Family Therapy Supervision as Counter-Induction

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ABSTRACT. In this paper, the phenomenon of therapist stuckness is addressed and related to the experience of hypnotic induction. A case example illustrates how efforts were made through the supervision process to counter-induce the therapist. Robotization (Schwartz, Liddle, and Breunlin, 1988) (i.e., supervisee responding to exact requests of the supervision team), was necessary while the therapist was mastering a very complex and difficult skill in the therapy context – that of changing from traditional therapeutic conversation to social conversation. Altering the conversation of therapy resulted in empowering the client to the point that she could "fire the therapist."

While the therapist's job is to induce in the client an alternative and enabling view of what's needed to get past a problem, the client's job is to induce in the therapist an appreciation of the difficulty of the problem. Between the two therapy takes place.

– Something Erikson
might have said.

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Journal of Family Psychotherapy, Vol. 1(3) 1990

INTRODUCTION

"How do I get therapy going again?" is often the covert if not overt question of the stuck supervisee at the onset of supervision. This symptom of "stuckness" experienced by therapists has been likened to "hynotic induction" (Protinsky, 1986; Simon, 1985). As a symptom, "stuckness" is created and maintained "by interpersonal patterns that surround it. That is, symptoms are anchored in redundant sequences of behavior that occur between people" (Protinsky, 1986, p.174).

In therapy, when families present their description of a problem in a redundant and unrelenting manner, it can resemble traditional methods of inducing a trance. For example, when a family presents a constraining belief about a problem, a therapist may be invited or induced to adopt a similar belief about the problem. Conversely, a family that presents with redundant silence may induce a therapist to non-action. Classical hypnosis involves arresting attention, holding focus and progressively and repetitively introducing suggestion (Hull, 1961). The therapeutic premise that constraining beliefs can be altered through the course of a therapeutic conversation, which may have been counter-inductive at the start, now becomes less accessible in the face of powerful hypnotic family dynamics.

Just as a client's constraining beliefs about a problem (O'Hanlon & Wilk, 1987; Watzlawick, Weakland & Fisch, 1974; Wright & Simpson, 1989) restrict solution, so too can supervisee's beliefs about a particular client restrict therapeutic solutions. This does not preclude that a particular therapist may have very facilitative beliefs starting an interview, but often these beliefs are neutralized through the course of interaction with clients. In fact when working with particularly challenging clients, therapists' beliefs about what basic skills constitute family therapy may also contribute to induction.

SUPPORTING PREMISES THAT FAVOR ENTRANCEMENT

There appear to be a few treacherous premises that foster "inductions" of supervisees. One is the curse of *helpfulness!* Most mental health practitioners seem to be born with this "genetic" need. This

predisposition leads to the tendency to objectify clients (White, 1986). Clients are viewed and treated *as* problems and/or conditions rather than persons who *experience* problems and/or conditions.

The handmaiden of helpfulness is *urgency*. This second treacherous premise can lead therapists to rush to judgments and/or actions which further solidify the "helpfulness" trait. Urgency quickly strips therapists of their therapeutic maneuverability and leaves them technically impoverished and without a viable hypothesis.

A third subtle but equally treacherous premise is the reliance upon "therapist questions" as the right and proper means of bringing forth clients' beliefs and premises (Wright, in press). If the therapeutic conversation is not progressing, then the constraining belief of the therapist is that by simply re-directing or asking new, imaginative assessment and interventive questions, that once again therapy will be effective.

IMPLICATIONS FOR THE SUPERVISION PROCESS

One of the goals of supervision is to not only participate in the process of assisting clients to alter their view of the presenting problem but also to alter the supervisee's view. Supervision is an enabling exercise aimed at shifting the therapist's notions about what they believe about what they are observing. If successful, a supervisee leaves with a fresh view of the problem because of new distinctions upon which to build further therapeutic distinctions. When the experience of therapy becomes stalemated, the supervisee requests assistance in redeveloping a context of change and a situation of movement, hope and empowerment. This requires challenging the "treacherous" premises.

For example, it may be necessary to challenge the tyranny of the conventional belief about helpfulness. When the drive to be helpful does not in fact produce help, something different must be tried. One therapeutic technique that we have found particularly "helpful" is *conscientious time wasting*. The execution of this clinical skill requires enacting social conversation rather than traditional therapeutic conversation. It requires the therapist to talk and involve oneself with the client in exciting and enjoyable conversational ways. The therapist moves from the posture of predominantly a

questioner/interviewer to one of storyteller and/or informer. More encouragement also needs to be given to supervisees to invite questions from clients as a further means of accessing family members' beliefs, assumptions and premises (Wright, in press).

Secondly, the temptation of urgency must be embraced as the bane to effective therapy. Supervisees need to be encouraged to ask a question more than once and then mull over their clients' responses as a way of helping themselves to slow down. While effective interventive questions (Tomm, 1988) can go to the heart of the matter, there are many things one can learn without recourse to clinical interrogation alone. As with the first suggestion above, evaluation and knowledge can be gained from any type of conversation. More importantly, it can also invite the disclosure and sharing of positive emotions rather than only those that are troubling or problematic. One example is the outcome of an interview with a depressed sixty-five year old man who claimed he became "worthless" upon retirement. During the interview, it was discovered that both the therapist and the client liked the sport of flyfishing. As the client's wife watched with increasing mirth, the therapist and client enjoyed an exciting exchange of stories and lies about fishing. This conversation invited energy and enthusiasm in the client where there had previously only been depression.

Treacherous conventional beliefs and premises' often lurk at the edge of the therapeutic encounter, i.e., that we should be helpful, that we should be brief/focused and that questions are the means for such. Therefore, it is useful for the supervisor to be ready when and if these treacherous beliefs arise.

CASE EXAMPLE

Client/Therapist Relationship

A thirty-two year old single parent mother of two children presented for therapy. The client did not seem to be asking for any specific change for herself but rather she described at length how she has been used and abused by everyone in her life; her ex-husband and his new wife; the legal system (with whom she had been in conflict for the eight years since her divorce), her children, and

the social welfare system (which was financially supporting her and her children). By the third session, the therapist was concerned about the lack of progress in therapy. It appeared that her client had a lifestyle (White, 1986) of contradiction, i.e., presenting problems would be minimized, the focus would shift and complaints about things at all levels would escalate.

Supervision Request

The supervisee requested assistance to obtain a focus for therapy and assistance with the method and mode of enquiry. When the supervisee had attempted to become more specific and focus on a particular complaint, the client would contradict herself, become more agitated and escalated her criticisms and complaints about others in her life. The supervisee described that in the therapy room all direction, goals and leadership seemed to evaporate. The supervisee's specific request was to "get her out of this non-productive state."

Supervision Response

The supervision team suggested that it was "as if" the supervisee was in a trance; immobilized by the relentess litany of complaints and minimal responses to therapuetic enquiry. Initial suggestions from the supervision team were to have the supervisee present to the client that she was overwhelmed by her problems and in need of direction from her. The hope was that the client would provide more clarity and focus by offering the opportunity for her to state the direction of therapy. This would be in contrast to other areas of this client's life where she was not experiencing being a "director." Unfortunately, this supervision suggestion was ineffectual and the complaints and contradictions continued unabated. From behind the mirror, it was the supervision team's perspective that the supervisee was again inducted.

In an effort to alter this pattern of interaction between the client and the therapist, the supervision team phoned in with a very direct "robotization" (Schwartz, Liddle, and Breunlin, 1988) form of suggestion. Without explanation, the supervisee was requested to wait a minute or two and then interrupt the client's complaining

statements and exclaim enthusiastically that her baby had just kicked (the supervisee was seven months pregnant) *and* then proceed to speak at length about the pregnancy and herself.

The supervisee, although uncomfortable with a seemingly non-therapeutic directive, proceeded to engage the client in social conversation for the next twenty minutes. The client and therapist discussed Mrs. M's previous experiences in pregnancy, childbirth and parenting in an animated and non-complaining manner.

During the intersession discussion with the supervisee, the supervision team explained the goal of "wasting time conscientiously." Mrs. M. seemed to know only one mode of talking to people—complaining. This mode prevented formulation of a problem (DeShazer, 1988). In the last half hour of the session, however, the client had a different experience moving from complaining and contradiction to social conversation. In this instance, social conversation was utilized to "waste time conscientiously." What was most fascinating, was that the client made no attempt to take the focus back to herself, *nor* complain or contradict.

The session ended with no further appointment scheduled. The supervision team suggested that perhaps this client had never been a customer but rather was always a visitor in therapy (Berg, 1989). The supervision team's conclusion was that Mrs. M. has had a successful "career" (White, 1986) in escaping the mental health system and that she should continue to escape the mental health system.

The team discussed how to terminate therapy in a way that would empower the client as well as give her an alternate view to her problems. The supervisee arranged for a final session with her client and in that session the following opinion was offered: "Mrs. M., as I see things, you have had a very frustrating "career" of dealing with the court system and with the welfare system. I believe that if you now become involved with the mental health system, you will have as frustrating a time with us as you had with the others. I can't help you with the legal system or the welfare system, even though I can see that you have been dealt dirt in your life by them and by others. However, I do not believe you will fare any better with the mental health system, and my advice to you is—stay away. I fear we would make too big an issue out of things which

you do not think are all that important, or too small an issue out of things which you feel are important. Therefore, I believe you would feel as misunderstood as you have with the legal system and the welfare system. I do not see you as a customer of therapy, and think it would be a mistake to try to make you one. Therefore, my one piece of advice to you is that you should consider firing me."

The client responded without contradiction saying that, "well, I have known it all along. There really is no one I can count on but myself; it's up to me." The client further concluded that she would just have to decide for herself how she was going to handle things in her life. The supervisee agreed with this and terminated therapy, letting the client know she could always call again, if she felt it was necessary.

Therapy became effective again when the usual style of therapeutic conversation was discarded and replaced by social conversation. This created discord for the supervisee, but not for the client. She was not bound by the context of therapy. The team "released" the supervisee from induction and offered "therapeutic robotization" as counter-induction. By explicitly following supervisory directives, the supervisee was once again directing therapy without demanding the client be different or implying that the client was resistant or pathological, which she was not. It was affirming to the supervisee to be reminded that sometimes the direction of therapy is to end therapy and to find a way to do this that empowers the client.

Supervision team's observations/comments. The pressure for therapeutic conversation and its underlying treacherous premises of helpfulness, urgency and interrogative enquiry had induced the supervisee. Counter-induction consisted of introducing social conversation through the supervisory process of robotization and in so doing opened space for new ways to view and participate with this client. The supervisee was able to move from her stuck position to an adventuresome and respectful position by changing her belief about her client. This was made possible by her ability to trust her supervision team and implement directives from us at a time when the therapeutic situation warranted immediate action (Liddle & Schwartz, 1983). Normally, our supervision team was much less hierarchal. Generally, we would ask each other such questions as "What would you think about doing . . . ?" However, it was neces-

sary in this situation that our experienced supervisee was able to enter into robotization and carry out very complex directives given on the phone-ins (Wright, 1986). Madanes (1988) has suggested that directives bring the most dramatic changes when clients are asked to do what appears absurd or ridiculous. In this case example, it was the *therapist* who felt "absurd and uncomfortable" but following the directives of her team she was able to bring about dramatic change and empowerment in both herself *and* her client. The therapist was able to counter-induce her client by giving her a vote of confidence that she did not need the mental health system. This alternate belief enabled the client to respond in a positive, affirming manner about herself. The isomorphic nature of the supervision process requires that many systems levels be addressed simultaneously (Wright & Coppersmith, 1983).

The rationale for these series of interventions with this client were discussed with the therapist. However, we concur with Haley (1988) that it is not necessary to discuss with the client the "machinery of therapy" (p. 365). In our case example, we did encourage the therapist to share the rationale for having the client "fire the therapist." This was done in an effort to empower the client as well as to avoid any possibility that the client might feel rejected by the therapist initiating termination. The last thing this client needed was to feel rejected by another professional system. *And* it was also the last thing she needed to become involved and potentially embroiled with another larger system. She had enough in managing the legal and welfare systems. Upon reflection, one of the most difficult tasks for our supervisee was to shift from participating in a therapeutic conversation to inviting a social conversation. However, this proved to be the turning point in the therapist's relationship with the client. Another description of this client was drawn forth through social conversation which enabled all of us to alter our beliefs about this client's ability to manage her difficulties.

CONCLUDING COMMENTS

Paramount to intervening in this way is appreciating that there are "customers" and "visitors" in therapy (De Shazer, 1988; Berg, 1989). "Customers" are clients with specified problems or com-

plaints that set the course therapy will follow with their therapist. The clients' and the therapists' energy is mutualized in the pursuit of the problem. With customers, solutions are explored, implemented and re-cycled, session to session. Outcome is generally well specified with both therapist and client knowing what they're working on and generally what will constitute progress.

"Visitors," are often sent by someone else or are only casually invested in the process, if at all. With visitors, it seems best to discuss their resources, capacity and potential in an appreciative or complimentary fashion; and the ways they've managed to stand up to the problem as well as they have (White, 1986). It seems that therapist "induction" is a product of treating visitors like customers. It is important to continuously make distinctions between the two as customers and visitors should be approached and treated quite differently in the therapeutic process.

Family therapy supervision is stimulating and challenging. If live supervision is the mode of skill development, it becomes an exciting and entertaining way to spend one's time (Madanes, 1988). Further, if one is fortunate enough to have a combination of a compatible and creative supervision team; a competent and trusting supervisee; and a client who can induce professionals to believing she doesn't need them, then it's pure enjoyment. This article described such an experience.

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