Journal of Marital and Family Therapy
1985, Vol. 11, No. 1, 67–73

THE STUCK-CASE CLINIC AS A GROUP SUPERVISION MODEL

William H. Quinn Brent J. Atkinson C. Jefferson Hood
Texas Tech University

This paper describes a conceptual framework and set of procedures which provide a format for advanced trainees in family therapy. Sections of the paper include a description of the theoretical orientation, organization of the clinic, trainee and supervisor roles, and advantages of the model for trainees, families, and clinicians in the community. A clinical illustration highlights the merging of treatment and training. We have found this model to be beneficial and well-accepted in our training program and believe that the ideas set forth can be generalized to other settings.

Our training model was established to meet the unique needs and provide challenge for our more advanced trainees. While we incorporate previously presented ideas about team intervention in our model (Berger & Dammann, 1982; Bernstein, Brown & Ferrier, 1984; de Shazer, 1982; Heath, 1982; Papp, 1980; Protinsky, Quinn & Elliott, 1982; Selvini Palazzoli, Boscolo, Cecchin & Prata, 1978; Wendorf, 1984), we offer here only material on variations which is specific to our training context and clinical setting. Uplifting in these reports and in our own experience is the intentional choice to conceptualize supervision as treatment and training, learning and doing, personal responsibility and colleagueship, and sobriety and playfulness.

We were particularly curious and challenged by those families who were observed to make positive changes slowly, if at all, and with whom trainees reported frustration and doubts about their own clinical understanding and intervention. Too, we began to realize that a larger number of trainees could benefit from the discussion and subsequent treatment of these most difficult cases. Hence, we established a "stuck-case clinic." We do not apply a strict definition of the nature of a stuck-case. These can be cases of immediate crisis (i.e., recent violence in the family, adolescent pregnancy), but are more frequently situations in which minimal progress has been made in therapy when more substantial changes are expected. Recently, we have developed a greater interest in following families seen in the stuck-case clinic on a regular basis to examine the impact of interventions and the process of change.

William H. Quinn, PhD, is an Assistant Professor and Director of the Marriage and Family Therapy Program, Department of Human Development and Family Studies, Texas Tech University, and Assistant Clinical Professor, Department of Family Medicine, Texas Tech University Health Sciences Center, Lubbock, TX 79409.

Brent J. Atkinson, MS, and C. Jefferson Hood, MS, are PhD candidates in the Marriage and Family Therapy Program, Department of Human Development and Family Studies, Texas Tech University, Lubbock, TX 79409.

Therapist Role

Each trainee is responsible for bringing a family to stuck-case clinic during training. The family is chosen by the trainee/therapist, using such criteria as the severity of dysfunction, immediacy of crisis, need for a shift in intervention format (inclusion of a team), and trainee interest in acquiring new information about the family. Families who are reluctant to participate in therapy using this format (a team of strangers observing the family when they have been organized around a single therapist in more "private" treatment) are encouraged to consider the value of having several "consultants" on the case, an "expert" on the family's particular problem, and the importance of new information (a varying perspective) from the team to be used in planning future treatment sessions.

In some situations the roles of the team (trainees not previously involved on the case plus the supervisor) are assigned prior to the session by the therapist on the case. The therapist has this option since certain individuals on the team may have a certain adeptness, may have prior knowledge of the family, or have certain characteristics making them an "expert" (i.e., cultural identification or family of origin similarities). Actually, the therapist's role and behavior shift automatically in this context to that of an interviewer. The objective is to gather data around the foremost problem in the family. New information is elicited regarding each person's thinking about the problem, manifestations of irritating or unacceptable behaviors, sequences of interaction, and attempted solutions which have previously failed. Questioning is employed to evoke perceptions of various dyadic relationships and highlight differences among family members which are meaningful. The supervisor exercises carefully a gate-keeping posture, assuring the relevance of data adhering to the theoretical view of the clinic. This is, of course, essential to the efficacy of any therapeutic model. Periodically, and after sufficient experience with this model, a trainee will take on this role as taskmaster. The supervisor in these situations acts as a meta-visor, providing commentary as related to the functioning of the team.

The interviewer informs the team of role allocation, or conversely, specifies a preference for the team to respond in a more flexible manner during the session and in the subsequent team meeting. During the session the team discusses their observations intermittently as observation continues throughout the session. Since the American Association for Marriage and Family Therapy (AAMFT) supervision standards require no more than six trainees in a group, there are from two to five trainees and a supervisor on the team. A team member may be chosen as co-interviewer when considered to have some special knowledge base in a relevant area of questioning (i.e., a trainee team member previously in the nursing field who could ask appropriate questions about a disability or chronic illness, a team member of the other gender needed to construct affiliations with certain family members or represent a different point of view, or a team member needed simply to help with the management of the session).

Team Role

Roles of team members serve to encompass the essential diagnostic areas of family life using the model of brief/strategic intervention. One team member is responsible for identifying the strengths of each family member. We find that this is crucial for motivating change in behavior. Frequently, family members are swept away by the positive evaluative aspect of the team's perspective. Instead of listening to an anticipated report of an individual's inappropriate or destructive behavior or the family's incompetence, as is typical in the classic sense of psychological assessment, the family is surprised and somewhat flustered by the convincing report of the family's strengths. In this way, the family is provided the opportunity to modify individual perspectives of other family members, and to construct an altered view of dyadic relations, thereby allowing a more

flexible and multi-dimensional view of one another to occur. In our team report, much attention is given to building a rationale for this judgment since establishing this connection to the family is crucial to subsequent interventions.

Another task of the team is to develop a description of family behavior drawn from observation of its pattern of viewing the world and human behavior. A creative and specific statement is constructed to convey to the family the team's acceptance of attempts to manage a particular problem. The team, seen as consultants to the family, becomes the harbinger of a "new truth," offering a diagnosis which modifies the family's view of itself in the world around the problem. At this point, a description (usually as a prescription) of what must be done to begin to resolve such a difficult ("but understandable") problem becomes palatable. This role of constructing such an *explanation* of the problem and *prescription* of how to manage it (what we have begun to think of as an "excription") usually falls on the entire team or subgroup thereof. In our method, the supervisor usually conducts the discussion and leads the group to coordinate ideas. Relevant information is integrated to form a compatible "excription" of innovative family behavior. A sequence of interaction circumscribing the problem is denoted and found acceptable by the team, then a directive to continue this pattern but with a modest modification is given. A clinical illustration will elaborate and document such a procedure.

The team discussion is generally open-ended, includes all members who wish to participate, and eventually is refined into something concrete during the interviewer/therapist's consultation with the team. In some situations, frequently when a sequence of interpersonal behavior is as yet unclear, a more general account of the problem is constructed and provided the family. This latter approach concludes with a set of questions to the family which expresses the team's concern regarding potentially helpful *and* destructive or unfortunate consequences from sustaining such a problem (the team has previously conveyed their understanding and acceptance of this problem). This description of the family's predicament, or "family dilemma," is an attempt to convey family stability with new premises fostering change. We contend in our team approach that framing the complementary relationship of change/stability (Keeney & Ross, 1983) is a way to promote more adaptive organizational patterns in the present painful or discouraged social context.

In particular, we find ourselves attending regularly to the stability side of the complementarity because we have assessed stuckness in family movement as an overemphasis on the change side in previous therapy sessions. This focus on change without sufficient recognition of family member requests for stability may be in part attributed to the incongruent demands and preferences among family members which make changes only perceived as satisfactory to a subgroup of the family. Thus, we instead simply mirror these different requests to advocate the change-no change indecision. Removing this push-and-shove quality of the family then contributes to revised patterns of interaction and a different lens for contextual interpretation.

Following the open team discussion, the supervisor gives a summation of the session and intervention constructed. Modifications are made for clarity, while vivid description of process (i.e., quotes from family members observed in the session) is inserted to highlight major ideas of the team about the family. The interviewer then returns to the therapy room to present the team report to the family. The team returns to the observation room to note the family's responses to this report. The interviewer does not make personal comments to the family unless planned to satisfy some therapeutic maneuver (i.e., conveying an overt split between the interviewer/therapist and team). Finally, the therapist ends the session and reconvenes with the team to discuss any noteworthy family responses observed during the presentation of the team's report and to debrief the session.

Case Illustration

The couple was a black male (age 43), an alcoholic, and a caucasian female (age 42), who had been married for 18 months. The presenting problem centered on the efforts of the husband to force obedience from his wife. These efforts were framed benevolently by Roy who expressed his desire to help his wife avoid the problems and pitfalls of life. However, Gretta described his attempts to protect her as his "trying to run my life."

In the first two sessions the therapist discovered a basic dynamic of the relationship which contributed to the current problems. The two had met when Gretta was managing an apartment complex and was having difficulties with two of her tenants. Roy stepped in to handle the situation, becoming Gretta's "black knight" as he rescued her from these dangers. This complementary relationship was adequate for bringing the couple together, but was not satisfactory for sustaining the relationship. It seemed that another view or an altered focus was necessary so that beneficial changes could be made. It was at this point that the clients were referred to the stuck-case clinic.

In the pre-session planning the therapist asked the team to derive a new perspective during the session. He also requested a letter from the team which would reflect their observations of the couple and, if appropriate, a task for the couple. The focus of the session was on the differing views of roles and interactional style for their relationship. It became clear that one of the problems was a fundamental disagreement as to *how* they were to manage the marriage. After 35 minutes of the session, the therapist left the room to meet with the team. The following sequence was constructed by the team: "Roy views his role as the protector of Gretta—Roy lectures Gretta on how to act—Gretta shuts him out and Roy becomes angry—If Roy gets angry enough—Gretta listens to him and conforms—Gretta resents Roy for his "forcing" her to give in but doesn't vocalize it—Gretta's giving in reinforces his need to protect and lead using whatever is necessary—(circle back to beginning)." The following letter was composed focusing on this sequence but in a twisted yet congenial and unexpected manner:

> Both Gretta and Roy have many strengths. Gretta is assertive, cares about her parents, believes family relationships are important, takes care of sick family members, and acts very civilized (calm and rational) when dealing with problems. Roy is very cooperative, committed to improvement in marriage, cares about parents, and has a good sense of humor.
>
> This power struggle between Roy and Gretta is a very complicated issue, probably associated with the merging of two different cultures. In Roy's world, men were given status if they could prove (or at least convince) family and friends that they were in control of their women. Men in Roy's community who had the power in their relationships were viewed as competent and worthy. Gretta, on the other hand, learned that women can make it in this world without the help of men. They are, in fact, the stronger sex in many ways, and to Gretta, her confidence is growing all the time of her ability to survive on her own.
>
> The team recognizes the dilemma, particularly since both Roy and Gretta are working at this! Why are they so stuck? The team has no easy answers to a complicated struggle of two people trying to find happiness. We have only a few thoughts:
>
> 1. If Roy were to give up his *desire* to *influence* Gretta, what will he have to replace it? How will he feel like a worthy spouse? How will his family handle such a cultural violation?
>
> 2. And, if Roy gave up this quest to dominate Gretta, will Gretta find ways to get closer to Roy? Will she initiate affection? Will she *loosen* up and be honest and open with Roy?
>
> 3. What is Roy's *secret* that cannot be revealed (not even to a spouse!)? Does Gretta have any secrets of her own which keep Roy from supporting her? Or do they have a secret together which is kept hidden from the team? Actually, an "inside joke" might do them good. Even further, if they don't have an "inside joke" they should invent one to add vitality to the marriage.

> Until Roy can be assured that he will be a worthy husband with self-esteem without "controlling" Gretta, and Gretta can choose on her own to help Roy as well as remain her own person, this is the best arrangement possible. There may be no way out of this. It has been our experience that for most couples, the full meaning of the letter like this is not grasped until it has been read five times. In the meantime, keep doing what you're doing to stay together until something else is figured out.

A follow-up with the therapist about this case elicited the view that the team in the clinic had shaken this couple's conflict—habituated interaction off dead center (a chronically rigid pattern) and provided the impetus for change in the relationship. While avoiding a lengthy theoretical discussion, this letter is presented to illustrate the format of our "excription."

Clearly there are theoretical and stylistic issues within this model which are associated with teaching and training. Some of these useful principles are set forth by MacKinnon (1983). Only with the broader training context of our program are we allowed to implement the procedures specified in this paper. Trainees are exposed to theoretical assumptions about family developmental stages, evolutionary or present orientation, utilization of information and notations about interactional behaviors, methodological aspects of therapy (neutral and/or direct stances, construction of prescriptions such as declared opinions or ritural formation), goal formation, and the nature of change in families.

Advantages of the Model to Trainees, Families, and Community Clinicians

1. It is a well known that dramatic changes often elicit, as well as follow, crises in families. The family therapist must be prepared and able not only to induce a crisis, but to refrain from reducing the intensity of the crisis prematurely. The stuck-case clinic offers a training opportunity which facilitates specialized training in crisis induction and resolution. Invariably, when the therapist trainee brings a family to stuck-case clinic, it is because the family is experiencing a crisis and the therapist is unsure how to handle it, or the family is stuck and in need of some sort of a crisis to facilitate change. In either case, learning to use crises therapeutically is a theme of the stuck-case clinic.

2. In contrast to many types of group supervision formats where trainees may try to "put their best foot forward" by presenting their more successful cases for observation, this model requires that trainees bring their problem cases. This tends to help remove the stigma from being stuck. In fact, since the clinic has been in operation, instead of looking bad for being stuck, a trainee is more likely to be looked at suspiciously if only a mildly disturbed problem family is brought in. The revelation that other therapists have cases that require consultation helps each therapist see that, if one does therapy long enough, one can expect to be stuck at least occasionally. Being able to recognize and deal with the therapeutic pacing of change/no change (at least as perceived by the family and/or therapist) promotes confidence and resolve.

3. The stuck-case clinic facilitates acceptance in the value of case consultation, even if it is only for one session. In the first few months of the clinic, therapists often had one of two attitudes as they brought families to the clinic: (a) "If I can't help this family after months of trying, nobody can in a single session. Soon the whole clinic will agree"; (b) "This family's plight is really unsolvable, and no kind of therapy will help them." As time went by, it happened that many who brought cases in with these attitudes saw their families change significantly after only one session of consultation. It was discovered that the difficulty of a case is due as much to a therapist's limited perspective than to any particular family situation. The value of short consultation has been realized, and trainees in the clinic are gaining valuable skills in brief consultation. In fact, one of the trainees who does therapy in a youth center with families of juvenile offenders (a population particularly prone to crises) recently decided to purchase his own video

equipment (and convinced the administrators to accept a team) so he could invite other trainees to consult with him by observing sessions on a video monitor in a room adjacent to the therapy room.

4. We have found the stuck-case clinic to be very well received by the families themselves. When therapy is not moving successfully, nobody knows it better than the family. As the therapist expresses concern about no change to the family and suggests they visit the clinic, the family's response is often one of relief and then anticipation. Typically, families enjoy all the extra attention which the consultation involves, including written messages depicting family strength and humor.

5. The stuck-case model affords the trainees opportunities to conceptualize about the process of family change. The discovery of alternative perceptions by the team about the family, the formation of creative tasks intended to modify interactional sequences, and peer exchanges around hypothesizing provide learning based on experience. Trainees become sensitive and appreciative of a much wider repertoire of possible therapist ideas, behaviors, and styles which connect to change. What becomes self-evident here is that, as Whitaker (1983) reminds us, the therapist begins to learn to use the self as the most potent agent of change.

6. Recently, the decision was made to extend the services of the stuck-case model beyond the university clinic to the larger community. An invitation was then issued for local clinicians to bring in any of their cases for either brief or ongoing consultation. Considerable interest has been expressed. A method to promote enthusiasm is to invite clinicians to a seminar in which the model can be explained and a case can be illustrated. Typically, these therapists will bring in families which are not responding to their usual treatment method. For example, one private practitioner brought a case where repeated attempts (over several months) to control an 11-year-old's thumb-sucking habit through behavior modification had failed. The stuck-case team was utilized, and the problem disappeared in two weeks. In another case, a clinician presented a middle-aged male diagnosed as "schizophrenic" before coming to see the clinician. While he was not convinced that the client was schizophrenic, the therapist could not alter the client's view. The follow-up comment from the client to the therapist reflected the utility of the team: "The team at the clinic said that I was not schizophrenic, so perhaps I had better rethink the evidence." Consultations such as this with community professionals tend to promote a reputation in the community that our clinic is particularly good with "tough" cases. And, our invitation to assign one of our team members as co-interviewer minimizes their concerns about being observed and evaluated by our group.

7. The stuck-case team fosters the competence of the community clinician in the family's eyes by drawing from the clinician's data about the family and giving credit to the clinician for ideas which were valuable and interventions which were successful. In addition, the area professionals receive greater exposure to systemic therapy, and doctoral trainees benefit from contact with these professionals (psychologists, social workers, physicians, clergy, etc.) and the variety of cases they bring to the clinic. Overall, the stuck-case model has promoted beneficial professional relationships between clinicians in the community and the staff in our clinic.

CONCLUSION

This model addresses both family interactional patterns and ideas about change as generated by the supervisor and trainees. Clearly these descriptions are the integration of observations, conceptualizations, creativity, and organization of the group supervision members. While we accept serious responsibility for promoting more functional family outcomes, we are equally concerned with the characteristics of group process and learning outcomes of this model. Thus, we do not hesitate to responsibly explore original

responses to family situations which are outside the frame of the therapist's previous work with the family. The two guideposts which organize our adventure are the theoretical tenets connected to our group discussions and responses to the family, and our attention to ethical and cultural issues which contextualize our modus operandi. This model is one of several methods which direct our training program, and one that complements the others because it promotes theoretical discussion of family process, heightens confidence in working with difficult cases, and sanctions use of self, characteristics which become transfused into specific treatment responses to families.

REFERENCES

Berger, M. & Dammann, C. Live supervision as context, treatment, and training. *Family Process*, 1982, *21*, 337–344.

Bernstein, R. M., Brown, E. H. & Ferrier, M. J. A model for collaborative team processing in brief systemic family therapy. *Journal of Marital and Family Therapy*, 1984, *10*, 151–156.

de Shazer, S. *Patterns of brief family therapy*. New York: The Guilford Press, 1982.

Heath, A. W. Team family therapy training: Conceptual and pragmatic considerations. *Family Process*, 1982, *21*, 187–194.

Keeney, B. P. & Ross, J. M. Cybernetics of brief family therapy. *Journal of Marital and Family Therapy*, 1983, *9*, 375–382.

MacKinnon, L. Contrasting strategic and Milan therapies. *Family Process*, 1983, *22*, 425–438.

Papp, P. The Greek chorus and other techniques of paradoxical therapy. *Family Process*, 1980, *19*, 45–57.

Protinsky, H., Quinn, W. & Elliott, S. Paradoxical prescription in family therapy: From child to marital focus. *Journal of Marital and Family Therapy*, 1982, *8*, 51–55.

Selvini Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. *Paradox and counterparadox*, New York: Jason Aronson, 1978.

Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. & Prata, G. Hypothesizing—circularity—neutrality: Three guidelines for the conductor of the session. *Family Process*, 1980, *19*, 3–12.

Wendorf, D. J. A model for training practicing professionals in family therapy. *Journal of Marital and Family Therapy*, 1984, *10*, 31–41.

Whitaker, C. Comments on Keeney and Sprenkle's paper. *Family Process*, 1983, *21*, 405–406.