Narrative approaches to supervision consultations: Reflections and options for practice

Lincoln Simmonds

Lincoln Simmonds can be reached at Blackburn Child Psychology Service, Daisyfield Mill, Appleby Street, Blackburn, BB1 3BL, England. Email: i.dl@virgin.net

Consultations where professionals working with people with difficulties see another mental health professional for advice and help, are an important part of the work of many therapists. This paper discusses how a narrative perspective can be particularly helpful in deconstructing one particular discourse that can at times dominate in consultations – that the therapist is the sole expert or authority on people's difficulties. Although this paper focuses on consultations with professionals, many of the ideas and issues discussed are relevant to consultations with non-professionals.

Keywords: narrative therapy, expert knowledge, power, outsider witness, re-authoring conversations

THE THERAPIST/CONSULTANT AS 'EXPERT'

Therapists working in mental health services offer consultations, whether face-to face or by telephone, to a wide range of professionals. In my experience, professional and non-professional people attending such consultation appointments often come with expectations of being *given* directive advice and opinions from mental health 'experts' who apparently know more than they do! From a narrative therapy perspective, we could refer to such expectations as a product of dominant discourse (Foucault, 1980; Harper & Spellman, 2002). In the sense that these expectations are ideas about how we as therapists work, they dominate by obscuring alternative ways of understanding our work practice. This is not to say that these dominant discourses (or stories) are 'wrong', rather that they are more prevalent and can, at times, be restrictive in terms of exploring alternatives.

This paper focuses on one particular dominant discourse that I often encounter when carrying out consultation appointments – the idea that the therapist (and the therapist alone) holds the 'expert opinion' on the person who is at the centre of the ideas. During the course of my work as a psychologist in a service for children, young people, and families, there have been many occasions when I have been invited into positions of acting as the mental health 'expert' to advise other professionals about a particular child or young person's difficulties.

Before going further, it is important to acknowledge that the professionals, carers, and parents who come to these appointments seeking help in their care of young people are often in situations that feel extremely stuck or overwhelming. I am not suggesting that therapists do *not* have considerable knowledge, skills, and experience that can be brought to bear in understanding and resolving the difficulties. However, the dominant discourse of 'expert opinion' often suggests that the people at the centre of the story have little contribution to make to the consultation. To counter this, I have found that I need to work hard to deconstruct the idea that I am the 'sole expert'. What is more, I have needed to find ways to create a context in which others' experiences, knowledge, and skills are given considerable weight in the conversation.

Within the rest of this paper, I will refer to professionals attending consultations as 'colleagues seeking help', and the subject of the consultations (who, in some contexts, might be called the 'clients') as being 'the young person/family at the centre of the work'.

CREATING A FORUM FOR ALL PARTICIPANTS TO CONTRIBUTE

Narrative therapy aims to 'centre people as the experts in their own lives' (Morgan, 2000). In this sense, I have found it important to make explicit efforts to enable colleagues seeking help to remain aware that their experience, knowledge, and skills are valued and should be brought to bear in understanding the difficulties they are facing. In other words, colleagues seeking help are the experts in understanding *their* experiences of the difficulties they are facing. I find it extremely important to 'set the scene' by talking about people's expectations for the consultation, which are often based on their previous experiences of meeting with professionals, and how this consultation would likely be different.

To begin, I like to introduce the consultation to the participants as a 'thinking space' in which everyone can bring ideas or thoughts for us all to discuss and consider. I invite participants to not treat it as a formal meeting, suggesting instead that people are welcome to share unformed ideas or views as opposed to just 'facts'. In this introduction, I explicitly refer to colleagues' knowledges and skills which can be brought to bear in terms of trying to understand the difficulties experienced by the person at the centre of the work.

SEEKING EXTERNALISED DESCRIPTIONS OF PROBLEMS AND UNIQUE OUTCOMES

I have found it important to think carefully about the aim of any consultation. Is it to talk about the experiences of the workers' (colleagues seeking help) or the experiences of the young person/family at the centre of the work (the 'clients')? Let us say, for example, that the aim is to explore the issues from the perspective of the young person/family at

the centre of the work. In these situations, we aim to place the experience of this family at the centre of our conversation. There are, however, hazards in carrying out consultations about people who are not present. As a facilitator of the consultation, it is important for me to be active in ensuring that the conversations will contribute towards the development of preferred stories of the young person/family who is at the centre of the work. It therefore becomes important to steer conversations away from tendencies to theorise or hypothesise about the young person/family and their relationships.

Dominant discourses in the field of mental health often speak of pathology, and thus can diminish people's sense of agency by emphasising stories of passivity and incapacity. In my experience, dominant discourses are often initially 'the meat and potato' of the consultation. In other words, pathological descriptions of the problem often initially dominate, and so it is important for me to find ways to elicit externalised descriptions of the problem and to hear richer and thicker descriptions of the person's life and their personal agency (White, 2000, 2004).

It is particularly important for me to hear about exceptions to the problem, also referred to as unique outcomes. Morgan (2000) gives a helpful definition of these unique outcomes which go beyond actions: 'a unique outcome may be a plan, action, feeling, statement, quality, desire, dream, thought, belief , ability, or commitment' (p. 53). Therefore, asking colleagues seeking help about what the young person/family at the centre of the work do for fun, about positive relationships in their lives, and so on, can be extremely helpful. Asking what the young person/family would say, or be interested in with regards to the consultation, can also bring the focus back to their experience. Such questions can be helpful in beginning to develop alternative stories about the young person/family's life – stories which may have been obstructed by dominant problem stories. Such stories often give scope to identify hopes, dreams, skills, and knowledges of the young person/family involved. In turn, this can create room for change and for people to develop more of a sense of agency over the path of their own lives.

LINKING LIVES THROUGH RESONANT RESPONSES

I have often found the use of the outsider-witness/definitional ceremony map to be a helpful way to structure consultations when the aim is to talk about the experiences of the young person/family at the centre of the work (Fox et al., 2003; Morgan, 2000; White, 2007). Through the use of this map, I ask questions that explicitly invite colleagues in the consultation to consider whether any experiences of the young person/family at the centre of the story strike a chord or resonate with any experiences that the colleagues have had in their own lives. These explorations can be particularly useful in generating richer appreciation of the young person/family's experiences. For example, in one consultation, I asked questions to facilitate the tellings of professionals' recollections of experiences in their own lives that related to the young person's preferred story development. These experiences spoke of times when they had been separated from usual networks of friends and family and placed in an unfamiliar setting. These tellings and re-tellings helped the professionals to begin to consider more richly the young person's experience of being taken into care after living at home.

Again, as the facilitator of the consultation, I need to be active in shaping these tellings and re-tellings in order to avoid responses being informed by discourses of diagnosis. Asking questions about what aspects of the young person's experience resonate for those in the consultation, enables colleagues seeking help to engage with client's preferred stories as one person to another person, as opposed to a more distant 'objective' professional perspective.

RECOGNISING KNOWLEDGE AND SKILLS

Having one's knowledges and skills recognised and acknowledged is significant not only for young people/families but also for professionals. Because of this, I find it important to acknowledge the ways in which professionals are already acting that are helpful to the preferred identity of the young person/family they are working with. In providing this recognition, I often find that professionals then step more into acknowledging the skills and knowledges of the young people/families with whom they work.

In one particular consultation, I assisted colleagues seeking help to identify unique outcomes in their work – times when they had been successful in assisting preferred story development in the lives of young people/families. In turn, these unique outcomes were linked across time into stories. These stories provided an alternative to the dominant problem-focused descriptions which had brought these colleagues to the consultation. They had spoken of it being difficult to see acts of progress on a day-to-day basis but, when a series of unique outcomes were placed in sequence unfolding over time (White, 2000), it became explicit to them that their acts as workers were consistent with helping the young person settle into their new environment, and supportive of the young person's preferred ways of living. As a result of the consultation, these colleagues proceeded to take further actions to support the young person's preferred identity stories. In doing so, they were also further developing preferred stories of their identities as workers.

REFLECTING ON LANDSCAPES OF ACTION AND IDENTITY

We can all say something about problems in our lives and how we want them to change, but to be asked, 'How would you know the situation was better?' and 'What would be happening if the problem's influence was diminished?' can open possibilities that are not just about a problem *not* being around. These enquiries can invite people to give accounts that *describe* preferred ways of living. They provide openings to what White (2000) refers to as 'preferred stories'.

The re-authoring conversations map of narrative practice (White, 2007) scaffolds the development of preferred storylines in relation to the 'landscape of action' and 'landscape of identity'. The landscape of action consists of unique outcomes, events which are outside of the problem's influence, while the landscape of identity consists of what these events and the actions involved in them *mean* in relation to the person's identity. The landscape of identity consists of people's hopes, dreams, values, and commitments. By moving between the 'landscape of action' and the 'landscape of identity', it becomes possible to build preferred stories about a person's life. These stories help people to foresee future actions, and how these would affect the person's experience of themselves and their identity.

I find the re-authoring conversations map extremely helpful in consultations as it enables us to explore possible future developments in relation to young people's landscape of action and landscape of identity. I recall a number of consultations in which we explored future positions of the landscape of action and landscape of identity in relation to one young person at the centre of the conversations. The colleagues seeking help had begun to notice that the young person wanted to make friends and connections in his local area, which they saw as a unique outcome. We explored other examples that thickened a story that 'making connections with other young people' was something that fit with the young person's preferred way of living. In doing so, the colleagues seeking help began to imagine further steps that the young person might take to step more into this preferred identity. This began to turn the focus of the discussion towards thickening this preferred story, as opposed to spending more time discussing the problem-saturated stories surrounding the young person. The result was that the colleagues seeking help developed a variety of creative ideas as to how they could collaborate with the young person to move the preferred story into actually 'being lived' as opposed to merely 'told'.

REFLECTIONS ON THE POSITION OF THE THERAPIST/CONSULTANT

Time and time again, I witness how a discourse that speaks of expertise residing solely in the therapist/consultant proves to be restrictive in producing positive and enduring therapeutic change. It can be seen as empowering the 'mental health expert' (the therapist), but often at the expense of the person at the centre of the work (the 'clients'), or of the colleagues seeking help (professionals, therapists, community workers, and so on).

This paper has described a number of ideas that I have found helpful in disrupting the discourse of 'therapist as expert' in consultation conversations. These are ideas which I find provide 'escape ladders' to professionals/carers/parents who may

otherwise be convinced by the dominating discourse that they have no agency to change the difficulties they face.

At the same time, however, this paper does not suggest that the solutions to problems reside solely within the young person/family at the centre of the work. A narrative stance gives weight to social and cultural influences on persons' perceptions, identities, and actions, and actively seeks out figures who can recognise, support, and acknowledge a person's preferred change, hopes, and wishes. One mistaken criticism I have heard about narrative therapy is that it suggests that therapists should 'not use their power' and therefore should have no influence within meetings with people seeking help. This is a mis-reading of narrative therapy. Narrative therapy works to remain explicitly aware of relations of power in therapy, and seeks to use the therapist's power and influence in a transparent manner.

Morgan (2006) refers to Michael White's ideas about positions that a therapist can hold in a therapeutic conversation, and refers to the position of 'decentred and influential' as the position most linked with narrative therapy (p. 60). She describes the 'decentred and influential position' as one in which possibilities for collaborative conversations are supported. The therapist actively works to provide a context in which the knowledges and skills of the person who is at the centre of the conversations are more richly described, and their preferred storylines are thickened.

The role of the narrative therapist is to create a context for a person to take a position on the problem, as opposed to reiterating people's experiences of being 'positioned' by others (White & Epston, 1990). In my experience, it is also possible to take a 'decentred and influential position' within consultation sessions. From this position, I have been privileged to bear witness to conversations that have led to rich preferred storyline development, not only for the young person/family at the centre of the story, but at times for the colleagues seeking help as well.

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