amundson, 1988; Robert & Kelly, 2010; Young & Borders, 1999), and develop a personalized theory of change or theoretical orientation (e.g., Halbur & Halbur, 2006).

Systematic Cognitive Developmental Supervision (SCDS)

SCDS was created to teach and implement Ivey's (1986, 1991) Developmental Counseling and Therapy model (Ivey, Ivey, Myers, & Sweeney, 2004). Rigazio-Digilio and associates adapted Piaget's the-

ory by incorporating a nonlinear, nonhierarchical metaframework consisting of four cognitive developmental orientations (vs. stages): sensorimotor/elemental, concrete/situational, formal/reflective, and dialectic/systemic. The sensorimotor/elemental orientation is characterized by the organization and use of sensory information. Supervisees who are predominantly within this orientation are able to attend to what is going on in the moment—they can track emotional reactions as they are occurring. However, supervisees in this orientation may become overwhelmed by intense emotions, and lack foresight, as they make decisions based on "what feels right" in a given moment. The concrete/situational orientation reflects a capacity to articulate therapy and supervision events in terms of cause and effect, and if–then hypotheses. Supervisees who depend solely on the skills associated with this orientation tend to ignore clinical discrepancies, exhibit a tendency toward confirmatory bias, and struggle to integrate multiple perspectives of the client and therapeutic process.

In contrast, the formal/reflective orientation is characterized by an ability to analyze clinical issues from multiple perspectives and engage in self-reflection concerning in-session reactions and interpersonal patterns. Supervisees who narrowly apply the clinical skills delineated within this orientation may become so preoccupied with thinking things through that they are unable to translate their thoughts into practice. Finally, the dialectic/systemic orientation is comprised of an ability to challenge the assumptions underlying one's clinical reasoning, consider the complexity of the client's circumstances and context, and recognize the limitations inherent in each treatment option. Supervisees who have not fully achieved this orientation may feel initially overburdened by their awareness of and sensitivity to these clinical nuances.

SCDS also stipulates four supervisory environments that correspond to the four cognitive developmental orientations (i.e., directing, coaching, consulting, and collaborating, respectively). Of particular relevance for CCC are the questioning strategies organized by cognitive developmental orientation and the supervision techniques organized by the four supervisory environments (see Rigazio-DiGilio et al., 1997, pp. 234–235 & 238–239). Supervisors working within a directive environment (i.e., to foster sensorimotor/elemental skills) may assist the supervisee with attending to how the client expresses emotions or engages in clinically significant observable behaviors. Alternatively, supervisors assuming a coaching stance to promote concrete/situational orientation competencies may ask supervisees to describe the temporal sequence of a therapy event to promote their formulation of testable clinical hypotheses. Supervisors who seek to create a consultative environment (i.e., to develop formal/reflective skills) may ask supervisees questions that stimulate the identification of overarching clinical patterns vis-à-vis themselves and/or their clients. Finally, supervisors who are operating within a collaborative environment to further dialectic/systemic orientation competencies may challenge the supervisee to make explicit the assumptions undergirding his or her clinical approach, as well as consider the client's context and cultural belief system (Rigazio-DiGilio et al., 1997). As such, per SCDS and in the context of promoting integrative case conceptualization competencies, the task of the supervisor is to (a) identify the supervisee's dominant cognitive developmental level and orientation, (b) assess the supervisee's strengths and deficiencies within each cognitive developmental level, and (c) help the supervisee master clinical skills within their

cognitive developmental orientation while challenging them to develop the clinical skills of other orientations in such a way as to meet the needs of the supervisee and client concurrently. For a more in-depth presentation of the SCDS, please refer to Rigazio-DiGilio and Anderson (1995) and Rigazio-DiGilio, Daniels, and Ivey (1997).

Chalkboard Case Conceptualization

Overview

The CCC provides a visual and readily applicable method that offers supervisors tangible tools geared toward facilitating the development of their supervisees' integrative case conceptualization skills. One of the basic premises of CCC is that case conceptualization skills are inherently linked to the supervisee's cognitive developmental level. That is, the supervisee's understanding of the client is delineated by his or her level of cognitive development in terms of the complexity, sophistication, integration, comprehensiveness, and degree of bias of his or her clinical reasoning. Hence, the goals of CCC are to teach supervisees to develop integrative case conceptualization skills and apply theory to clinical cases (cf. Ingram, 2006; Murdock, 1991) by providing supervisors with a framework through which they can evaluate their supervisees' cognitive developmental needs and illuminate accompanying gaps in clinical understanding.

CCC provides a framework for supervisors to teach supervisees to organize the data about a client, make connections and integrate the data, and articulate clearly the assumptions and theories that guide their case conceptualization. In CCC, we separate inferences from observations (e.g., Pepinsky & Pepinsky, 1954), systematically attempt to falsify competing hypotheses (e.g., Wampold, Davis, & Good, 1990), and endeavor to be cognizant of judgmental biases and inferential errors (e.g., fundamental attribution error, confirmatory bias; Dumont, 1993). In this way, we seek to incorporate and apply theory, principles of research methodology (e.g., Kerlinger & Lee, 2000; Wampold et al., 1990), and knowledge of assessment/measurement concepts to clinical practice (e.g., Meier, 1999, 2003). Thus, the CCC adopts a competency-based approach by facilitating the extent to which supervisees apply theory and evidence-based practice (EBP) when they conceptualize clinical cases and in turn, intervene with clients (e.g., Fouad et al., 2009, p. S21). As a versatile method, CCC allows the supervisor to use multiple modalities to engage supervisees in learning to develop their conceptual clinical skills (e.g., visual and verbal presentation of concepts). Moreover, CCC transcends particular theories of change as it provides a medium through which supervisees can learn to conceptualize diverse clinical cases across multiple theoretical orientations. Below we delineate the CCC method for clinical supervision, provide an illustrative example, and address its strengths and challenges.

Basic Method

In the context of group or individual supervision of individual therapy, a supervisee is asked to develop an understanding of the client's presenting concerns and address diagnostic, conceptual, and treatment issues in an ethically and culturally sensitive manner. Thus, CCC is appropriate when the supervisor or supervisee identifies the need for an integrative understanding of the supervisee's client, and wants to teach/learn case conceptualization skills, as well as how to integrate clinical data. The supervisor needs access to a large chalkboard, whiteboard or writing surface, with preferably at least two colors of chalk or markers such that different aspects of the client's presenting problem are clearly differentiated. CCC is often initiated early on during the course of supervision. Upon experiencing CCC, supervisees are encouraged to use CCC throughout their clinical practice to develop their integrative case conceptualization skills across multiple training experiences and supervision contexts.

A breakdown of the implementation of the CCC method is presented in Appendix A. In brief, CCC entails the clinical supervisor listing 8–10 categorical column headers on a large chalkboard. As noted, we consider the categories to be pantheoretical, and therefore usually include the following headers: the client's presenting issues, thoughts, and behaviors; medical/medication/substances; developmental levels; support system; strengths; cultural-diversity-contextual; career-vocational; metaphors; and layers of emotions (i.e., client feelings). Beyond these overarching categories, other categorical headers are added depending on the supervisees' preferred theoretical orientation (e.g., functional analysis; O'Brien & Carhart, 2011), treatment issues, specific clinical concerns, and available psychological assessment data. For example, additional categories (e.g., functional behavioral analysis, disabilities-functional impairments, and treatment implications) depend on the particular context and purpose of supervision and treatment. Thus, the supervisee or supervisor can add, combine, and modify categories as the presentation unfolds and treatment progresses.

In group supervision, CCC typically requires 1 to 2 hours to complete. The CCC method consists of an Information phase (typically 45–60 minutes) and an Integration phase (30–45 minutes), assuming integration and synthesis of data occur solely during the Integration phase. The Information phase begins with a supervisee presenting a 5 to 10 minute video/audio-recorded segment of a session. In so doing, common clinical material is provided such that all supervisees in the group actively participate in CCC, thus affording an opportunity ripe for mutual learning, and future self and individual supervision experiences. The supervisor asks the supervisee what he or she wants and needs from the supervision session. Supervisees are then invited to bring up any observations and information about the client while the supervisor listens attentively, writing these statements on the chalkboard in short phrases (1–4 words) under the appropriate categorical header, and verifying with the supervisees that these phrases accurately reflect what was said (typically 30–45 minutes). The supervisor can either solicit information for a specific category, or choose the categorical header under which the information should be placed as the client is discussed. Once data are provided for the other categories, the supervisor directs the supervisees' attention to the client's affect (i.e., *layers of emotions*) to foster the supervisees' empathic attunement and skills (usually 5–10 minutes). The client's feelings are depicted in concentric circles; the client's readily expressed feelings are listed on the outer circle, the supervisee's impressions of the client's underlying and core feelings are listed within the innermost circles.

After the data are compiled and supervisees have had the chance to add any additional or last minute information, the supervisor

moves into the Integration phase (30–45 minutes). At this point, the supervisor directs the supervisees to consider possible connections and patterns among the data to facilitate an integrative understanding of the clinical case, including alternative views or connections that are not immediately apparent. The supervisor draws the proposed links on the board with different colored chalk (i.e., using lines, circles, stars). Questions are asked to stimulate the integration of data across categories, apply theory, provide a rationale for clinical hypotheses, diagnostic impressions and potential implications for treatment, as well as advance the supervisee's cognitive skills (e.g., challenging the supervisee to move beyond concrete, dualistic conceptualizations toward capturing the clinical nuances; see Biggs, 1988; Granello, 2000, 2010; Murdock, 1991; Rigazio-DiGilio et al., 1997).

Illustrative Example

The supervision context. At the community based mental health training clinic, each supervisee receives 1 hour of individual and 2 hours of group supervision each week. The group for this supervision session consisted of one clinical supervisor and three supervisees, two of whom had previously completed 1 year of supervised practicum at the clinic.

The supervisee. A 28-year-old White female supervisee/therapist with a master's degree in counseling presented the following case in group supervision at the beginning of her advanced practicum. The supervisee had completed 2 years of supervised practicum and had worked primarily with adults in community settings. She expressed comfort in the setting, and in her role as a therapist. She identified interpersonal process and client-centered approaches as her preferred orientations, but was interested in applying other theories to meet the unique needs of her clients. The supervisee characterized her client as psychologically minded and therapy experienced. The supervisee wanted assistance integrating the available historical information with her observations about the client in the initial interview to gain a meaningful understanding of the client and to identify missing information necessary to develop a comprehensive treatment plan.

Using this supervisee's own language, the supervisor assessed the supervisee's cognitive development level using the guidelines from SCDS (Rigazio-DiGilio et al., 1997). In this case, the assessment indicated that the supervisee was clearly able to describe therapeutic events in terms of cause and effect transactions (concrete/situational cognitive developmental orientation), and at times, she was able to use reflective reasoning and examine patterns within cases (formal/reflective orientation). However, the supervisee had not yet demonstrated an ability to recognize and consider patterns across cases in relation to herself (formal/reflective orientation), nor was she able to challenge the assumptions underlying her conceptualizations without assistance (dialectic/systemic orientation). The supervisor recognized the supervisee's strengths in describing observations and organizing clinical information (sensorimotor/elemental orientation) and in identifying some patterns between the client and herself (formal/reflective orientation). Thus, the supervisor had a fairly comprehensive assessment of the supervisee's cognitive developmental level regarding her integrative case conceptualization abilities, as well as areas of strengths and deficits therein. Using the CCC, the supervisor was able to ask probing questions to facilitate the supervisee's

synthesis and integration of case information, attend to the counseling relationship and cultural diversity, and promote reflective self-awareness, thereby helping the supervisee to advance her integrative case conceptualization competencies.

The client. A 51-year-old biracial (White/Native American) woman presented at the clinic to resume psychotherapy after having discontinued treatment with another psychologist due to financial concerns. Prior to seeing the supervisee, the client attended seven sessions with another therapist who used cognitive–behavioral therapy (CBT) to address anxiety and panic attacks. During the initial interview with the supervisee, the client reported that the last panic attack occurred over 1 month ago, and that she was now able to anticipate a panic attack and use CBT strategies to manage and sometimes prevent a panic attack. The client's stated goals for the new treatment were to work on relationship issues. In terms of background information, the client stated that she was divorced from an alcoholic man, was living with and engaged to another man who was an active alcoholic, and had a history of relationships with neglectful men. Identifying prominent trust and jealousy issues, the client expressed a desire to break the recurring patterns in her relationships with men.

The Chalkboard Case Conceptualization. After the supervision group viewed a video-recorded 10-min segment from the initial session selected by the therapist supervisee, the supervisor listed the categorical headers on the chalkboard (see Figure 1). The supervisee began by discussing information relevant to the *presenting issues* category (including signs and symptoms for making a provisional differential diagnosis) while the supervisor listed the information using brief phrases under this heading and encouraged the other supervisees to collaborate in the process. Members of the group collectively contributed observations and inferences about the *client's strengths*, *cultural/spiritual*, *background/history/contextual, vocational/career*, *medical/substances*, *support systems*, and *developmental concerns*. The supervisor often prompted the group for particular theory-based information within a heading (e.g., where was the client in terms of specific developmental theories: Super's, 1990, 1994 vocational development, etc.). The group was able to identify data for each category, and additional clinical information needed to develop and implement a treatment plan. A rich and complex picture of the client, her strengths and resources, her challenges and concerns, and treatment issues emerged (see Figure 1). The information listed in a column represents the sequence of the information that was provided (top first, bottom last).

After filling in information for each category, the supervisor focused on the client's affective realm and worldview (*layers of emotions*) to foster the supervisees' empathic understanding. The supervisor asked the group to identify the client's range of emotions, beginning with feelings on the surface (e.g., what feelings does she show readily?) and proceeding to observations and inferences about feelings below the surface (i.e., the next layer down) and at the core (rarely expressed and perhaps foreign even to the client herself; Teyber & McClure, 2011). The layers of feelings were depicted on a figure of concentric circles on the chalkboard. For example, at the core, the group hypothesized that the client held intense feelings of sexual contradictions/confusion, being unlovable and defective, rage, terror, profound shame and blame, extreme loneliness, and massive ambivalence/chaos. At this point, the group expressed amazement about the amount of information
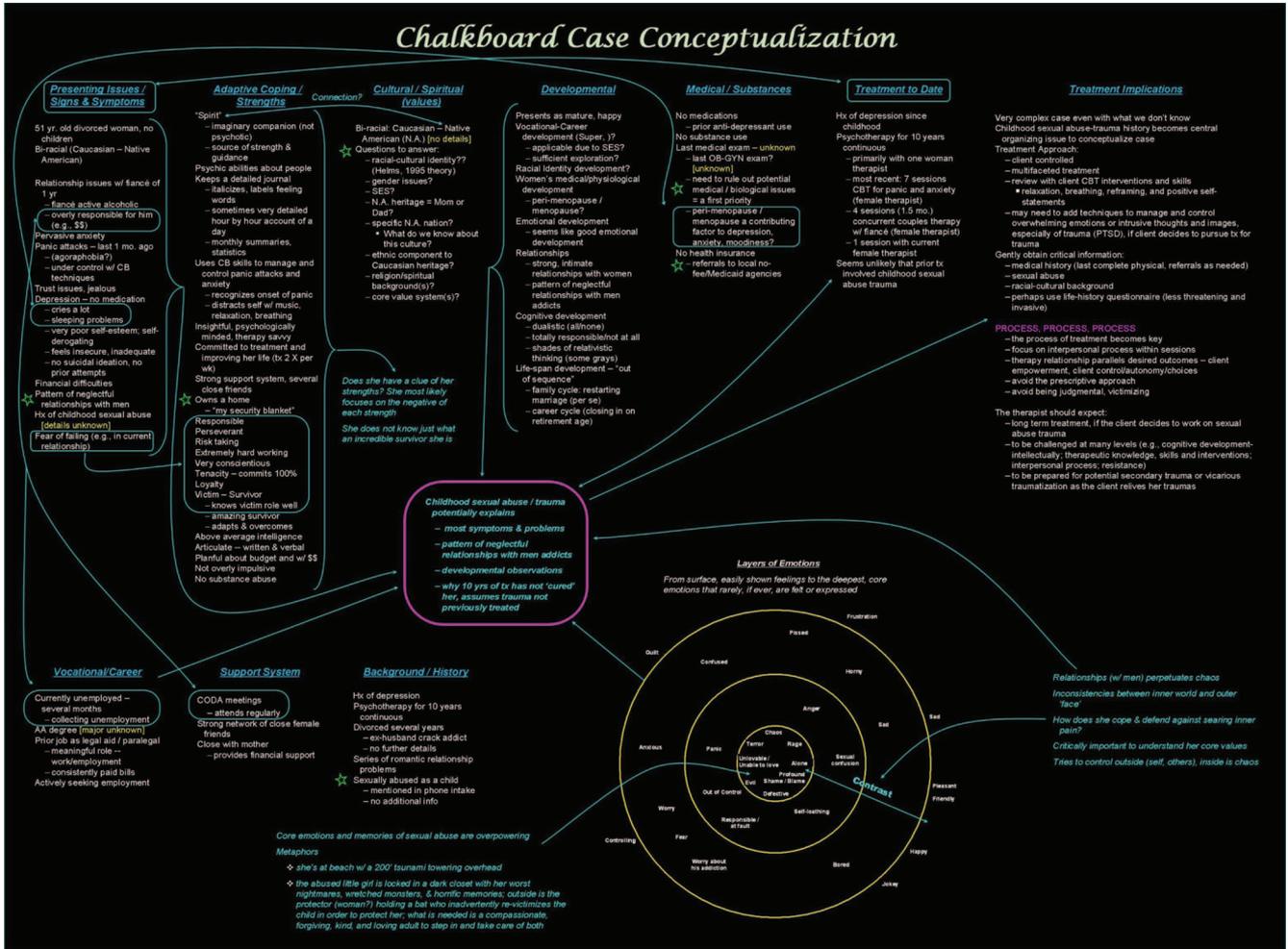
Figure 1. Chalkboard Case Conceptualization.

already available to them for case conceptualization. The group also experienced a deeper, nuanced understanding of and a stronger emotional connection to the client.

The final challenge for the group was (a) to synthesize, integrate, and prioritize information in the case conceptualization; (b) to formulate testable clinical hypotheses; and (c) to determine the information to be gathered in subsequent sessions. Although linkages may be defined at any time during the process, connections and patterns among the categories and within the feelings circles are the primary focus during the final phase. In this CCC session, the supervisor encouraged the group to consider linkages between information, including those between seemingly discrepant/opposing ideas (Biggs, 1988; Ellis, 1988; Meier, 2003; Murdock, 1991; Rigazio-DiGilio et al., 1997). For example, medical and biological factors were advanced as possible explanations for some of the depressive symptoms. Thus, the supervisee was encouraged to inquire further about the client's current health and medical history. The possibility of administering a measure to assess overall physical, social, and mental functioning (e.g., Patient-Reported Outcomes Measurement Information System; PROMIS; Cella et al., 2010) was also discussed. Supervisees also wondered if the

client's "spirit" companion was related to her Native American heritage and accompanying belief system. The latter hypothesis sparked a discussion about potential racial-cultural considerations, which elicited several important questions for the supervisee in terms of determining the extent to which the client identified with Native American culture and potential indigenous resources that could be accessed and incorporated into therapy. Finally, the supervisor noted that no positive feelings or personal strengths had been offered during the group's discussion of the *layers of emotions*. The supervisee hypothesized that because the client presented to the first session in a state of despair, it may have been difficult for her to volunteer spontaneously any personal strengths or relational supports. Another supervisee in the group suggested that addressing the progress the client had made in managing and preventing her panic attacks may be a way to transition into discussing the client's strengths and resources in the next session. Hence, a more balanced appraisal of the client could ensue.

In the course of developing the CCC presentation for the client, her history of childhood sexual abuse became a central unifying theme, incorporating data about the client's presenting concerns, symptoms, relationships with men, developmental issues, treat-

ment history, and strengths. At this point, little was known about the client's history of childhood sexual abuse as it was addressed, but not in detail, during the initial phone intake at the clinic. As such, the supervision group concluded that her early history of trauma warranted further exploration by the supervisee as a possible focus of treatment. After an in-depth discussion of the sexual abuse trauma and its connection to salient data on the chalkboard, the supervisor channeled the discussion to implications for treatment (see Figure 1). A client-initiated and controlled multifaceted treatment approach seemed appropriate to foster the client's autonomy and address her treatment goal of breaking her relationship patterns with men. However, the supervisor emphasized the need to assume a tentative stance—several questions remained that needed to be addressed before making any firm conclusions regarding treatment planning, diagnosis, and prognosis. The CCC session concluded with the supervisee summarizing what she learned from the session and her intentions for the next therapy session.

Applications of CCC to Other Training Contexts

Although the supervisee in the above case example was providing individual therapy, CCC can be easily adapted to other training and therapeutic contexts.

CCC of group therapy.   In this context, either the group may be considered as a whole entity or one or more members may be conceptualized within the larger group context. The existing categories may be expanded upon to include *group development* (e.g., formative, transitioning, working, terminating), *therapeutic factors* (e.g., instilling hope; see Fuhriman & Burlingame, 1994; Yalom & Leszcz, 2005), and *group cohesiveness, group norms,* and *group member roles*. The patterns of interactions among members may be considered as another category (e.g., Does one or more member dominate talk time in the group? Is subgrouping evident?). Theory-based categories (e.g., transferences, cognitions, images/metaphors) may be added to address specific theoretical approaches. The feelings circles (i.e., *layers of emotions*) can be applied to the group to promote cohesiveness and empathy by considering which feelings group members readily express, and which feelings lay beneath and at the core. One or more clients in the group may be considered individually for case conceptualization by combining categories from the example (e.g., *presenting issues, strengths* etc.) with group-specific categories (e.g., *group norms, group development*). In this way, the individual client's developmental levels relative to the group's development can be captured. The roles that the individual member serves relative to other members in the group may elucidate aspects of the social microcosm in group therapy (cf. Yalom & Leszcz, 2005).

CCC of family therapy.   As with groups, CCC may be applied to an entire family or by considering one or more family members. Beyond the pantheoretical categories discussed, additional categories may include parenting skills and concerns, family values, developmental stages/tasks for each family member, alliances and triangulations between members, school/vocational issues, and specific theory-driven techniques (e.g., child-parent interaction analysis, family structural models). An alternative is to include an additional "presenting issues" category for each family member or to have a separate category for each member of the family unit. As the CCC process unfolds, linkages drawn between the presenting issues of the various family members can illustrate the systemic nature of family problems. The emotions (surface, inner, and core) may be considered relative to the individual or to the entire family unit.

CCC for clinical supervisor training.   In addition to teaching supervisors-in-training how to use CCC so that they can instruct their supervisees in integrative case conceptualization skills, supervisors-in-training can use CCC to conceptualize the developmental level, strengths, and needs of their supervisees. When conceptualizing supervisees, the categories may be expanded upon to include the *supervisee's presenting concerns, caseload/specific client of focus, strengths* (as therapist, as supervisee), *cultural/religious/contextual dimensions, developmental issues* (cognitive, interpersonal/relational, therapist etc.), *supervisory working alliance* (agreements on supervision goals and tasks, and the emotional bond, Bordin, 1983), *therapeutic orientation* (supervisor/supervisee), *skill deficits/deficiencies, knowledge needs, personal issues and reactions, and parallel process.* In light of the ethical implications of multiple relationships and boundary issues (Welfel, 2010), supervision should not become personal therapy for the supervisee and thus, we generally recommend that the layers of feelings not be applied to supervisees. If the layers of feelings are used, the trainer should be extremely cautious to avoid pathologizing the supervisee or treating the supervisee as a client. Instead, supervisees' comfort and facility with managing and reacting to their own and their client's emotions may be subsumed under other categories (e.g., strengths or skill deficits). Again, patterns and linkages are drawn to help the supervisor-in-training to synthesize and integrate the information about the supervisee and to plan appropriate supervision interventions.

Strengths

The potential to address simultaneously three interrelated goals of competency-based clinical supervision is perhaps the greatest strength of this technique (Falender et al., 2013). That is, CCC is a method designed to synthesize clinical data into an integrative case conceptualization, to incorporate counseling theory, research, and EBP into the supervisee's clinical work, and to foster an understanding of the supervisee's cognitive reasoning and corresponding supervision needs as they apply to his or her case conceptualization skills. The categorical headers provide a cue to stimulate supervisees to think divergently, to disconfirm hypotheses, and to identify multiple sources of information relevant to therapeutic or supervisory interventions. In so doing, CCC fosters scientific thinking and the formulation of appropriate clinical hypotheses (e.g., Pepinsky & Pepinsky, 1954, see pp. 144–170), thereby facilitating the achievement of the clinical competencies described in the Competencies Cube and Competency Benchmarks (Fouad et al., 2009; Rodolfa et al., 2005). For example, the process of identifying *layers of emotions* and linkages among categories prompts supervisees to be explicit and intentional about their theoretical assumptions, cultural biases, and other implicit hypotheses about clients. Further, identifying patterns and relations among the clinical data facilitate convergent thinking, integration, and synthesis of information. When working with several supervisees in a group, CCC can be used to engage an entire group of supervisees to collaborate, participate, and be actively engaged in cognitively processing

information about a client and considering treatment implications. Alternatively, when working with a supervisee individually, the CCC method can serve as a way to focus the supervision session and facilitate an in depth discussion of the client's presenting issues and concerns. In CCC, information is presented through multiple modalities (verbal, visual, symbolic, pictorial) in order to capitalize on the diverse learning styles of supervisees. The supervisor can adapt the approach to be more or less structured (e.g., systematic movement from one category to another vs. fluid/flexible movement among categories), depending on the developmental needs of the supervisees. Thus, the flexibility of CCC, plus its application to individual, group, and family counseling, and to supervisor training, constitutes additional strengths of CCC. Finally, the CCC method can also be applied to supervisees across training levels. Whether they are beginner or highly advanced level trainees, the categorical headers that comprise the CCC provide a viable framework from which integrative case conceptualization competencies can be developed and enhanced.

Challenges

Two of the greatest challenges that we have experienced with CCC are the need for sufficient chalkboard space and to manage time effectively. The visual presentation of material requires access to a sufficiently large chalkboard or writing surface. From our experience, it is essential to have all of the information available and visible at one time, rather than erasing, and replacing information on a smaller board or surface. This way, supervisees do not need to tax their cognitive resources by juggling the information in their working memory (Kirschner, Sweller, & Clark, 2006). As with all supervision tasks, supervisors are encouraged to check in regularly with their trainees to ensure that they understand the CCC method and the connections being made therein. In terms of time management challenges, once CCC is introduced and applied to a case example, less time is needed later. In our experience, the first-time process requires 1 ½ to 2 hours to complete, especially with the chronic, complex cases we see at our clinic. If CCC is attempted without the time needed to integrate and synthesize data to attain meaningful hypotheses or prioritize treatment needs, the supervisor may leave the supervisees feeling overwhelmed by the sheer volume of information and lack of an integrated understanding of these data. Without attention to identifying and synthesizing the relations among the clinical data, the CCC is reduced to another taxonomy for gathering information (e.g., Hulse & Jennings, 1984). Hence, specific instruction in integrating clinical data is essential to cultivate integrative case conceptualization competencies.

Another challenge for the supervisor is to not make the connections and provide the integrative understanding of the clinical data him or herself, but rather, to guide the supervisees to do this work. That is, to facilitate the conceptual and cognitive development of the supervisee, the supervisor needs to challenge the supervisees by asking questions that stimulate the process by which the supervisees are able to make the connections for themselves (e.g., Biggs, 1988; Ellis, 1988). Inasmuch as supervisors are expected to implement supervision theory (e.g., Stoltenberg & McNeill, 2010) to assess and promote the supervisee's development, CCC is also predicated on supervisors learning and applying SCDS (Rigazio-DiGilio et al., 1997). Thus, the challenge is to master cognitive

developmental theory and SCDS sufficiently so that supervisors can identify the supervisee's cognitive development orientation and ask questions based on the corresponding supervisory environments. This is analogous to supervisors implementing the Integrative Developmental Model (IDM; assessing developmental level and matching the supervision environment per Stoltenberg & McNeill, 2010).

Suggestions for Research

As with any new training method, the CCC should be tested empirically. Several potential directions for research seem appropriate. The efficacy of the CCC could be tested against standard clinical supervision in addition to other therapist training methods (e.g., Rigazio-DiGilio et al., 1997). More specifically, the CCC should be tested to determine if it facilitates therapist supervisees' ability to synthesize clinical data into an integrative understanding of the client, to assimilate clinical theory and empirical findings into clinical practice, to develop case conceptualization skills, and to engage in advanced cognitive reasoning. As no measure currently exists, developing a psychometrically sound measure that assesses trainees for changes in learning and cognitive developmental shifts, as they pertain to integrative case conceptualization abilities, would be a fruitful line of future inquiry. Researchers could also investigate the extent to which CCC is effective in the training and supervision of individual, couple/marital, family, and group therapists, and the training and supervision of clinical supervisors. Researchers could investigate its differential use in individual and group supervision contexts. As recommended by Stein and Lambert (1995), the acid test for CCC is to determine if therapists who receive CCC master integrative case conceptualization skills which in turn, lead to improved outcomes for their clients. Future empirical efforts could jointly target whether supervisee skill development and client outcomes are enhanced through the CCC.

Conclusion

Building on the extant competency-based supervision literature (Falender et al., 2013), we presented CCC, a theory based supervision method developed to teach supervisees how to synthesize clinical data into an integrative conceptualization of the client, assimilate counseling theory and empirical findings into clinical practice, and foster the supervisee's conceptual competence. Whether CCC can achieve these competencies invites empirical inquiry.

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(*Appendix follows*)

Appendix A

Breakdown of the CCC Method

Information Phase [45–60 Minutes]

Supervisee presents basic information about the client/case in clinical supervision (5 minutes)

● Supervisee indicates what he or she wants and needs from supervision

Supervisee presents a 5–10 minute segment of an audio/video-recorded counseling session [optional but recommended]

Supervisor provides overview, assumptions, purpose, and procedures of CCC

Supervisor selects categorical headers, writes them on the board

● Pantheoretical headers: presenting issues, medical/medication/substances, developmental levels, support system, strengths, cultural-diversity/contextual, career-vocational, metaphors, and layers of emotions (i.e., client feelings)

Supervisees provide information for each heading (30–45 minutes)

● Supervisor needs to be succinct, using abbreviations and condensed phrases to capture in words the idea being presented (i.e., 1–4 words)

● Supervisor verifies that the information he or she wrote on the board captures the essence of what the supervisee said

● Supervisor can be as directive/structured as needed given the developmental level of the supervisee and his or her needs (and group needs)

● Often, it is helpful to be more structured/directive with neophyte counselors (e.g., Q & A for each category); advanced counselors often prefer more flexibility and responsibility (they talk, supervisor writes information under appropriate headings)

● Headings may or may not be addressed sequentially (i.e., one heading at a time)

Supervisor and/or supervisees can add, combine, or modify headings to better fit the supervisee, client, and context

Depending on the cognitive developmental level and sophistication of the supervisee, connections and integration may begin to occur as categories are being filled in (i.e., usually with more advanced counselors)

Once headings are completed or mostly completed, draw and fill in the layers of emotions or concentric circles of feelings (5–10 minutes)

Add any additional data or last minute information provided by the supervisees

Integration Phase [30–45 Minutes]

Ask supervisees what connections and patterns they see between and among the data on the board [different colored chalk is helpful here]

● Supervisors draws connections (ovals & lines) on the board and highlights (stars) the most salient information/data

● Supervisor adds patterns, integrative information on the board

Identify key missing data (information the counselor/therapist supervisee may want to obtain)

Ask questions to stimulate supervisees to consider alternative views/connections not immediately obvious (e.g., impact of cultural background, gender issues, religious upbringing)

Ask questions to stimulate and challenge conceptual and cognitive development (see Biggs, 1988; Ellis, 1988; Rigazio-DiGilio et al., 1997) and synthesis of data (e.g., Murdock, 1991)

Guide supervisees to prioritize the clinical issues and provide a rationale

Check-in with the supervisee to see how he or she is handling the process (rarely, some supervisees may become overwhelmed or feel more confused)

Apply the data to a counseling theory and formulate treatment strategies [optional]

Develop a diagnosis with a rationale [optional]

Delineate implications for treatment (e.g., treatment goals, strategies, interventions, expectations, prognosis)

Note: The time estimates assume that minimal integration and synthesis of data occurs during the information phase.