Supervision Skills for Clinical Teachers: Introduction to theory

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We teach an approach to supervision for clinicians that is based on a particular attitude of mind, and a set of techniques that convey that attitude. This paper offers a brief description of the theoretical ideas behind the attitude and the techniques.

We want to emphasise two things from the start. Firstly, the attitude of mind is more important than the theory. Some people instantly grasp the attitude but are bored by the theory (which is fine). Others get very excited by the theory but don’t seem able to apply it in live supervision (which isn’t fine). So if you struggle to understand some of these theoretical ideas it may not matter. Equally, if you fall in love with them it still may not mean that you can supervise well.

Secondly, we are applying ideas that we have learned through our training in family therapy. This mystifies some people since they wonder how on earth ideas from therapy with families can possibly be relevant to supervising doctors, dentists and other clinicians. However, the ideas have a history that is quite independent of family therapy, and these days they are increasingly being used elsewhere including management and education. You do not have to be a family therapist to understand them or apply them skilfully to supervision.

Our approach draws on two distinct but related fields of thought: systems theory and narrative studies. The following sections describe each of them in turn, with a linking section that describes a school of thought that in some ways bridged the two sets of ideas.

**Systems theory**

Systems ideas have been around since the middle of the twentieth century. They arose in many different disciplines including engineering, physics, cybernetics, biology and
anthropology. They are associated with a number of names that have largely been forgotten outside specialist disciplines. These include Norbert Wiener, Heinz von Foerster and Ludwig von Bertalanffy. The best known of all the systemic thinkers was a man named Gregory Bateson. He was British but lived much of his life in California.

Bateson was something of a polymath. His essays covered a huge range of interests including evolution, political theory, religious mysticism, art and psychiatry. Unfortunately he was not a very clear writer and his arguments can be hard to follow but they can all be summed up by a single idea: everything in the world is ultimately connected with everything else, through a complex pattern of interactive loops that never really has any beginning or any end. Because of this fact, all that we can ever perceive of any phenomenon is only partial and provisional. Moreover, we ourselves as observers are really only a part of the pattern of interactive loops and can never really stand outside it and be entirely objective.

A typical example of Bateson’s thinking relates to the problem of schizophrenia. Rather than focussing on the individual person with schizophrenia, Bateson preferred to talk about ‘schizophrenic interaction’. While recognising that some people might have a genetic tendency towards schizophrenia, he pointed out that this could only be a small part of a much wider pattern. People behaving in a schizophrenic way would inevitably have an effect on everyone around them, and these effects would then have other effects. For example, family members might react by treating them as weird or dangerous, and this in turn might make them more likely to be so.

Or, in a more complex way, people who showed schizophrenic behaviour might be likely to choose partners who behaved in similar ways to themselves. This would result in children who would have an additional genetic tendency to the same kinds of behaviour but would also be nurtured in an environment where these kinds of interactions were more common. The social circle around them would then respond in turn by marginalising them, thus adding to their problems. If anyone caught up in such multiple interactions saw a psychiatrist, the problem might then be amplified further, especially if the psychiatrist dwelt only on the abnormal aspects of the person’s behaviour and emphasised the diagnosis rather than ever engaging in normal conversation with them.
Bateson argued that this kind of ‘systemic’ thinking was useful not just in clinical fields but in every area of human experience. Let me give a personal example. I regularly visit a café near my workplace where there is a young black waitress whom I used to find very bad tempered. I used to respond in kind by giving her fairly curt requests and not leaving tips. One day I noticed her laughing with a group of young black customers and I began to wonder if she was grumpy with me because she expected me as an older white man to behave exactly as I was doing: namely being curt and ungenerous. I altered my behaviour and of course she did too. Hopefully we both learned from this, in a way that may make a small contribution to lessening racism, sexism and ageism more widely. Of course we are likely to have less impact on the wider social contexts that determined her previous behaviour and mine, or on the enduring effect of colonialism on black and white people, nor indeed on a range of wider contexts including the relations between males and females, or between in-groups and out-groups across all human cultures. But you never know.

Bateson was not himself a clinician but he worked for a time with psychologists and psychiatrists. He was particularly influential on a group of people who became the founders of family therapy in the 1950s and 60s. These people started to use his ideas not just with schizophrenia but with alcoholism, behaviour problems in childhood, marital discord and a host of other problems. Instead of seeing any problem as ‘belonging’ to a single individual, they started to focus on how people interacted with each other and how this could make any problem far worse - or far better. They would see patients together with their close relatives, and work with the whole family system to try and understand and help what was going on.

Although family therapy has changed in many ways since its earliest days, family therapists continue to use Bateson’s ideas. In particular, they tend not to make interpretations about the ‘cause’ of a problem, nor to give advice about how to deal with it. Instead, they ask questions in order to stimulate everyone’s interest in the nature of the problem, how it arose, and what is keeping it going. They hope that by thinking about such questions, everyone involved may become more aware of their own contribution towards the situation in the ‘here and now.’ By working in this way, they aim to help people question the objectivity of their own fixed judgements and labels, and to explore new ways of seeing the world around them and their part in it. It is also from Bateson that we take the idea of “the difference that makes a difference”. This
informs our thinking about how to help people think about change. People need to do something different but not too different so we ask about the smallest steps they can take that might be useful.

In the context of supervising doctors, we find that Bateson’s thinking, and systemic ideas generally, are helpful in all kinds of ways. They can make people aware of how any problem may only become a problem in the context of human interactions, and how those interactions can contribute to it, or make it better. Systemic ideas can also help people to see that any understanding of a problem can only ever be partial or temporary, and that solutions - or resolutions - can only really be generated by the parties involved. The role of supervisors is therefore to be curious and sympathetic but also to be challenging - in the sense that they will never simply accept the supervisee’s account as the only possible description of what is going on, or as the ‘truth’ of the matter.

Double binds and strange loops

One of the areas that Bateson worked in was communication theory. With a team of other people, he looked at how conversations could sometimes go wrong and lead to misunderstandings or conflict. He was the first person to name the so-called ‘double bind.’ This is the kind of interaction where people seem to put each other down or disqualify each other at every turn. It can happen in a single conversation or take over a relationship. A common example is where one partner says to another ‘I wish you showed you loved me by hugging me more often’, but then responds to hugs by saying ‘You’re only hugging me because I asked you’. As Bateson pointed out, one of the features of such interactions (apart from their repetitiveness) is that it usually seems impossible for the partners to stand outside their interaction as observers and to analyse it or comment upon it.

A famous example of this occurs in Joseph Heller’s war novel ‘Catch 22’. The hero, Yossarian, realises that his commanding officer in the air force is so incompetent that every single fighter pilot in their squadron is getting killed in action. He goes to his commanding officer and says that his fellow pilots must be completely insane to follow orders to go on flying missions. The response of his commanding officer is to say: ‘I completely agree with you: if you’ve realised this you are absolutely sane. And we need
sane men like you to go on flying missions, not the insane ones who are going out at the moment!’. Communications theorists since Bateson have paid further attention to these kinds of exchanges. Two theorists named Cronen and Pearce have proposed that everything we say carries a set of implicit contexts with it: these implied contexts mean that any statement is (for example) a response to what somebody has just said, a contribution to a conversation, part of a relationship, and also representing a set of social and cultural rules about conversations. These contexts nest inside each other like Russian dolls. Sometimes both parties have an unspoken understanding of what all the contexts are and how they fit inside each other, but sometimes the parties are at odds without being aware of it. Their conversations then get into terrible muddles, although neither party quite understands why this is.

The unsettling quality of Yossarian’s conversation in ‘Catch 22’ is strangely familiar. It shows an extreme example of something that probably goes on a great deal. Cronen and Pearce suggest that there are ways of understanding these exchanges, and ways of dealing with them. Specifically, they argue that there is an implicit conflict here over contexts and their relative importance. Yossarian is basically saying: ‘For me, the decision over whether or not to fly in this squadron is a defining context for anyone’s sanity’. His commanding officer then reverses the contexts by saying: ‘For me, sanity is a defining context for the decision that someone should definitely fly.’ Cronen and Pearce call this reversal of contexts a ‘strange loop’. They point out that the only effective way of dealing with them is to stand outside the whole interaction and comment on it from what they call ‘a higher context’. For example, Yossarian might say: ‘You don’t understand me, Major. Because I’m sane, I’m absolutely refusing to fly’. By saying this, Yossarian would be assigning a higher context to the conversation (misunderstandings), and then an even higher context for their relationship (the right of a subordinate to disobey irrational orders). Cronen and Pearce call this kind of correcting tactic a ‘charmed loop’.

Strange loops seem to happen quite a lot in medical consultations. We may be aware of them only through somatic discomfort or a heightened sense of anxiety rather than through any logical analysis. Doctors probably correct them intuitively as well, restoring charmed loops without realising exactly what they are doing at an intellectual level. Here is a typical example. Supposing a young fit man comes to see me as a GP
because of back pain. Implicitly, there is an assumption that I will understand the cause of his pain because (a) I know something about the body (b) I am a good doctor (c) I am a caring human being. One could see these three assumptions as contexts that nest inside each other or (as Cronen and Pearce would put it) are at increasingly high levels. Each higher context governs the lower ones, so that being a human being is the cause for becoming a doctor, which is a cause for understanding the body. Equally, each lower context confirms the higher ones, so that my knowledge of the body demonstrates my identity as a doctor which in turn demonstrates to my patient that I am a caring person.

Supposing, then, that in the consultation I reach the conclusion that the patient’s back pain may be related to stress, and accordingly I start asking him questions about his work, his home life and so on. Implicitly in my mind there is a new context, nestled inside the other ones. This new context is my belief that psychological factors can influence the body and someone’s experience of it. As I start to ask these questions, the patient may well go along with the process quite happily at first, expecting that in due course I will return to the higher context of the body and offer an explanation of the pain that may incorporate some of the ‘lower context’ information about stresses in his life and so forth.

But supposing I go on asking such questions to the point where my patient starts to feel anxious, uncomfortable or even angry? He may conclude that I have raised the status of my psychological inquiry to a level where his body has now become a lower consideration. While I carry on happily inquiring into his private life and sexual habits in the belief that this will eventually shed light on his low back pain, he has now decided (a) that I am completely uninterested in the body and obsessed with people’s private lives because (b) I am an inattentive and incompetent doctor (c) I am a nosy and uncaring individual (and possibly a pervert). In Cronen and Pearce’s terms, the misunderstandings about the lower levels of context have had serious implications for his perceptions of me at all the higher levels.

In a consultation like this, the likelihood (I hope) is that I would actually spot his discomfort fairly early on and attempt to respond to it, probably at an intuitive level. I might, for example, apologise if my questions had seemed intrusive but explain that sometimes this kind of information can be relevant to understanding back pain.
(Cronen and Pearce call this a 'context marker'). If I then confirm the higher importance of the body by carrying out a careful physical examination, the patient may suddenly recall occasions in the past when I have made an accurate diagnosis (therefore I am really a good doctor) or visited a member of his family in hospital (therefore I am really a caring human being). Harmony between contexts has been restored, and the strange loop reversed into a charmed loop.

How might this apply in supervision? Probably the commonest example is when a kind, thoughtful supervisor has to talk to a junior about a lapse of judgement or a poor decision. Since all their previous conversations have been positive and friendly, the supervisor starts out by trying to elicit the junior’s account of events, in the hope that the junior will spontaneously come out with an admission that things went wrong, and with an apology. However it sometimes happens that the junior does not realise anything was amiss, and describes the case as if nothing went wrong. The supervisor then starts asking more and more persistent questions until the trainee starts to feel first puzzled and then harassed. If the process goes on for long, the supervisor the junior may redefine the supervisor as somebody inconsistent, untrustworthy and a bully. This might have been avoided if the supervisor had offered a simple context marker: ‘Look, I know you’re normally a great doctor and most of the time all I have to do is to praise you and help you develop even further, but on this occasion I need to talk to you about something you’ve got wrong’. This statement hopefully preserves the context of being a caring supervisor while making it clear that one of the roles of such a supervisor is also to talk about mistakes.

When doing peer supervision, it is helpful to look out for strange loops and draw attention to them. One example might be: ‘You’ve told me you’re the senior partner but you’re also telling me about lots of occasions when your team made major decisions without consulting you and then you get blamed for them. How does that fit together?’ This might lead the supervisee to consider (for example) the possibility of relinquishing the label of ‘senior partner’ on the grounds that it was meaningless label within the actual hierarchy. Equally it might lead the person to decide to reassert their seniority so that no decisions could be made without their involvement. Either tactic would restore a charmed loop in place of a strange one in which the senior partner gets blamed for running an organisation in which the senior partner isn’t allowed to function properly!
It’s easy to assume that all strange loops are bad while all charmed loops are good. This isn’t necessarily the case. Strange loops can be used constructively as well. The most frequent case of this is when someone says something like, ‘I never really set aside time for leisure...I can only remember a few occasions in the last few months when I’ve really had fun’. An astute questioner might then ask: ‘So what made it possible for you to create the conditions for having fun?’ Instead of demonstrating how difficult it is to set aside time (because this is so rare) the exceptions are used to demonstrate the opposite. In effect, the few episodes of fun are redefined as the higher context rather than the lower one.

The best reason for understanding and identifying strange loops is because they can hamper the whole conversation when the supervisor and client are working from different assumptions about what is actually going on. A ‘funny feeling’ that you aren’t quite on the same wavelength as the client is usually an indication that this is happening. You then need to ask a question to re-establish an agreement at a higher level of context. An example of this kind of question might be: ‘You started by talking about a case, and now we’re concentrating on the way your nurse mismanaged it: do you want focus now on how to deal with the case or on the nurse’s performance?’ Another example might be ‘When we started this conversation you were clear there was a definite problem to look at: can I check with if you think that’s still the case – and if so what the problem is?’ Manoeuvres like this are also helpful whenever you feel as a supervisor that you are going round in circles, or have lost your bearings. In some cases it may be worth checking out your basic assumption that your client still wants to go on with the conversation. Sometimes they may be trying to answer questions in a way that shows you they have had enough, while you are blithely responding to each answer as a prompt for a further question about the ‘problem’. This is a classic – and common – strange loop in supervision.

The Milan team: a bridge from systems to narratives

Like every other branch of psychology, systemic thinking and family therapy have given rise to many different schools of thought. However, the followers of Bateson who have most influenced us are a group of Italians known as the Milan team. These were four psychiatrists who were also psychoanalysts. In the 1970s they became frustrated and disaffected by some aspects of psychoanalysis including its emphasis on the individual and its apparent certainty about the mind and how it works. Using principles derived
from Bateson, they developed a way of working with families (and later with individuals, and then in supervision) that depended almost entirely on using questions to open up new ways of thinking for their clients. Eventually they proposed that their approach could be understood in terms of three simple guidelines: hypothesising, circularity and neutrality.

When they talked about hypothesising, the Milan team were trying to draw attention to the fact that it is quite impossible not to form ideas in your mind about causes, reasons, explanations and interpretations for anything you hear about. However there are two quite different ways of responding to these ideas. On the one hand you can assume that your own ideas are right and to try and persuade other people of this. On the other hand, you can regard these ideas simply as different descriptions of what is going on, and then to try and find out if these descriptions are of any interest or use to the other person.

The conversion of hypotheses into questions is one of the key skills of systemic questioning. It not only involves identifying what you are thinking in the first place, but it also includes the discipline of becoming sceptical about your own ideas at the same time, and then asking a question that gives no hint of your opinion. To use the example I gave earlier of the ‘bad-tempered’ waitress, somebody listening to me talking about her might quite reasonably form the idea that I was being unfair or prejudiced in my description of her. In normal circumstances they might just tell me so – but at the risk of offending me and therefore not helping me to think about my behaviour. If they questioned me on Milan principles instead, they would ask me something like: ‘Does she seem grumpy with everyone or have you ever seen her behave in a different way?’ Ideally, they would ask this in a way that showed genuine curiosity and no hint of criticism of me, making me more inclined to reflect on what had happened from an interactional perspective.

The Milan team’s next guideline of circularity covers the idea that the person doing the questioning in a systemic interview (whether in a consultation or when doing supervision) should always note in careful detail what the response is to each question, and use this to frame the questions that follow. This involves a willingness to ‘go with the flow’ of a conversation even if it is going in a quite different direction from the expected one. One of the necessary skills for the interviewer here is what the Milan
team called ‘not being wedded to your hypotheses’. This implies the ability to respond with equal interest whether or not the ideas in one’s own mind are confirmed.

Taking the ‘grumpy waitress’ example once more, I might conceivably respond to the interviewer’s question by asserting stoutly that I had only ever seen her being grumpy, whoever she dealt with. A good interviewer would take this at face value and move on immediately to a different hypothesis and a different question, for example: ‘Can you imagine any situation outside her work where she might not be so grumpy?’ Another possibility is that I might confess that I had indeed seen the waitress behave cheerfully with young black people, opening the way for a further question like: ‘What explanation do you have for why she behaves differently to you?’ The Milan team’s view, and our own experience, is that such a question would be far more likely to induce me to explore my own set ideas and alter them.

The Milan team’s third guideline - neutralty - really flows from the previous two. It expresses the idea that interviewers should constantly maintain an open, tolerant stance that allows their client or patient the maximum possible space, unimpeded by the intrusive beliefs or prejudices of the interviewer. The Milan team were at pains to emphasise that this did not mean that interviewers should have no beliefs and prejudices of their own. Nor did they ever rule out the possibility of situations (including dangerous or life threatening ones) where it was legitimate and ethical to declare these. What they did argue, however, was that clinicians very often found themselves in situations where they could do more harm by inappropriate certainty than by carefully considered neutrality.

In time, one member of the Milan team named Gianfranco Cecchin wrote a further paper in which he boiled down the approach of the team into one word: Curiosity. If one felt and expressed adequate curiosity, he suggested, everything else necessary for a systemic interview would follow automatically. This would not only include a helpful exploration of the nature and content of the problem, but also the client’s response to the interview itself. (‘How is this conversation going for you? How helpful are you finding it? Are there any other questions I should have asked you? Am I getting the balance of questions to advice about right? Am I showing any prejudices that are getting in the way of your thinking?’ and so on).
In our trainings in supervision skills we have used the ideas of the Milan team in all sorts of ways, but the most important of these are probably the stress we place on attentiveness to language, and on following feedback. In our experience many doctors are quite empathic and sensitive to the general tone of feeling in a conversation but they may have inadequate skills in noticing the tiny, giveaway, words and phrases that can act as cues for curiosity and helpful questions (eg the word ‘always’ in the expression ‘always grumpy’). Equally, they may never have been trained to be sufficiently aware of their own certainties, so that they are inclined to plough on with a particular, predetermined line of questioning even when every response is indicating that it would be better to pursue a different set of ideas.

One specific point worth making here is whether it is useful to impart a list of systemic questions (sometimes referred to as ‘circular’ questions) that are useful in many different situations. The answer is probably ‘Yes and no’. We do sometimes give as set reading a famous paper by a follower of the Milan team named Karl Tomm, who systematised their approach to questioning (although they repudiated his system as too rigid and militating against spontaneity). From time to time we also ask groups to generate their own list of ‘favourite effective questions’. However on the whole we regard such approaches to questioning as essentially anti-systemic. By definition, a set of prepared questions cannot possibly relate to the specific language cues given by individuals in particular conversations. However, when they are learning this technique some people find it very helpful to have a few “favourite questions” handy to refer to in their consultations or supervision conversations.

The Milan team never explicitly described themselves as narrative therapists or narrative practitioners. However, in their preoccupation with language and its importance they were very much in accord with a rising interest in narrative that was also emerging around the same time.

**Narrative ideas**

The narrative movement that emerged in the 1980s was entirely distinct from the world of systemic thinking. However, like systems theory, it emerged in a whole range of different and apparently unrelated fields including the social sciences, philosophy and literary studies. Pioneers of narrative thinking included the psychologist Jerome Bruner,
the literary critic Paul Ricoeur, the philosopher Charles Taylor and the Russian linguist Mikhail Bakhtin - who had actually written much of his important work fifty years earlier but was now being rediscovered.

A narrative is simply a story. People within the narrative movement have taken all sorts of different theoretical positions, but they all basically share the same central ideas: human beings are story-telling creatures. This means that we make sense of our realities by telling each other stories (or bits of stories) and we experience our lives in ways that resemble stories - in other words with characters, plots, motives, suspense, beginnings and endings and so forth. Another feature that narrative thinkers generally have in common – and that Bakhtin emphasised - is that stories are made up not by single individuals but between them. Who a story is being told to (and where, and when, and why) is just as important as who is doing the telling.

This is not the place to explore the relationship between the narrative movement and other similar movements from the late twentieth century including post-modernism and social constructionism. Nor is it the place to examine the different approaches that narrative thinkers have taken to the philosophical question of whether stories approximate to something that really exists, or whether the only reality we can ever know consists of the stories that we tell ourselves and each other. What is important, however, is to notice the points of similarity and overlap with systemic thinking. These include a crucial emphasis on interaction (who is telling what to whom) and on context (how our story-telling is determined by our various identities and relationships in terms of family, culture, belief systems and so forth).

Narrative thinking has affected family therapists just as profoundly as systemic thinking. It is probably true to say that many or most family therapists working in the UK nowadays would probably describe themselves as working within a narrative framework as much as a systemic one. Narrative ideas have also affected other schools of psychology as well, including psychoanalysis. There is in fact an emerging consensus in many schools of psychological thought that people’s problems are changed not so much by helping them find the ‘real reason’ or the ‘best answer’ to their problems, but by helping them to find a coherent story that provides them with a satisfactory meaning for what they are going through.
In our work in supervision skills training, we particularly use the concept that clients usually bring a ‘stuck story’ to supervision. They may have told the story over and over again to themselves and to others, so that the story itself (often involving a sense of being helpless or overwhelmed) has become part of the problem. We promote the idea that thoughtful and sensitive questioning can invite people to retell their experiences to themselves in a different way. Quite often, for example, we notice that someone will start to present a problem in supervision with a phrase like ‘Well, it’s a very complicated story...’ Fifteen or twenty minutes later, they may actually say ‘I guess it’s really fairly simple and I’ve known all along what I ought to do’. People also sometimes start by presenting something for supervision that they think is fairly simple but the process of supervision develops something more complex. They may be entirely unconscious of how they have been helped to reconstruct their narrative in this way unless they review the process on video.

**Our own synthesis**

Our use of systemic and narrative ideas changes all the time. The emphasis we put on different elements of systemic and narrative ideas inevitably alters, in response to each course we teach. The account we give of our thinking also changes. We make use of ideas from other fields as well. For example, some psychoanalytical ideas (like the word ‘unconscious’ in the previous paragraph) still inform our hypotheses and our language at times - not least because they are so embedded in popular thinking and in medical culture. However we also try to remain sceptical about our hypotheses and the language we use, and open to challenge in all our teaching and our ideas.

We recognise that our own particular area of interest - supervision for practising doctors, dentists and other health professionals - requires a theoretical approach that draws on systemic and narrative thinking but is not entirely dominated by it. Broken bones, strokes and death are not just words: they are real. We realise the need to balance the scepticism and relativism of systems theory and narrative ideas on the one hand, with an ethical sense of what is solid and non-negotiable in medicine and health care on the other hand. Having said that, we find time and again that what supervisees (and patients) find most helpful in an interviewing stance is the one thing that Cecchin said most characterised the systemic approach to helping people: Curiosity.
Suggested further reading


