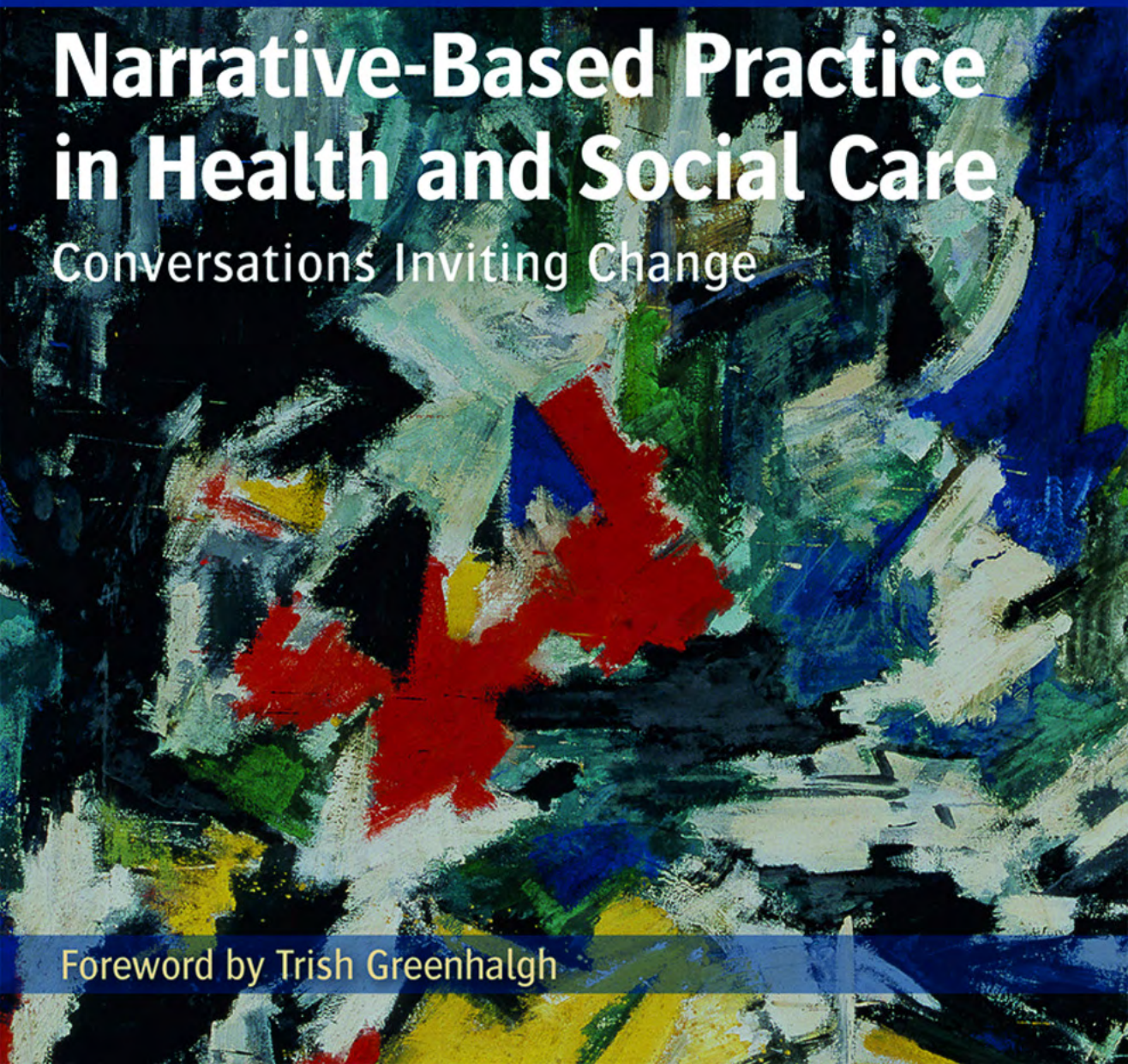
SECOND EDITION

ROUTLEDGE

John Launer

Narrative-Based Practice in Health and Social Care

Conversations Inviting Change



Foreword by Trish Greenhalgh

Narrative-Based Practice in Health and Social Care

Narrative-Based Practice in Health and Social Care outlines a vision of how witnessing narratives, paying attention to them, and developing an ability to question them creatively, can make the person's emerging story the central focus of health and social care, and of healing.

This text gives an account of the practical application of ideas and skills from contemporary narrative studies to health and social care. Promoting narrative-based practice in everyday encounters with patients and clients, and in supervision, teaching, teamwork and management, it presents "Conversations Inviting Change," an established narrative-based model of interactional skills.

Underpinned by an account of theory from narrative studies and related fields, including communication theory and systems thinking, it is written for students and practitioners across a broad range of professions in primary and secondary health care and social care.

More information about "Conversations Inviting Change" is available at www.conversationsinvitingchange.com. This website includes podcasts, presentations and further teaching material as well as details of forthcoming courses, and is continually updated with information about the approach described in this book.

John Launer is Associate Dean at Health Education England, an Honorary Consultant at the Tavistock and Portman NHS Foundation Trust, and Associate Editor of the *Postgraduate Medical Journal*.

"Reading John Launer's *Narrative-Based Practice in Health and Social Care: Conversations Inviting Change* gave me a powerful surge of hope. John finds words to express our deepest thoughts and visions for a truly respectful and effective health care. His transparent prose brings his reader to experience the clarity and value of narrative practice. Reading John Launer, awakened by his purity of thought, falling under the spell of his idealism, charged by his optimism, I feel myself in the presence of those giants of vision and faithful representers of 'the other.' We all gather, with John as host, in the clearing of a narrative path toward wholeness. If you care for the sick, read this book."

– Professor Rita Charon, Columbia University, USA

"This book guides us through the rapids and challenges of how to conduct conversations that lead to meaningful change. John Launer articulates with wonderful simplicity the subtleties of a narrative-based approach which enables people in difficult situations to negotiate and realise new ways of going forward. Given the ubiquity of calls for change and innovation, this book must be everyone's first port of call to make sure their plans and initiatives benefit from Launer's transformational approach to narrative communication."

– Professor Rick Iedema, King's College London, UK

"How can practitioners and patients become more receptive and responsive to each other? Launer's book addresses this question, and resonates with today's policy preoccupations; the need to develop relationships between practitioners working with the same patients in the same teams to improve collaborative practice. Narrative-based practice has yet to receive the attention in interprofessional education that it merits. 'Conversations Inviting Change' offers a remedy for this that I shall certainly keep to hand."

– Hugh Barr, President, the Centre for the Advancement of Interprofessional Education, UK

Narrative-Based Practice in Health and Social Care

Conversations Inviting Change

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John Launer

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For Lee, for Ruth, for David

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Contents

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During that formative time, none of my own clinical and teaching work would have been possible without the exceptional multidisciplinary team at the Forest Road practice in Edmonton, north London, most importantly my long-standing GP partners Ron Singer, Mary Logan and Sally Jowett. They kept me going, along with the hundreds of people who saw me as patients. Necessarily anonymous here, they are the principal inspirations for the narrative in these pages. My work was also enhanced greatly by the psychologists who carried out collaborative work with me at Forest Road, either clinically or through research. These included Emilia Dowling and Alan Nance.

In more recent years, the team of teachers who have taught "Conversations Inviting Change" at the London Deanery (now part of Health Education England) have all made huge contributions to developing the approach, and in extending it to secondary health care and social care, as well as to team facilitation and conflict resolution. Active encouragement and resolute support for this came from Jonathan Burton, Neil Jackson and Tim Swanwick. Among the trainers who have been responsible for the work, I especially want to thank Helen Halpern, Lisa Miller, Serena North, Sarah Divall, Sue Elliott and Diana Kelly – as well as Nerys Cater, Christine Strickett and Sam Ferman for their administrative support (and with apologies to the many teachers and other staff there is insufficient space to mention here). The recent establishment of the Association of Narrative Practice

in Healthcare (www.anph.org) has also created a highly creative forum for all of us, and provided further impetus for developments that are reflected in these pages.

As narrative-based practice has grown worldwide, it has been a special privilege to build up links with those pursuing similar work abroad, and to know some of the eminent thinkers in the field, including Rita Charon in the United States and Arthur Frank in Canada. I have greatly appreciated working alongside Maria Giulia Marini and Paola Chesi in Milan, Anat Gaver and Amnon Toledano in Israel, Pekka Larivaara in Finland, as well as Esperanza Diaz, Eivind Meland, Edvin Schei and their colleagues in Norway, Bent Stolberg and Bent Gyldenhof in Denmark, Akira Nakagawa and Akira Naito in Japan, and many other gifted and inspiring teachers elsewhere.

I have benefitted from the generosity of several friends and colleagues who have been willing to look at earlier drafts of this book – although its failings are self-evidently mine alone. For their thoughtful comments on different parts of the book (or in some cases, all of it), I want to thank Pooja Bhambra, Dariusz Galasiński, David Goosey, Jeremy Greenwood, Helen Halpern, Alasdair Honeyman, Lisa Miller and Julie Rooke.

As well as being a tactful and challenging reader, my wife Lee Wax has been unwavering in her love and in her encouragement to do the work that lies behind this book, and the book itself. It is dedicated to her and to our twins, who were born not long after "Conversations Inviting Change" first began, and are now about to go to university.

Foreword

John Launer is a friend, a fellow general practitioner and what might be termed a co-mentor. Our paths have crossed many times – as doctors, as scholars, as parents, as Londoners and more.

John is a fine storyteller himself, but his particular gift is helping others to tell and interpret their stories. Once or twice, when I have struggled with life's challenges, he has drawn a narrative of hope and healing out of me. Many times, we have (as doctors do, in professional confidence) exchanged anonymised stories about patients. What did these symptoms mean? How should I have reacted to this story fragment? What else should I have asked or offered? How should I respond next time the patient brings an update to his or her story? Always, John responded with more questions. Always, he enriched the narrative and inspired my clinical and moral imagination. He never told me what to do, and he never pretended that complex problems have simple or single answers. But through the wisdom of narrative conversations, I discovered options for taking seemingly unsolvable problems forward.

When I was very sick (in the middle of chemotherapy for cancer), John came to my house laden with treats and helped me construct what I later described as "the strangest story I have ever told" (Greenhalgh, 2017). While my medical prognosis was good (I had a small, treatable cancer that had not spread), in the early stages of my illness I was confused, frightened and suffused with (largely self-imposed) stigma. I discovered the truth in Arthur Frank's words: "A self that has become what it never expected to be requires repair, and telling autobiographical stories is a privileged means of repair" (Frank, 2000, p. 135).

As Bakhtin observed, it is impossible to craft a story without a listener. And to draw out the most productive stories, the listener must be open, interested, curious and imaginative. As John writes in his introductory chapter, the basis of all professional [clinical] practice is "attentive listening, careful inquiry, and the attempt to offer opportunities for easier and more creative narration." Sitting patiently beside me as I lay on the sofa, and saying remarkably little, John helped me make sense of what was happening and rebuild the strong, hopeful person it was happening to.

John has spent much of his professional lifetime developing a unique approach to training clinicians and therapists in the important but all-too-rare quality of active therapeutic listening. In this book, he describes his approach with numerous illustrative vignettes. These techniques are based on time-honoured and perhaps old-fashioned professional principles – but they are as important now as they have been down the centuries. I hope this book will be read widely and contribute to a renaissance of the narrative approach to clinical method.

Professor Trish Greenhalgh, Professor of Primary Care Health Sciences, University of Oxford

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Preface

This is a book about health and social care, and about stories. It describes an approach to everyday professional practice called "Conversations Inviting Change." The approach is based on a simple idea. *Everyone in health and social care – whether as a patient, service user, or practitioner – tells stories about their experiences, and can benefit from being skilfully questioned about them.*

The ideas in the book originate from a course at the Tavistock Clinic in London that Caroline Lindsey and I led for many years. Caroline had a background as a child psychiatrist, and I as a GP. We were both also trained as family therapists; in fact, Caroline had been my tutor. We strongly believed that narrative ideas and skills from the world of family therapy, if suitably adapted, could be useful in almost any professional encounter in primary health care (Launer, 1996a, 1996b). We thought the same skills could also be applied to peer supervision, training, management and team building. The original participants on our course included GPs, practice nurses, health visitors and community nurses, pharmacists and optometrists, and dentists (Launer and Lindsey, 1997). Caroline gave our approach the name "Conversations Inviting Change." The courses gave rise to a book called *Narrative-Based Primary Care: A Practical Guide* (Launer, 2002), the precursor of this one. Its aim was to make the ideas better known, so that people could try them out for themselves and integrate them into their existing forms of practice if they wished.

Once our course was well established, we started to receive requests to run workshops for groups of people elsewhere wanting to apply "Conversations Inviting Change" in their teaching and clinical practice and in supervision (Burton and Launer, 2003). Caroline retired, but a number of colleagues from different professional backgrounds who had completed our courses at the Tavistock became outstanding teachers of the approach. Together, we began to run trainings for the "London Deanery," the organisation that was responsible for postgraduate training of doctors in London at the time, and for developing their teachers and supervisors. We gradually transferred all our work there, and built up a multilevel system of training, ranging from one-day introductory workshops to extended

courses where we taught more people to teach "Conversations Inviting Change" in their turn (London Deanery, 2012).

As we gained in experience, *we found that people who acquired narrative skills through doing peer supervision on our courses became more proficient in applying these to their work with patients and clients*. This became a central principle of our work. Hence, we focused on applying "Conversations Inviting Change" to workplace supervision (Launer, 2013). We also learned how to adapt everything we taught to contexts where people might have problems that everything we taught could be applied in any health care context – even ones that were highly complex technically, or more critical in terms of risk. We had to "get real" about the limits of narrative ideas and skills in situations where professionals or clients might have far more urgent needs than telling their stories, and where learners or colleagues might experience difficulties that required supervisors to do far more than listen and ask questions. We extended the use of the approach from training in peer supervision to applying it to team facilitation, conflict resolution, and to trainings in reflective practice and professionalism.

People from a far wider variety of professions became drawn to our courses. We extended our intake to include medical specialties right across the board, from transplant surgery to psychiatry, as well as nurses, allied health professionals, counsellors, managers, social workers and social work educators. The London Deanery itself became part of a national training organisation, Health Education England. As a result of all these developments, "Conversations Inviting Change" evolved from a fairly esoteric approach for a self-selected group of people to a mainstream supervision method taught across many professions. Invitations to run workshops and give presentations started to come in from all around the United Kingdom, and abroad. We demonstrated our approach and ran training workshops in Israel and Norway – and then in the United States, Canada, Japan and Australia, as well as widely around Europe. We found that the approach appeared to have cross-cultural value, possibly because stories are so universal, and a narrative-based approach made sense everywhere. In many of the places we have taught, the distinction between primary and secondary health care is not as sharp as it has been in the United Kingdom, and nor indeed is the division between health and social care.

We have now taught "Conversations Inviting Change" to several thousand practitioners in the United Kingdom and around the world. Almost everyone we teach recognises straight away how the skills can be applied in their own profession, discipline or specialty, and in their own work setting. The dilemmas we help people to address are not the province of any single profession. They are universal, across the professions. These dilemmas include:

- How do you practise when the authority of professionals, including doctors and social workers, can no longer be taken for granted?
- How can you share power with patients and clients, without letting go of evidence and best practice?

- How do you work alongside colleagues with other professions, views, beliefs and priorities?
- How can you practise humanely while following a huge agenda of risk assessment, targets and statutory duties?
- How can you hold on to optimism about the possibility of change, while seeing many people who are intractably distressed about their problems?
- How can you manage all of this when time and resources are so short, and organisational change is constant?
- How can you be a care professional and remain a caring person?

This book aims to address these questions. In an age when health and social care are becoming increasingly integrated, we believe there is an increasing need for "Conversations Inviting Change" across all the health and social care professions.

Notes on terminology

1 The terms "patient," "client" and "service user" all appear in this book, recognising that professionals in health and social care follow different kinds of usage, and that this is constantly changing. Wherever it is possible without causing confusion, we prefer the word "people" anyway. Likewise, the terms "practitioners" and "professionals" are both used to cover anyone working in health and social care, but the word "interviewer" also appears when referring to someone's role in holding effective conversations.
2 Some writers make a distinction between the words "story" and "narrative." We find it makes more sense to use them interchangeably. In practice, the main advantage of the word "narrative" is that it can be inflected into a verb ("to narrate," "narrating," etc.), conveying more of a sense of flow and dialogue. In some ways, our approach might be better described as "narrating-based."
3 Some readers will recognise many of the ideas and skills presented in this book as "systemic" just as much as "narrative-based." The similarities and distinctions between these terms are discussed in the Introduction.

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Introduction

Narrative, health and social care

Key ideas in this chapter

- We experience, communicate and indeed create ourselves as individuals and human networks through the use of narratives or stories.
- Narrative ideas can provide a framework for thinking about everything that goes on in health and social care, including encounters with clients and between professionals.
- Health and social care professionals can make good use of such ideas and still remain grounded in the world of action and physical facts.
- Ideas from family therapy can act as a helpful bridge between narrative thinking from the social sciences, and the practical world of health and social care.
- Practitioners applying narrative-based approaches in health and social care can learn a great deal from each other in addressing the challenges involved.

Why narrative?

Storytelling is a defining human activity. Stories unite all cultures, cross all history, and arise in all circumstances. Stories in this sense are not fables, lies or fairy tales. They are the way we understand, experience, communicate and create meaning for ourselves, both as individuals and communities. They are the way we try to influence others, or assert our own positions in relation to theirs. The stories affect how people are seen, and how others tell stories about them in their turn. Stories are also dynamic: they constantly change as people tell them, and hear responses to them.

People generally come into contact with health and social care professionals because they have problems, but nearly always they present these problems by narrating them in a flow of words: "This happened, and then that happened, and I felt affected by it . . . I talked to some other people about it . . . Now I want to know what you think about it." In one sense, an account such as this is merely the way that people communicate their problems. In another sense, it is the story itself that needs attention. Whenever possible, they want to go away with a story that has a more helpful meaning for them: "I understand it better now . . . It all makes a bit more sense . . . I think I know what to do . . . I feel a bit different . . . "

Professionals tell stories to their clients too: "This is how I see your problem . . . This is what I think you should do about it . . . I hope that what I suggest will make things better . . . " Professional stories such as these are often connected to "official" narratives such as scientific evidence and public policy. Whatever the task, it is always embedded in a story for the client, and a story for the professional.

There are multiple opportunities in health and social care for service users to create new stories by sharing them with others. The same person may tell different stories to a receptionist, a practitioner and a passing cleaner – and will receive other proffered stories in exchange. None of these stories is definitive, nor are any of them distortions. Each is recreated in a different way, the outcome of the listener's role, identity, experience and power as much as the teller's.

Work settings offer similar opportunities for professionals to recreate narratives with each other too, as they exchange these in corridor conversations or team meetings. Thus, for clients and professionals alike, health and social care can be seen as spaces for the continual search for new and better meaning. Each time a story is told, or heard, or questioned, it changes. If the quality of the listening and the sensitivity of the questioning are well attuned, the change will be for the good.

A narrative-based approach sees attentive listening, careful inquiry, and the attempt to offer opportunities for easier and more creative narration as the basis of all professional work. Narrative ideas offer a conceptual framework for understanding all the different discourses – professional, scientific and political ones, together with lay or folk accounts of the world – that have to be integrated into everyday work. They can help practitioners to make sense of all the storytelling activities that they participate in with clients, colleagues, within teams, and throughout the health and social care services. Narrative ideas can also provide professionals with the skills to help themselves, along with clients and colleagues, to question, re-evaluate and continually adjust their own understanding.

Where the ideas come from

In the last part of the twentieth century, a wide range of academic and practical disciplines undertook what has generally been called a "narrative turn."

Broadly, one could describe this as a move from asking the question "what is *really* going on here?" to asking "how are people *giving an account* of their experiences?" This has happened in all kinds of fields: in psychology (Bruner, 1986; Roberts and Holmes, 1999), in the humanities (Ricoeur, 1984), and in the social sciences (Geertz, 1973). In all these subjects, the focus moved away significantly from observing the content of people's lives to examining the processes of living. These processes are characterised by speaking and thinking in a flow of words.

The world of narrative studies or narratology is now vast (Porter Abbott, 2008; Bal, 2009). People have studied how we construct our memories and our life stories in a similar way to authors writing novels: with time frames, characters and themes, and with elements such as plots and suspense. They have looked at how our stories change as time passes, and how they change as we have conversations with others. They have examined how we present ourselves to others in narrative form. They have described how stories change according to the power relationships between the people concerned, and the positions in which they wish to place themselves and their conversational partners (Harre and Moghaddam, 2003).

Many ideas about narrative have a "postmodern" flavour. Postmodernism rejects overarching accounts of reality (Lyotard, 1984). It challenges the idea that bodies of knowledge such as science, medicine or the law are purely objective. Instead, it understands all knowledge as the product of culture and of power: in other words, as stories that are accepted in any one time and place, but might one day cease to have meaning. Postmodernist thinkers reject the idea that exploring reality is like peeling away the layers of an onion, looking for the inner meaning concealed at the centre. Instead, they see it more like a tapestry of language that is continually being woven. This way of looking at language and reality is also related to the view described as *social constructionism* (Berger and Luckmann, 1966; Harre, 1986; McNamee and Gergen, 1992). Social constructionists believe that it is language that largely determines how we see reality, rather than the other way around.

Until relatively recently, there was very little interest in these ideas in the worlds of health and social care. Phrases such as "narrative studies," "postmodernism" or "social constructionism" meant nothing to most practitioners, unless they happened to work in academic departments. That has now changed, and it has changed radically. Partly this has come about because of social and political changes that have knocked the professions off their pedestals. Partly it is because of movements such as feminism and anti-racism that have invited people to look at their own beliefs and behaviour, and how these reflect their own vested interests. Consumerism has also had an effect. So have client pressure groups and disability rights activists. All these interest groups have different kinds of stories to offer, and they want to be heard. As a result, most health and social care professionals are now aware that few service users these days believe that what practitioners say or do is entirely objective or politically neutral. Professionals are coming to accept

that they do not have a monopoly on describing people's experiences, or on telling them what to do about it. Our realities, in other words, have become contestable and open to negotiation.

Family therapy: a bridge between narrative, health and social care

Although narrative ideas have now taken hold in health and social care, there is another related field where they have been around for far longer – the field of family therapy, where the ideas set out in this book originated. To understand these more fully, it helps to know a little about the origins of family therapy, how it evolved, and how narrative ideas entered the field, before they spread to health and social care.

In its origins, family therapy drew largely on systems theory. This examines how parts of any system, human or otherwise, interact to affect each other. Family therapists were influenced by thinkers such as Gregory Bateson, a biologist whose theories explored the idea that everything in the living world is ultimately connected with everything else, through mutual influence or so-called "feedback loops" (Bateson, 1972). This means, for example, that you cannot really think about any single individual without considering the family members with whom they engage, as well as other important systems around them, including their community or workplace. The focus of family therapy is therefore on how people interact with each other, rather than how any particular individual feels and behaves. Because they look at the world in this way, family therapists often describe themselves as "systemic" therapists, or systemic practitioners. They generally work by seeing two or more people together – a couple or a family – and helping them to reflect on how they talk or deal with each other and with those around them. Equally, systemic practitioners usually take a lively interest in how different professionals or agencies interact, and how this impacts on the care of people and their families.

Over time, family therapists had to adapt their approach and their techniques to a world where they could no longer take notions such as objectivity and authority for granted. From fairly early on, they took social constructionist ideas on board. They largely moved away from theories that tried to explain what people and families *should* be like and how they *should* behave. Instead, they took the view that they needed to help people explore which ways of understanding the world made most sense for themselves, and how best to negotiate these with others. Increasingly, they have had to acknowledge the major effects of racial and other kinds of discrimination in their clients' lives, including gender issues (McGoldrick and Hardy, 2008; Burnham, 2011). They have had to take the religious beliefs

of their clients into account. Family therapists have also turned their attention to their own beliefs and the power systems in which they operate. Probably more than other professions, they have tried to become aware of how their own practices and institutions can be oppressive, even with the best intentions. At the same time, they have tried to respect people's expectations that they should still have some expertise to offer, and that they should remain professional, ethical, competent, serious, and comply with the law.

In the last 20 years, family therapists have been particularly influenced by narrative ideas. This development is commonly associated with the Australian social worker and therapist Michael White. He emphasised the importance of the stories that people tell about themselves, and how these can evolve, or be "re-storied," as a result of therapeutic interventions (White and Epston, 1990; White, 2007). White's approach is known explicitly as "narrative therapy" and has been highly influential. Even practitioners who do not describe themselves as narrative therapists often base their work nowadays on the technique of asking creative questions, in order to invite people to construct new narratives (Dallos and Draper, 2010; McNab and Partridge, 2014). As a result, family therapists can often give other professionals in health and social care helpful guidance about how to apply narrative ideas and skills in their own work, especially in relation to holding therapeutic conversations.

"Systemic" and "narrative": what's the difference?

Since many people who train as family therapists come from health and social care, and often continue to work there, many words and ideas from family therapy have now entered those settings too. However, it is worth noting that the words "systemic" and "narrative" have acquired slightly different meanings in the world of health to that of social care. To avoid confusion, it is important to know about these differences.

Systemic ideas have affected social care a great deal. Many social workers are likely to have some understanding of what a "systemic" approach means, and how it differs from other, more individualised approaches, including psychoanalytic or behavioural ones. In their basic training, and subsequently, they may have heard about the way that systemic practitioners go about their work – for example, by interviewing a couple or a family together – and how this might be applied in social work, or when managing interagency work in social care (Fish et al., 2008; Goodman and Trowler, 2011; Munro, 2011). Conferences, courses and other activities related to systemic social work are now commonplace (Milowiz and Judy, 2013). In addition, some social care professionals, particularly in Australia

and Canada, may be familiar with the specific practice of narrative therapy as introduced by Michael White, as described above. If the word "narrative" has resonances for them, it is likely to be specifically in connection with White's work and that of his followers, and its application in their own setting.

Within health care, perceptions of these terms are different. Doctors and health professionals may have some knowledge of systems theory, but this is far more likely to be in connection with physiological or organisational systems than with families. Most will be relatively unfamiliar with family therapy or the way the term "systemic" is used there. For doctors and nurses, the word also has an extraneous, and (in this context) rather unfortunate meaning: that of "intravenous"! Hence, they may find the term "systemic" puzzling in the context of human interactions. By contrast, they will generally feel much more comfortable with the word "narrative." They will connect this term not with Michael White or narrative therapy (which they are unlikely to have heard of), but with the emergence of a new movement known as "narrative medicine" (Greenhalgh and Hurwitz, 1998; Frank, 2001; Charon, 2006; Mehl-Madrona, 2007; Engel et al., 2008; Charon et al., 2016; Marini, 2016). This is a field that first developed around the turn of this century, coinciding with the early years of our own teaching of "Conversations Inviting Change."

Although narrative medicine drew on some of the same prior sources in the social sciences and elsewhere that inspired family therapists, it developed quite independently from the world of therapy. The mission of narrative medicine has been to restore humanity, imagination, and moral engagement to the medical world. It has asserted the importance of lived experience, and the recounting of that experience, in the face of the dominant intellectual voice in modern professional practice. This dominant voice often creates the impression that practice should be regulated only according to abstract principles or quantitative measurements. Narrative medicine encourages a commitment to what has been described as "narrative competence," including a literary-level sensitivity to the detailed content and contexts of every client's story (Montello, 1997; Charon, 2001; Grant, 2016). It acknowledges and respects scientific facts, but also emphasises how facts are narrated and acquire meaning in the minds of both practitioners and patients. It judges medical practice not just by successful technical outcomes, but also by whether it pays attention to the patient's story and contributes to one that is more cohesive and richer in meaning. A related concept is that of "narrative humility" (DasGupta, 2008), namely the capacity to acknowledge that people's stories are not objects to master, but dynamic accounts to engage with, while remaining open to their ambiguity, and engaging in constant self-evaluation about our own roles, expectations and responsibilities, and how the stories are affecting us personally.

Narrative medicine has now generated a tremendous variety of activities, including the study of literary texts and personal narratives of illness, as well as encouraging reflective writing by medical students (Kalitzkus and Matthiessen,

2009; Jones and Tansey, 2015). A similar movement is now emerging in social work, taking narrative as its basis, but without focusing exclusively on ideas from narrative therapy (Parton and O'Byrne, 2000; Milner, 2001; Riessman and Quinney, 2005; Roscoe et al., 2011; Gibson, 2012; Baldwin, 2013; Payne, 2014; Burack-Weiss et al., 2017).

Both narrative medicine and narrative social work are also closely aligned with the field known as narrative ethics (Charon and Montello, 2002; McCarthy, 2003; Wilks, 2005). In contrast to the abstract principles of traditional ethics, narrative ethics emphasises the importance of storytelling and listening, and on the role of professionals in conducting conversations ethically. According to this view, every juncture in a professional conversation is an opportunity for offering choices, so that clients can mould their own encounters with less direction or control by the professional. This can happen, for example, by inviting the client explicitly to choose which path to take (e.g. "Which aspect of the problem would you like to explore at this point?"). Instead of posing as a "fixer," the expert becomes a conversational partner. Clients can direct professionals towards what matters, and articulate what they actually want from the encounter. They can do so far more effectively than if the professional tries to second-guess these things for most of the conversation. "Choice" is therefore not just about decisions. It is embedded in every moment of every interaction (Launer, 2014, 2017). Where choices are genuinely constrained by statutory requirements, an approach guided by narrative ethics would also prompt the practitioner to be transparent about this, and to point out how and why the client's choices might be limited.

In its early years, we described "Conversations Inviting Change" as a systemic approach, but we found this caused puzzlement among doctors and health care professionals – so we changed to calling it a narrative-based approach. We do so not because it is derived from narrative therapy (it is not), but because it draws on the kinds of narrative ideas and skills that are widely used by all family therapists. We also do so because we feel our values are aligned with the narrative medicine movement, with the emerging movement of narrative social work, and with narrative ethics. At the same time, our work remains firmly rooted in systemic ideas, even though we do not often use the word.

Comparisons with coaching, counselling, motivational interviewing and CBT

Many health and social care professionals have had exposure to a variety of models and trainings in interactional skills before encountering narrative ideas. These include psychodynamic counselling, motivational interviewing, coaching, cognitive behavioural therapy, person-centred care and a variety of alternative

approaches (Ronen and Freeman, 2007; Jacobs, 2010; Miller and Rolnick, 2013; Stewart et al., 2013; Rogers and Maini, 2016). Almost everyone who comes on a course in "Conversations Inviting Change" is curious to know the difference between such models and narrative-based practice.

What sets narrative practice apart from other approaches is its insistence on precise attentiveness to language, and on the idea that, wherever possible, the goals of any conversation should not be predetermined. It emphasises the need for conversations to be minutely responsive to the other person's self-expression from moment to moment, offers precise skills for doing so, and a closely choreographed and disciplined training methodology for helping people to acquire these skills. Another distinguishing feature is that we regard the whole range of belief systems and conversational frameworks that professionals apply as themselves forms of narrative, each imbued with certain assumptions related to their historical origins and the power relations they represent. For that reason, we encourage people to maintain a certain detachment and scepticism towards all these frameworks – including narrative-based practice itself. What ultimately matters is not whether any conversational model is applied slickly and consistently. It is whether the language of the practitioner arises out of the encounter itself, and is influenced as little as possible by prior prejudices, formulaic ways of working, or the unreflective application of professional dominance. This stance has been described as being "dogmatically undogmatic."

Interestingly, once people have had some exposure to narrative ideas and skills on our courses, some report how similar these seem to what they have learned from alternative frameworks, while others say it seems to challenge some of the cherished truths they have learned elsewhere. Paradoxically, one person may say they feel there is nothing new to learn because "this is identical to CBT/psychodynamic counselling/coaching/motivational interviewing, etc.," another may say they cannot adjust to a narrative approach because it questions their certainties, while a third person reports that they feel liberated because some of their reservations about other approaches have been confirmed!

A possible explanation for these diverse responses is that all effective approaches to conversational skills do share some commonalities, including an emphasis on positive regard and open questioning. Some people who use these spontaneously have therefore discovered for themselves the same kind of responsiveness that we teach. Others, by contrast, have learned to place more emphasis on more specific techniques such as goal-setting, active guidance or psychological interpretations, all of which we distinctly downplay in "Conversations Inviting Change." People's individual responses to what we teach may therefore reflect their own choices of how they have applied other models, rather than the models themselves.

Ultimately, almost everyone who acquires narrative-based skills finds ways of integrating these with other skills and techniques they already practise. Some do so only partially, for example by remaining largely within their previous modes

of interaction, but adopting some narrative strategies that they find fit particularly well with these. Others develop ways of combining "Conversations Inviting Change" with approaches they have learned previously, in a syncretic fashion. Many decide to adopt narrative-based practice as an overall stance within which other ways of working can be offered with a lighter touch, or with more negotiability, and with a greater readiness to cede control of the conversation and move back to the client's own preferred trajectory if that turns out to be more appropriate.

Health and social care: differences and connectedness

In most teaching and writing, health and social care are treated as separate sectors. This is largely an arbitrary distinction. As every reader will know, many of the problems brought to one sector carry over into the other. One aim of this book is therefore to enable readers to help people working in one sector learn *about* those in the other, and *from* each other's work. A related aim is to indicate how frameworks such as narrative practice, or "Conversations Inviting Change," can serve both sectors equally, and help to bring them closer together.

In the United Kingdom and elsewhere, there is increasing convergence between the two sectors in organisational structures, funding streams and public policy. A similar convergence is happening with primary and secondary health care, and between social work and the wider world of social care. The boundaries between different fields are becoming more open to question. For example, many traditional hospital services are being moved into the community. Many of the responsibilities that social workers carried in the past are now commissioned from independent agencies, including private ones. In both health and social care, new roles and job titles appear each year (for example, "physician assistant" or "personal officer"). These are only a few examples of how the landscape is changing. Such developments pose challenges to existing professional identities – especially when they are associated with organisational upheaval and cost-cutting, as is often the case. Yet the trend is likely to be irreversible. Established professionals need to find ways of working with colleagues across old boundaries, and with new colleagues who may have different assumptions and expectations. Narrative practice may have its own contribution to make, by helping people to hear the different stories that people bring to their work, and how these stories change over time.

The descriptions and case vignettes in this book sometimes relate to identifiable professions, but elsewhere they simply refer to "practitioners," "professionals" or "interviewers" (see note on terminology in the Preface). This is intentional. Many of the issues that people in health and social care face in their work are

not technical ones that only someone with the same training can help them to address. Far more often, they involve uncertainty, complexity or ethical dilemmas that could benefit from "talking through" with any other professional who is curious, sympathetic and suitably trained for this task, regardless of formal role. In the courses we have run over the years in "Conversations Inviting Change," some of the most exciting exchanges we have seen involved the most seemingly improbable of combinations: an anaesthetist supervising a counsellor, or a mental health social worker helping a medical education manager to reflect on a work problem. Seeing encounters such as this, and taking part in them, has helped to inspire the wide focus of this book. The variety of case vignettes are not present so that readers can seek out the ones that seem most obviously related to their own fields. Instead, they are there to demonstrate interprofessional similarities, and to indicate how much cross-fertilisation of ideas might be possible.

Challenges to narrative-based practice

The attractions of narrative ideas for health and social care professionals are clear. They offer a respectable intellectual framework for working in the twenty-first century – one that is no longer rooted in eighteenth-century mind/body dualism, or in Western individualism. They provide a single consistent way of thinking about all the different levels of their activity, including encounters with patients and clients, assessment, care planning, supervision, training, management work and political negotiation. They encourage us to question some of the apparently solid certainties of science and evidence. They offer a new view of such things as assessment and diagnosis, and sensitise practitioners to popular beliefs about illness and social deprivation. In addition, a narrative approach can help professionals to become more aware of their social and political roles. It encourages them to examine the power relations in their encounters with clients and with team members. It helps them to notice how power can be expressed in the subtleties of language, as well as in more obvious ways such as rudeness or paternalism. It can enrich their work by drawing their attention to the variety of cultures and beliefs with which they come into contact. It raises their awareness of gender, ethnicity and social class, including their own. It alerts them to the experiences of people living in adverse circumstances such as refugees. It can also assist them in letting go of a constant sense of responsibility for other people's problems, and in acquiring a greater sense of the possibilities open to the people they see in the course of their work.

If attractions of this kind of approach are numerous, so are the challenges. People expect professionals to be experts who can offer conventional explanations for their problems and deal with them accordingly. A narrative approach

should help those working in health and social care to let go of rigid certainty about facts, but it should not make them so uncertain about everything that they feel unable to do their jobs. Professionals are not only paid to listen and speak. They also have to do things: to assess capacity, write care plans, mediate, advise, assess risk, take statutory action, stick needles into people, dispense drugs and carry out operations. They have to face disagreement, hostility and aggression. A narrative approach cannot ignore power relationships or exclude action. Nor can it be a licence for avoiding all the other normal professional tasks, such as giving advice, educating people, offering reassurance, assessing risks, or breaking bad news. It needs to fit a world where practitioners are regularly crossing over between different activities – such as helping with a marital or parenting problem and then having to make a court recommendation.

There is another obvious challenge. Most professionals have to work under tremendous pressure of time and workload. They face demands from managers and politicians, as well as resource shortages and constant organisational change. There is no point in trying to import narrative ideas and skills into everyday encounters if these only work in conversations lasting an hour, or when seeing people at regular intervals of every week or two, or by regularly inviting whole families to attend. Nor will they be helpful if they open up a "Pandora's box" that the interviewers do not have the skills or the resources to cope with.

One common first response of professionals when they encounter narrative-based practice for the first time is often: "In an ideal world we would use it, but it isn't possible given the kind of pressure we work under nowadays." They cite such constraints as limited consultation times, performance targets, standardised guidelines, the presence of computers and electronic record-keeping, along with wider problems of changing demographics among clients (including many who do not speak English and may need interpreters), as well as changing workforce patterns, including locum working. In addition, when people try out some of the techniques of narrative practice, they may find at first that it prolongs encounters. Very often, however, they later report that acquisition of a narrative-based stance leads to working that is not only faster, but actively assists most of the other tasks that need to be addressed in pressurised workplaces. It seems that a focus on the client's narrative from the outset creates trust and rapport, which then makes it possible for interviewers to address some of their official tasks such as record-keeping more transparently and efficiently. In the same way, approaching encounters with the conscious intention of paying attention to context (for example, cultural differences, the effects of translation or the transience of the professional relationship) makes it easier to take them into account and adjust to them than if these are regarded as obstacles to good practice. In the course of this book, there will be many examples to demonstrate how narrative-based practice can actually facilitate more effective working under pressure rather than adding extra unrealistic demands.

The "narrative turn" itself has also had its critics. Some have pointed out – with justice – that the term "narrative" is now used by different writers to describe everything from short spoken utterances to so-called "grand narratives" such as Marxism or neo-liberalism (Woods, 2011). Others have drawn attention to the tendency of narrative scholars to place an emphasis on Western middle-class constructions in place of culturally diverse ones (Saville-Troike, 1989), on long-term instead of episodic experience (Strawson, 2004), on good stories in preference to deceitful or manipulative ones (Gabriel, 2004), and on language at the expense of other forms of expression, including body language and silence (Sartwell, 2000). In spite of this, narrative theorists have, by and large, been able to hold on to their positions through accommodating to these critiques, and by promoting the strengths of their defining stance, rather than trying to defend specific articles of faith.

The biggest challenge in taking a narrative approach is knowing when to stop. Disease, disability, deprivation and death are not "just stories." Although they may be open to different interpretation by different individuals and cultures, they each rest on a bedrock of incontestable reality. Professionals who get carried away by narrative ideas to the point where they forget this are not safe (Launer, 1996). Knowledge applied uncritically can lead to abuses of power, but pursuing narratives without a sense of realism can be literally fatal. Narrative ideas can help people question their own convictions, but no one should play linguistic games with people's lives.

The approach described in this book is an attempt to address all these challenges. It tries to do justice to a complex and sophisticated body of contemporary thought, while also paying respect to the realities of life in the health and social services. It imports some quite difficult concepts and techniques, without overloading busy professionals with excessively abstract theories or with jargon. The overriding intention is to present ideas in a way that is accessible and applicable. The aim is to bring them into routine work in a way that enables practitioners and shares more power with clients. When the book refers to therapy, this does not imply formal sessions, nor working with whole families. It means therapy in its literal sense: a form of healing.

This is emphatically a book about *practice*, specifically about the use of "Conversations Inviting Change." It does not give a detailed account of narrative theory, of the kind you might find in textbooks of social science, nor does it explain how to use literary texts to enhance professional training or sensitivity. It contains no guidance about carrying out narrative research into the stories that patients and/or professionals tell and write. Instead, this book is about how practitioners and their clients can create richer meaning in their encounters. It chiefly addresses the question "How do we speak (or not speak), and what do we do (or not do) from moment to moment, if we understand the world as constructed to a significant degree by the stories that we and other people tell each other?"

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