

From Microscope to Comfy Chair: Imaging Control in Interview Situations

Susan Fairbairn
Gavin Fairbairn

Abstract

We present a simple model for thinking about control in interview situations that was developed as a tool for use in analyzing clinical interviews during research on the teaching of communication skills in nurse education. It takes the form of a series of metaphorical images—microscope, picture frame, mirror, and two comfy chairs—that correspond to points on a continuum of levels of control exerted by interviewers. We elaborate our description of the model in relation to two areas: clinical interviewing and the supervision of nursing students during clinical placements. We also discuss the idea that running alongside the continuum from microscope to comfy chair is a second continuum, from low to high empathy, with *microscope* representing the lowest level of empathy and *comfy chair* the highest. Finally, we draw attention to some other areas where this model may be helpful.

Many professional situations involve dyadic communications in which one person directs or controls the course of the interaction, such as:

- Consultations or interviews between clinicians and patients
- Supervision sessions between trainee nurses and their supervisors
- Interviews between lawyers or social workers and their clients
- Research supervision between doctoral students and their professors
- Discussions between sales representatives and customers
- Interviews between police officers and suspects.

We present a model that we find useful for thinking about the ways in which, and the extent to which,

control is exerted in such situations. The model takes the form of a series of metaphorical images—microscope, picture frame, mirror, and two comfy chairs—that correspond to different levels of control. We focus on two areas: clinical interviews and the discussions that go on between student nurses and their clinical supervisors. However, it is clear to us that what we have to say is just as relevant in the other situations listed and in many that we have not mentioned.

Origins of the Model

Many years ago, one of us was involved in research about the teaching of communication skills in nurse education. This research focused on the ways in which clinicians conduct interviews with patients, and it included reference to, for example, clarification, structure, and control. A series of metaphorical images were helpful in achieving interrater reliability on control among research staff who rated these interviews:

- A high-powered microscope
- A picture frame
- A mirror
- Two comfy chairs.

These four images were used to represent a continuum from a highly specific and focused approach to interviewing, suggested by the image of the microscope, all the way through to the more relaxed and easy approach represented by the image of two comfy chairs. They corresponded to different levels of control on the part of the clinicians who were its subjects.

Whereas a clinician in microscope mode would zoom in on very particular details of the patient's life, the message conveyed to a patient by a clinician using the comfy chair approach was typically something

Susan Fairbairn is a Researcher and PhD candidate at the School of Cultural Studies, Faculty of Arts and Society at Leeds Metropolitan University in Leeds, United Kingdom. E-mail: ssnfrbrn@aol.com.
Gavin Fairbairn is Professor of Ethics and Language at Leeds Metropolitan University in Leeds, United Kingdom. E-mail: g.fairbairn@leedsmet.ac.uk.

such as “Here, let’s sit down together. What shall we talk about?” Between these extremes, picture-frame clinicians allowed patients more room to decide what they talked about than those working in microscope mode, and those who adopted mirror mode gave them even more room, though they were less open than comfy chair clinicians.

From Microscope to Comfy Chair: A Continuum

Though this set of images was developed as a research tool, we have subsequently found it useful in discussing many situations in which dyadic communication plays a significant role, including clinical interviewing and the support and supervision of student nurses undertaking placements. Our particular concern is with the way in which in such situations one person—the clinician or teacher/supervisor—exerts control over what is talked about and when it is talked about. The images are as follows.

Microscope

The microscope is about focus. In the context of nurse education, for example, it is about the kind of encounter with a student where a nurse teacher might say, “Did you manage to take Ms Royton’s blood pressure?”

This question gives the student no room to maneuver. By focusing on one clinical skill, the teacher imposes a fixed and limited topic for discussion and has no interest in anything else for the moment. In a clinical context, a community nurse working in cancer care who scored “microscope” might, for example, enter a patient’s home and get right to the point by asking, “Are you coping better with the implants now?” or “Is the pain a bit less today?” or “Have your bowels moved yet?” To use educational jargon, the microscope approach is often about very closed questions and frequently leads to little more than a simple yes or no answer.

Picture Frame

The picture frame suggests more room for movement and choice about what to talk about, than the microscope, but it is still constrained. For example, in a clinical context, community nurses in picture-frame mode might ask patients, “How has the pain been since your medication was changed?” By doing

so, they invite patients to reflect on and report any changes in their pain that have occurred. However, attention is still focused on one of the topics in which they are interested (the pain) rather than allowing patients to choose what to talk about.

In an educational context, nurse teachers in picture-frame mode give students some freedom to decide the agenda, to share concerns and worries, and perhaps to ask for advice, help, guidance, or information. However, their questions, some of which might be more open and others of which are gently leading, implicitly limit the answers that are possible. In other words, in this approach, nurse teachers bound discussion with students by a frame of relevance beyond which they will not go. For example, they might ask, “How did things go when you took Ms Royton’s blood pressure today?” By doing so, they give students an opportunity to elaborate on their experience of this simple procedure, thus leaving space for them to explain, for example, that although they managed to measure Ms Royton’s blood pressure successfully, they had taken a little time before doing so to talk about her problems with her washing machine.

Mirror

Clinical teachers in mirror mode are likely to ask questions that are more open than those that they might ask in picture-frame mode. For example, they might ask, “How are things going on the unit?” This question gives students permission to refer to problems or achievements in their work, but the extent to which students feel empowered to share issues outside this context, including personal concerns about, for example, classroom examinations or relationships, is likely to be limited. In other words, in mirror mode clinical teachers will simply reflect things back to students, thus in a sense inviting or even just leaving them to take responsibility for their own growth and development. This might be viewed positively, as an exemplar of student-centered learning. It might be viewed as modeling reflection, helping students to examine their practice and their feelings, as well as their use of knowledge and skill. However, it might be viewed negatively. For example, someone who believes that clinical teachers should offer supportive feedback in relation to what they have observed and heard might frown on teachers who simply reflect back to students whatever they say, all the while expecting them to assess how well they are doing, rather than drawing attention to observed weaknesses

Our particular concern is with the way in which in such situations one person—the clinician or teacher/supervisor—exerts control over what is talked about and when it is talked about.

or strengths. At worst, this might be viewed as a lack of willingness to share responsibility for the students' progress or lack of progress.

In a clinical context, community nurses in mirror mode might ask patients, "How have you been since you left the hospital?" The image of the mirror captures the fact that although they are giving patients a lot of freedom to decide what to talk about, what follows is not a genuine dialogue. Rather, they are simply reflecting back the things that patients say in a kind of parody of Rogerian counseling.^{1,2} However, it is worth noting that because clinicians who adopt this approach are "holding the mirror," they still retain control over which topics are reflected or ignored.

Two Comfy Chairs

Comfy chair clinicians are motivated by the belief that the best way to help patients is to engage them as whole people, whose health both influences and is influenced by everything that happens to them. Comfy chair clinicians believe that the most efficient way of working out how best to help is to give patients the space to talk and the opportunity to identify health concerns in their own way. To do so, comfy chair clinicians need to put patients at ease, so that they feel able to talk about anything that might be affecting their health. That is why, for example, clinicians in this mode will typically use a very open style of interviewing, asking, for example, "How are things?" or "What would you like to talk about?" Apart from helping to put patients at ease, this personal style allows for the possibility that whatever a patient's problems, they may be best helped at that moment by being given the opportunity to talk about aspects of life that may seem objectively to have nothing to do with their condition. For instance, cancer patients who, objectively speaking, are faring very poorly may have other things on their mind that it is important to address, because in addition to being a patient, they are also people with other concerns; they may, for example, be preoccupied with worry about a child who is underachieving at school.

The clinician who takes the comfy chair approach would probably agree with Tuckett et al³ that encounters between clinicians and patients are essentially "meetings between experts." Those who share this view recognize that although patients will usually have limited clinical knowledge, they will always be experts on their own lives and symptoms. At the same time, however, they will also acknowledge that clinicians will typically have a greater grasp of what

the patients' symptoms might mean, even though they do not share directly in their experience.

In an educational context, the comfy chair approach is exemplified by nurse teachers who say to their students, "Here, sit down and tell me about it. What matters to you right now? What can I do to help and support you?" At times we all need to have the space to share what is worrying us, because unless we do, we may not be able to focus well enough on the work that we are doing, to be able to do it properly. Student nurses might want to use discussions with teachers or supervisors to clarify an understanding of some aspect of knowledge or skill relating to nursing. However, given the opportunity, they might appreciate support with aspects of their personal lives, because at the moment those are their highest priority. For example, they might be so distracted by concerns at being rejected by a friend, or by worries about rent or a troublesome neighbor, that they are unable to perform their roles on the unit as well as they might.

To function efficiently, nurses and practitioners in other professions that involve caring for human welfare and flourishing, such as medicine, counseling, and social work, depend, for example, on their ability to observe carefully, to make reasoned decisions, to act confidently and competently, and to make therapeutic use of their relationships to patients or clients. It is because important abilities such as these can be adversely affected by anything that impinges negatively on the physical and psychological functioning of the clinician that it will often be appropriate for teachers and clinical supervisors to adopt the comfy chair style of looking after students during their training. Of course, this is also an important reason that those who manage the delivery of health and social care should take seriously the need to provide all of their staff with opportunities for clinical supervision.

Some people might form the view that mirror mode and the comfy chair approach are rather similar, because both provide a context in which people can raise a range of issues. However, the comfy chair approach gives people more room than mirror mode to make their own decisions in relation to what they speak about. In addition, it is important to note that comfy chair practitioners are at least arguably more respectful of the other as a person because they structure their interaction in ways that are more mutual, and in doing so, they are more present as a person in their interactions.

Empathy and Control

So far we have described a way of thinking about two-way transactions of a kind in which one person has responsibility for the other. The examples we have discussed have related to two areas: interactions between clinicians and patients and interactions between nurse teachers and student nurses undertaking clinical placements. Our particular concern has been with the way in which, in such situations, one person—the clinician or teacher, exerts control over what is talked about and when it is talked about. However, some people might form the view that as well as differences relating to control, there are, in the examples we have discussed, also differences between the extent to which empathy plays a part in the ways that teachers or clinicians interact with students or patients. The claim would be that running alongside the continuum from *microscope* to *comfy chair*, there is a second continuum, from low to high empathy, with *microscope* representing the lowest level and *comfy chair* the highest. There is a sense in which, at first thought, this idea seems reasonable. However, the relationship of empathy to the model is not so simple.

Empathy has been much discussed in recent years, mostly because of its popularity in the caring professions, where it is perhaps most closely associated with the work of person-centered counselors and therapists, whose approach is modeled on the work of Carl Rogers.^{1,2} However, with the growth of what we might call the counseling culture in many countries, talk of empathy has become common even among laypeople, who often speak about *empathizing* in situations in which they might, in the past, have said that they *understood* or *cared about* another person.

We can empathize with others in their joy and in their sadness; in their excitement; in their confusion, anxiety, and distress. Potts⁴ wrote that "... most people feel they can empathize when necessary." The truth is that whereas most of us cannot avoid being overcome with sympathy at times, empathy is another matter. Sympathy is an emotive response. Tschudin⁵ pointed out that it means "suffering with, feeling the same suffering." I (GF)⁶ write that it "comes from the gut, and may for that reason overwhelm us whenever we identify closely with another's situation." By contrast, as Carkhuff⁷ suggested, when we empathize, "... we try to understand with our minds what a person feels in his gut."

Whereas sympathy is an uncontrolled and im-

mediate emotional response to another, empathy is more controlled. It allows caring practitioners to get alongside others in times of trouble and pain and is often described as the "ability to see the world from another person's shoes," in other words, as the developed ability to imagine what one might feel like were one to find oneself in a given situation. I (GF) disagree with this view⁶ and have argued that empathy is more demanding than this:

It is about the attempt to understand and to experience things as another human person understands and experiences them, about the attempt imaginatively to inhabit another's world as that person, rather than to imagine what one's own experiences, perceptions and feelings would be, were one in that world.

More pithily, perhaps, Burnard and Kendrick⁸ wrote that in empathy, "... the person tries to imagine how it is to be the other person. Feeling sorry for that person does not really come into it."

As we move through the stages of our model from microscope to comfy chair, the level of empathy required of the interviewer might seem to increase. After all, at first glance it might seem that asking very direct and focused questions in microscope mode would take little thought, and that it need not, for example, involve any attempt on the part of the interviewer to understand the effects that the question might have on the other person. By contrast, the comfy chair approach seems, on the face of it, to demand the greatest attention to an individual's feelings and experience and the greatest effort on the part of the questioner to hear and understand what is said, from a position of imaginative engagement with the speaker. However, as we have already said, things are not so simple.

For example, in an educational context, clinical supervisors might adopt what looks like a comfy chair approach in relation to students, simply because they find that this is in general the best way to fill sessions with talk, rather than because they want to engage with students at a deep level. And clinical supervisors might adopt microscope mode, not because they are lacking in empathy and in the intention to relate to and understand the student as a person, but because they have worked out that in order to give that student the best possible help with an identified problem, they need to gain detailed information about the ways s/he is thinking, and about his or her understanding of some part of nursing practice.

Finding the Right Approach

From what we have said about the four images that comprise our model, it might seem that we want to persuade you that *comfy chair* is superior in a number of ways to the other approaches we have outlined, and there is perhaps a little truth in this; for example, we suggested that it is at least arguably more respectful of the other as a person. We do both have a special liking for the comfy chair approach, which seems to embody the values of respect for people that we hold to be centrally important in all ethically grounded human interactions. However, it is best to be clear that we do not believe that any of these approaches is unequivocally the right way to frame communications with another person in all situations, whether they are, for example, a patient or a clinical supervisee. Depending on the circumstances each approach will be appropriate at different times.

Comfy chair mode provides an overarching approach to making people feel comfortable and able to communicate as easily and as naturally as possible. This can be helpful not only in clinical and supervisory interviews but also in interviews of all kinds, even though for many people, communicating about some topics—for example, about serious health problems or about personal difficulties—will be hard, no matter the personal and professional style of the other person. Providing a kind of umbrella or metalevel for the whole enterprise, the comfy chair approach can allow interviewers to select from a range of more or less distinct interviewing modes, aimed at exploring topics in a detailed way while still allowing respondents or interviewees the opportunity to feel as comfortable as possible.

Skillful and committed clinicians who believe strongly in an approach to patients that regards them in their wholeness as people with lives that extend far beyond their symptoms and who thus favor the comfy chair approach will nonetheless at times probe microscopically in order to determine the facts about patients' experience that are necessary both for diagnosis and for making treatment decisions. At others, they will adopt picture-frame mode, allowing patients some room to digress from a focused approach, but less than they would in comfy chair mode; this might be appropriate in contexts where it is necessary to convey to patients not only the fact that they are important as people but also that time is unfortunately at a premium. Finally, if clinicians

were exploring emotive territory with a patient—for example, news of a terminal prognosis—they might adopt mirror mode as a way of allowing the patient to move gradually to a realization of the gravity of her or his situation.

Concluding Remarks: Applying the Model to Other Situations

The series of metaphorical images we have described was developed as a tool for analyzing interviews in a clinical context, and we have discussed its use in thinking about clinical interviews and about the supervision of student nurses during placements. We want to end by briefly elaborating our view that it could also be useful in thinking about any two-way human communication in which one person directs the course of the transaction. For example, we think it will prove useful in any context in which supervision is provided as a way of facilitating the development of skills and understanding, including the supervision of research students and the supervision of students undertaking professional placements in school teaching, social work, and law, as well as in clinical areas.

Finally, the comfy chair model of control in interview situations may also be useful in thinking about the variety of approaches to research interviewing, which may be conceived as lying on a continuum between a questionnaire in which the interviewer records the respondent's responses, through to narrative interviews. It seems to us that this continuum maps fairly well onto the model we have described. For example, research interviews whose purpose is to collect data for survey or questionnaire-type research seem to correspond pretty much to the microscope approach, whereas at the other end of the continuum the conversational interviews favored by narrative researchers seem to involve a kind of comfy chair approach, because they explicitly acknowledge the expertise of respondents in relation to their lives and experiences and give them a great deal of scope to talk about what matters to them.

Most medical and nursing practitioners will have received some training in communication skills and accumulated many hours of experience in interviewing situations. As a result, they will be able to

... the conversational interviews favored by narrative researchers ... explicitly acknowledge the expertise of respondents in relation to their lives and experiences and give them a great deal of scope to talk about what matters to them.

use a number of different skills in their interviewing. Our modest aim in this article was thus not to teach those who perhaps have more experience of interviewing than we have how they should engage in helpful dialogue with patients and students. Instead we wanted to share a way of thinking about control in interview situations that we have found helpful and that we hope colleagues may find of some use, both in reflecting on their own practice as interviewers and in enabling others to develop interviewing skills. ❖

Disclosure Statement

The author(s) have no conflicts of interest to disclose.

Acknowledgment

Katharine O'Moore-Klopf, ELS, of KOK Edit provided editorial assistance.

References

1. Rogers CR. Client-centered therapy, its current practice, implications, and theory. Boston, MA: Houghton Mifflin; 1951.
2. Rogers CR. On becoming a person; a therapist's view of psychotherapy. Boston, MA: Houghton Mifflin; 1961.
3. Tuckett D, Boulton M, Olson C, Williams A. Meetings between experts: an approach to sharing ideas in medical consultations. London and New York: Tavistock; 1985.
4. Potts S. Everylife: death bereavement and life through the eyes of children, parents and practitioners. Salisbury: APS Publishing; 2005.
5. Tschudin V. Ethics in nursing: the caring relationship. London: Heinemann; 1986.
6. Fairbairn G. Storytelling ethics and empathy. *Ethical Space* 2002;3:48–55.
7. Carkhuff R. The art of helping. Amherst, MA: Human Resource Development Press; 1973.
8. Burnard P, Kendrick K. Ethical counselling: a workbook for nurses. London: Arnold; 1998.

The Gift

We are born weak, we need strength;
 helpless, we need aid;
 foolish, we need reason.
 All that we lack at birth,
 all that we need
 when we come to man's estate,
 is the gift of education.

— *Jean-Jacques Rousseau, 1712-1778,*
Swiss philosopher, writer, and composer