A narrative-based approach to supervision

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Narrative and medicine: the key ideas

Many psychologists nowadays argue that story-making is a fundamental part of being human. They claim that we all have a basic need to seek meaning and to give others an account of that meaning — in the form of stories, or narratives. In the last few years, ideas about narratives have also become influential within the world of medicine. Whereas the idea that people need to ‘construct’ their stories, or their versions of reality, seemed fairly abstruse to most doctors and health professionals a decade ago, it is now fairly commonplace. It is even possible to talk of a contemporary movement towards ‘narrative based medicine.’

From a narrative based perspective, every medical encounter can be seen as a collaborative attempt by a patient and a practitioner to construct an agreed story about what is going on. (Launer, 2002) One way of looking at consultations is as a place where patients bring stories that contain puzzles, questions, or things that do not yet make sense. They want clinicians to try and help them to pull together a new and more coherent story. There may be a need for some practical and technical solutions – such as a prescription, injection or operation. However, patients are unlikely to accept any advice or treatment unless it also makes sense as part of a new narrative.

If patients have a basic need to construct new stories, health professionals have the same need too. Telling anecdotes about cases is one crucial way that doctors create meaning out of what they do. Just as patients need to go away from consultations with stories that they feel they can recount to themselves and their families with new certainty and hope, clinicians too need continual opportunities to reconstruct their own stories about what they do and what they achieve.

Patients’ stories can get into a muddle, or hopelessly stuck. So can professional narratives. The practitioner who comes away from an encounter with a story of confusion, guilt, or fear, may be just as distressed as a patient with a similar predicament. Similarly most tales of ‘heartsink patients’ are in reality tales of ‘heartsink interactions’ or of ‘two heartsink story-tellers’. If patients come to professionals because they need to transform their stories into better ones, clinicians
also need such help. One definition of supervision might be that it is an opportunity for a clinician to change a story about a working encounter, by holding a conversation with another clinician.

Conversations between clinicians often serve to reinforce stuckness. Professionals tend to use narratives to place themselves in a particular light, perhaps as heroes or victims, and to cast the other players in a more negative light - for example as adversaries. Such narratives often have a stereotypical quality about them. The characters are portrayed as unchangeable, and the outcomes seem to be the only possible ones. Yet unless the professional can imagine alternative stories about the patient, the next encounter unlikely to produce anything new. The task of a clinical supervisor might therefore be seen as challenging the supervisee to change stories that seem to be superficial, judgmental or unhelpful.

Not all the stories that clinicians tell are about their patients. Many concern colleagues. Often, problematical stories about patients are linked to problematical stories about teams and professional networks. Helping professionals to explore better stories about their work with patients also involves helping them to think about their interactions with other professionals. It may be impossible for practitioners to change their narratives about cases until they can tell stories about their team mates that are also less fixed and stereotypical.

As an act of story-making, clinical supervision is inseparably linked both with reflective clinical practice and with effective team work. It suggests ways of generating more imaginative stories in consultations. It can propose more flexible and self-critical stories about working relationships. Clinical supervision can therefore be seen as a way of providing professionals with a chance to reflect on the story-making process itself, in all its different stages.

One concept encapsulates the narrative approach: *we all live and work within a web of interconnecting stories* (Bruner, 1990). Some of these stories are internal ones that we recite silently to ourselves in order to make sense of what we are doing. Others are stories that we hear or tell in conversations with patients and colleagues, relatives and friends. The stories constantly influence each other. They may reinforce elements of plot and character that are already established, or they may challenge these - so that next time the story is told in a different way. The stories that go on in our heads when we see patients are inseparably related to the stories that we tell colleagues about them afterwards - and to the stories we then tell to others concerning the colleagues themselves.
How we teach supervision skills

In our teaching, we address supervision in a number of different ways:

- We demonstrate it in one-to-one interviews by an experienced tutor, with the rest of the group observing.

- We ask group members to take turns at supervising each other on cases, by working in pairs, usually with one or more people observing them. We invite interviewers to take occasional breaks in order to hold a discussion with the observers: in effect to receive their own supervision.

- We encourage practitioners to create or explore opportunities for supervision of this kind in their workplace.

We teach a particular technique for supervision. Its formal name is ’interventive interviewing’ but we prefer to use the description ’conversations inviting change’. The main idea is that properly structured conversations can lead to the production of a useful new story. In contrast with the Balint approach, we promote an interviewing style based mainly on questioning. We believe that this helps interviewers to avoid becoming over-involved or directive, and allows interviewees to have enough mental and emotional space to generate new ideas and solutions.

We also train interviewers to follow feedback constantly, by tracking the exact words and phrases used by the practitioner, and making inquiry into these: for example, ‘When you say you’re confused about why he came, what are the different possibilities that go through your mind…?’ We particularly encourage interviewers to ask question about the contexts surrounding the story. This usually involves seeking some understanding of who else is involved in the case apart from the practitioner being interviewed. It also involves a curiosity into the contexts surrounding the index patient: family, work colleagues, ethnic or cultural identity and so on: for example, ‘Are there any areas of the patient’s life that you might want to ask about, to shed light on what she’s describing?’ The reason for this is that such questions often help practitioners to identify the gaps in their knowledge of the patient.

Interviewers can help by holding onto a view of the world as constituted from circular processes rather than linear ones. This means, for example, an ability to notice and draw attention to the effect the practitioner may be having on the patient, and vice versa. It means being alert to the ways in which people can intensify or modulate each other’s stories. Interviewers need to be
neutral in relation to the story being presented. This means showing a non-judgmental attitude towards the interviewee and also to the patient being described. It also helps if the supervisor can stay neutral in relation to the ‘facts’ of the case - including the diagnosis, causes and so on – without showing a clear preference either for or against any of the particular description or solution being proposed.

One additional aspect of neutrality is in relation to theoretical beliefs: this means avoiding any fixed way of looking at the world if this does not appear to be helping the practitioner. It means avoiding over-certain formulations like ‘Your patient sounds depressed’ and instead asking questions like: ‘Did the patient use the word depression? Did you use it? What effect would it have if you suggested the word to your patient?’ and so on.

When people first practise this style of interviewing, they often say how they find it hard to maintain a neutral and questioning stance, particularly if the case is similar to ones of their own. Learners also describe how they can feel stuck and uncertain in the early part of the interview – almost as if they have been infected by the supervisee’s distress and inertia. However, with practice there is generally a big change in the interviewer’s ability to ask imaginative questions. Most people also say that skills acquired through learning to conduct supervision in this way are useful as consulting skills in their everyday work. Indeed, many say that they find it easier to learn a narrative based consulting style through supervising colleagues than they do by other means such analysis of videotaped consultations.

As for interviewees, they nearly always report how useful it is to have an independent person question them in a way that invites them to have new thoughts about cases that may have been upsetting, confusing or angering them.

Three frequently asked questions

1. What opportunities are there in everyday work to practise this kind of supervision?

This approach can be used in all kinds of ways and at all levels of skill. People who have attended a single afternoon’s workshop have reported that it changed the way they subsequently offered help to their colleagues. Others have said that they are much readier to initiate conversations about their own cases with anyone who is available in their work setting. This might be a colleague from their own or another discipline, or with a medical student or registrar in the room (‘Can I tell you what’s going on in this case and ask you to question me about it?’). Practitioners who have studied the approach for a year or more will obviously be much more proficient in offering and receiving this kind of supervision, and they may also go out of their way to seek
formal arrangements with a colleague for ‘co-supervision’. However, there is no intrinsic reason why the method cannot be used, or adapted, for just about any case discussion between colleagues.

2. Is this kind of supervision mainly useful for psychosocial cases or can it be used for more medical ones?

There are no exclusions. It can be artificial to try and set up distinctions or say what supervision can and cannot cover. If a supervisor thinks it would be helpful to point out, for example, that the patient’s cough might be caused by antihypertensive medication, it would be pointless to feel it was ‘out of order’ to mention it. The only proviso we suggest is that such information should always be offered in the form of a hypothesis (‘do you think it’s worth considering…?’) and not as an answer (‘well it’s probably because he’s on Ramipril.’). We also advise that it is generally better to wait until the supervisee has had a chance to explore their own ideas first. There are obvious exceptions to this rule, where one simply needs to tell a trainee or colleague what to do.

3. Does this method work only in one-to-one supervision or can it be used in teams?

We have always found that the most effective way to teach narrative-based supervision is by using one-to-one interviews. So we generally break up any large group into groups of three or four people for intensive practice. A tutor stays with each small group, intervening as necessary to teach or reinforce the ‘micro-skills’ needed. Our overall objective is to help interviewees to ‘change their story’ through exploring different hypotheses, sometimes using ideas from the members of the small group as well. Our experience is that, when we work with a larger group, case discussion usually becomes too wide ranging for this to happen. People too readily offer advice, or bring up different cases for comparison, instead of remaining neutral and questioning in their stance. One way we overcome this when teaching large groups is by putting the interviewer and case presenter in a ‘fishbowl’, with the rest of the group functioning as a ‘reflecting team’, invited to offer comments at intervals in the conversation, but in a structured way. On longer courses, a group working in this way can acquire sufficient skill and discipline to follow the ideas of interviewer and interviewee closely, and to ask appropriate questions rather than try and ‘solve the problem’. It is then possible to use the method in a large group.

4. What about power differences in supervision?

Many if not all conversations between trainers and trainees are affected in some way by power, or by the way people see the power relationship. Trainees may guard their speech because they fear the consequences of expressing disagreement, or they may ‘second guess’ what their trainer
would consider to be the right answer. Equally, trainers may adapt what they say through fear of being seen as bullies. Although there are no simple recipes for managing power issues like these, the consistent use of a narrative approach appears to build up trust over time between trainers and trainees, and hence to make candid conversations easier. With practice it’s also possible to develop a repertoire of questions to make power issues more transparent, by integrating them into the conversation (‘if you ignored my own preferences and gave your own gut reaction, what would you choose to do yourself in this situation?’) At the same time, there are limits to what can and cannot be said at any particular moment; a trainer may need to take time between conversations to think through the best way, for example, to turn an over-deferent relationship into a franker one.

5. Can you offer criticism within a narrative framework?
Yes. When a supervisor feels it necessary to move from a facilitative stance to a critical one it’s useful to flag this up: (‘I think you’ve got something wrong here so I’m going to stop asking questions for a minute and explain what you should have done.’) If the criticism is respectful and the supervisee receptive, it may be perfectly possible to return to a questioning stance afterwards (a ‘narrative sandwich’). On occasion it can be hypocritical to delay offering criticism and more honest to flag up the need for criticism straight away, using a narrative approach afterwards for dealing with its impact (a ‘narrative open sandwich’). However if the error is so bad that it calls for serious action, such as escalating the concern to the educational hierarchy or reporting it to the Trust, then it’s more important to follow correct procedures than to worry about asking good questions.

Teaching example
This example describes a supervision interview taking place as part of a teaching session. It has been drawn together from a number of different examples, in order to illustrate key points. All identifying details have been changed.

Some time ago, a group of about sixteen consultants, dentists and GPs attended a three day course on supervision skills. As usual, we spent the beginning of the first morning looking at the basic concepts of narrative based supervision. After the coffee break, we asked if anyone had a clinical case from their own practice that was causing them concern and might benefit from supervision. Dr Matthew – an experienced GP – said he had a case. Dr Khan, one of the supervision trainers leading the course, offered to interview him, with the rest of the group observing. (We normally have three or four supervision trainers present to help with skills demonstration and coaching.)
Dr Khan didn’t initially ask Dr Matthew to talk about the case itself. Instead, she posed a few questions to help him set the context:

*Is there anything we need to know about your practice or the way you work, to help us understand what is happening in this case?…*

*Are you the only person currently involved in this case or do we need to know about any others?…*

*Is this a case where we need to know about previous contacts with family members?…*

*What was it about this case that made it spring to mind when the tutor asked for a volunteer just now?*

(Commentary: Contextualising questions like this serve a number of purposes. They ‘bond’ the interviewer and interviewee in a non-threatening way. They establish important information that helps to make sense of the case – especially the kind of information that may get lost later on in a welter of factual content or strong emotion. They also invite the interviewee to start thinking about the case in a more reflective way and from an interactional perspective.)

Dr Matthew’s case, it turned out, was someone that he had only seen for the first time the previous afternoon: a fifteen year old girl called Sandy who was pregnant and unsure whether she wanted an abortion. From his answers to the opening questions, we already knew a great deal that was likely to be relevant: for example, that Dr Matthew worked in an inner city practice of four partners who were all willing to see fifteen year old girls in confidence and willing to refer patients for abortions. We also knew that the girl’s mother Karen was single and was currently seeing one of Dr Matthew’s partners for a drug problem and depression. Apparently, what had brought the case to mind, and led him to feel that supervision might be useful, was that the girl had seemed so casual. In spite of being nearly twelve weeks pregnant, she had seemed more concerned in the consultation to ask him to look at a clicky jaw that was bothering her. This put him, in his own words, ‘off balance’ in the consultation, and he felt he had not really conveyed the urgency he felt about her need to make a decision.

Dr Khan then asked Dr Matthew to think of some possible reasons for Sandy’s casualness, and also for finding himself caught ‘off balance’ by this. Dr Matthew said he
thought she might be very scared but was ‘testing him out’. Alternatively, it was possible
that she was genuinely ignorant about pregnancy and abortions, and thought that there
was lots of time to make a decision. Also, it could be that she was simply ‘in denial’. He
thought his own difficulties in the consultation were because he didn’t want to alienate her
by pressure, or by second-guessing her decision. As a result, he felt he had had ended up
too ‘laid back’ in his approach, and now felt cross both with himself and with Sandy.

(Commentary: Inviting hypotheses like this is generally a good way of inviting ‘new stories’
– not just single ones but multiple possible narratives. It invites interviewees to think of
new perspectives and dimensions on the problems that are bothering them)

After further questioning, Dr Matthew said he felt that the likeliest explanation of Sandy’s
manner was that she was ‘all over the place’, unable to focus on anything except the
relatively trivial or superficial, like the clicky jaw. He said she was due to see him again in
three days, but he was now unsure how to help her take on board the seriousness of her
predicament, or to decide what to do.

Dr Khan then paused to invited everyone in the group to offer ideas about further
questions that he could ask Dr Matthew. Going round the circle, there was a richness of
suggestions. People were interested in whether Sandy had disclosed the pregnancy to her
mother, her boyfriend, or anyone else. A lot of the doctors present wanted to know more
about Sandy’s current relationship with her mother, how Karen’s drug habit and
depression affected her, whether Sandy too might have the same problems, and whether
she had any contact with her father. One person wondered if there was a teacher at
school, or another trusted adult, that she could talk to. Was there anyone she might like to
bring along to help her think about her pregnancy? A couple of people in the group were
more curious about Dr Matthew’s own reaction: what did he fear might happen if he did
actually spell our how serious things were, or asked her to think about what it would be like
to have a baby – or to abort one?

(Commentary: Team discussions like this can be enormously productive of new ideas, but
they can also overwhelm the person with the problem. For that reason, it is usually helpful
for comments to be directed at the interviewer alone. The interviewee can sit back and
listen – or tune out – as the various suggestions come up, selecting the ones that seem
most helpful).

Following this discussion, Dr Khan framed a series of questions to put to Dr Matthew in
order to complete the interview:
What ideas have struck you most from the team discussion?

Are there any particular questions you now want to ask Sandy when you next see her?

How do you think you might deal with Sandy if she seems casual again, or if you feel you're getting too laid back, or cross?

At the end of this conversation, Dr Matthew reported that the interview had made him think a great deal. In particular, he felt he had a whole repertoire of questions to help Sandy take on board what was happening to her and think about how to deal with it. He also felt he was now equipped emotionally to steer a course between being avoiding the issue or being too harsh.

Conclusion

What we know from teaching narrative based supervision, and evaluations, is that it can help practitioners from many different disciplines learn a new way of looking at cases. It can give them a new view of their own needs for supervision and support. It offers an approach they can employ for themselves and their colleagues. For some, it can revolutionise their way of working. However, one drawback of the method is that, while people readily appreciate the underlying concepts such as interventive interviewing and neutrality, they discover how difficult it can be to apply these in their everyday work without further skills practice and training. There is a risk that, for some, a brief exposure to this method will lead them to feel relatively deskilled. Our task as tutors is therefore often to help people to integrate this approach into their existing ways of working, rather than to leave them feeling we have offered a ‘gold standard’ from which they will fall short. We also recognise that we have a wider task that is in some sense a cultural one: namely, to disseminate this kind of approach so that disciplined forms of peer and educational supervision become much more the norm in primary care.

While we have good information regarding the effects on the practitioners we teach – in the form of their formal and informal feedback – we do not yet have measures of any change that might be effected on their clinical performance. We do not know if their patients notice anything different or whether they like what they notice. We certainly do not know whether, at the end of the line, patient outcome improves as a result of practitioner training or practitioner supervision. We share
these limitations with practically every other form of supervision and support currently on offer, but we also acknowledge that these are important issues that need to be addressed in the future.

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**Historical footnote; how our courses first developed**

In 1995 a group of us at the Tavistock Clinic in London began to teach a regular course for GPs and nurses from primary care. We came from a variety of backgrounds including general practice, child psychiatry, clinical psychology and social work, but we were all trained as family therapists as well. We hoped to use certain family therapy ideas to look at the whole range of primary care work – not just family work but also everyday consultations with individuals. We also wanted to use these ideas to look at a wider context of primary care, including practices, teams, and the wider social and political systems surrounding these (Launer and Lindsey, 1997). One of our intentions was to provide an alternative to the more traditional ‘Balint groups’ for GPs that had originated at the Tavistock and had run there for nearly fifty years. We aimed to offer skills training rather than case discussion alone. Instead of focusing mainly on the doctor-patient relationship, we wanted as well to encourage professionals from primary care to pay more attention to how people interact within their families, workplaces and in the other human systems that surround them. We also wanted to teach a course that was multidisciplinary.

Our primary care courses continued for nearly a decade. In that time we developed both our thinking and our approach to teaching in many ways. We began to teach far less about ‘systems’ like families and teams. We concentrated more on the stories, or ‘narratives’, that people tell. This is very much in keeping with changes in contemporary psychology and also within medicine (Greenhalgh and Hurwitz 1998.)

Through our teaching, we also became aware that clinicians had an enormous need to talk about cases and about problems in their work settings such as disputes with colleagues, or interdisciplinary conflicts. We therefore came to realise that there was a conspicuous gap for doctors in this area and that we needed to fill this gap by giving it a high profile on our courses. We came to think and talk of a style of clinical supervision that can accurately be described as ‘narrative based clinical supervision’. (Burton and Launer 2003)
We were aware that only a limited number of doctors could attend an extended course so we started to explore ways of offering a basic introduction to narrative based clinical supervision in a variety of ways including one day workshops and three day courses. These were taken up by the GP Department of the London Deanery from 2003. Then, in 2005, the Deanery started to invite consultant and registrars from all specialties in secondary care to attend these courses, as well as dentists. These became increasingly popular, so that we started to run them in hospital trusts as well, as part of the Deanery’s programme of faculty development. Now, our narrative-based approach has become the principal approach to supervision skills training across the London Deanery.

References


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