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Carol A. B. Warren
University of Southern California

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Carol A. B. Warren
University of Southern California

ABSTRACT

This paper explores the interpenetration of clinical and research interviewing processes in research interviews The data are interviews with 17 women diagnosed as schizophrenic, and with their husbands, over the period 1957–1961. The interviews began with the first week of admission to Napa state hospital, and ended up to two years after discharge. The respondents were in a situation of medical uncertainty and marital disruption. They utilized both the form and the content of the research interviews in a therapeutic manner, seeking advice, opinions and information from the interviewers. The interviewers, as they had been trained to do, attempted to resist their respondents' demands, not always successfully.

With the entry of Clinical Sociology into Sociology's ever-widening range of subspecialities, the issue of the interpenetration of clinical and research interests in interviewing and field research has become increasingly salient. This paper is concerned with the clinical implications of research interviews, a theme which is represented only sparsely in the existing literature (e.g., Laslett and Rapoport, 1975; Rubin, 1976). With the development of internships in behavior-changing programs for clinical and other applied sociologists, the problem has also been analyzed "the other way around" as it were, with reference to the insertion of research agendas into clinical field placements (e.g., Vogler, 1982).

The data upon which this paper is based are 15,000 pages of interviews

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Correspondence to: Carol A B Warren, Social Science Research Institute, University of Southern California, University Park, Los Angeles, CA 90089

with 17 schizophrenic women and 16 of their husbands collected between 1957 and 1961. The mean number of interviews per respondent averaged 50, and took place at intervals ranging from weekly to bimonthly, beginning with the first week of mental hospitalization for schizophrenia at Napa State Hospital, and ending up to two years after discharge. The women were all white, between the ages of 26 and 40, and with at least one child. For all but two of the wives this was their first admission. This data set has become known as the "Bay Area" study (Sampson et al., 1964).

Because the Bay Area interviews were on the topic of mental illness and hospitalization, and were repeated over time, they are an ideal data set for the analysis of clinical processes in research interviewing. Two other interview studies which attend to this same issue also utilized repeated interviews, but were not focused on the topic of mental illness: Rubin's (1979) interviews with working class families, and Laslett and Rapoport's (1975) interviews with the families of British "school leavers."

Clinical and Research Models

Both clinical and research interviewing involve the elicitation of self-talk from a client or respondent by an interviewer, with the respondent's beliefs, feelings, ideas, or life-situation at issue rather than the interviewer's. Although the specific topics of clinical and research interviews may be similar, the responses they elicit are utilized for different purposes. While the talk elicited in the clinical interview is designed to help the client achieve some increase in life satisfaction, the talk elicited in the research interview is utilized in a manner unconnected with the respondent's feelings or goals.

Both clinical and research interviews are undertaken by persons trained in particular ways. Clinicians are trained to elicit information and provide help according to explicit models of appropriate therapeutic intervention, while researchers are more often exhorted to avoid very similar sorts of behavior. Clinicians in general see the task of therapeutic intervention as one which nonclinicians should refrain from, on the grounds that harms rather than benefits may flow from the untrained and the unlicensed. Research interviewers seem to concur. The Bay Area researchers were warned by their supervisors not to act as clinicians during interviews. In the initial negotiations, Napa psychiatrists expressed fears for their clients related to the overlap of the research and the clinical in the interview situation:

> [Dr. H, a psychiatrist] listened quietly [to one of the researchers who was trying to convince him to grant interviews with patients] and then began to present hesitations. He was "certain" that there would be "significant dilution of the therapeutic relationship" [if the re-

> searchers were allowed to interview the patient]. He "understood our point of view" but any sort of regular relationship was bound to be therapeutic (or antitherapeutic) notwithstanding our "intentions."

Ironically, about a month after he had granted the researchers access to patients, Dr. H attempted to utilize the research interviews to obtain data on one patient, Ann Rand,[1] as part of his clinical case development. At this point the tables were turned, and the researcher became concerned that the interview material would interfere with Mrs. Rand's therapy:

> I then asked to talk to Dr. H for a few minutes and he agreed, and we went off to his office. I said that I wanted to talk to him about the problem of my communicating my findings and data to him. I understood that he was planning to see Mrs. Rand on an outpatient basis, and . . . I wondered about the possible effect it might have on his own handling of the case. I said that I would rather postpone my presentation until he was completely through seeing Mrs. Rand. Then followed some brief discussion on our part about the problems I face in interviewing the patient and her husband, and of the uncertainties involved in not having any therapeutic relationship and trying to avoid one, and yet at the same time looking for information which could frequently come out only in a therapeutic kind of situation.

The researchers' fears of doing harm to their respondents surfaced from time to time during the interviews. One interviewer, for example, blamed himself for the respondent's failure to perform well at her discharge conference. His preconference interview, he believed, had helped to precipitate her readmission to the state hospital:

> (Mrs. Sand 7.30.58) Gradually, as I probed into such areas as her relationship with her husband and plans for the future, she became more preoccupied, and somewhat depressed and withdrawn . . . I felt somewhat concerned about her, and also felt, realistically or not, that I was in part responsible for her being this way as a result of my questioning her in these troublesome areas . . . I had helped to break down her defenses against depressive feelings, which interfered with her ability to handle herself at [the discharge] conference.

At other times, talking with the interviewers functioned to relieve, rather than exacerbate, the respondents' negative emotions:

> (Mrs. Baker 1.13.59) she greeted me [and] went on to say, "Ever since I exploded and talked to you it seems to have lifted a great big cloud off my mind."

The supervisors in the Laslett and Rapoport (1975) team study were concerned not so much with avoiding dangers related to the therapeutic or antitherapeutic dimensions of research interviewing as with accounting for them as a dimension of method. The researchers note that what is different about their "collaborative" interviewing method is the emotional involvement of respondents in the research enterprise. They state that:

> What is specific to this method is the amount of effort expended to make the interviewer aware of his or her own feelings in the interview situation and how these feelings affect the interview process. It is here that the psychodynamic aspect of the research technique is particularly evident, in its concern with processes of transference and countertransference as they affect the interview and analytic procedures. (Laslett and Rapoport, 1975:970)

De Santis (1980:93) also refers to the development of mutual transference "bonds" in her one-shot interviews with physicians:

> The circumstances [of the interview] permitted us, two previously unacquainted individuals, to create a powerful bond which was forged in the process of sharing personal thoughts and opinions.

The Bay Area supervisors (two psychiatrists and a sociologist) and the eight interviewers (including the three supervisors) were similarly attentive to the methodological implications of the repeat-interview method (Sampson et al., 1964). They were also concerned with the opposite problem—that of ad hoc clinical interventions by research interviewers during the interview process. Although the Bay Area interviewers were to look for the "real meanings" of respondents' communications in both a psychological and a sociological sense (Sampson et al., 1964), they were not to offer these interpretations to the respondents. They were also to avoid giving advice and opinions on both clinical progress and marital relationships. Like both Rubin (1976) and Laslett and Rapoport's (1975) team, the Bay Area interviewers were additionally faced with special problems related to interviewing both the husband and the wife of a spousal dyad.

Despite these various prohibitions, however, the Bay Area interviewers were asked continually for advice, opinions, and information concerned with clinical, marital and more mundane everyday life problems. They were drawn

into dyadic conflict; they made verbalized interpretations of the "real meanings" of communications; and they tailored the frequency, length and other structural dimensions of the interview to the perceived "emotional needs" of the respondents. The interview transcripts also provide evidence of various transference and (less commonly) countertransference phenomena; if one wishes to translate from psychodynamic to social psychological terminology one might refer to attempts at identification with the researcher on the part of the respondent (very, very rarely the reverse.)[2]

Information, Opinions, and Advice

Researchers, clinicians, respondents and clients have a variety of needs and aims in the interview situation. Clients in a therapeutic situation want to be heard with care and courtesy.[3] Respondents in an interview situation must be willing to engage in structured interaction (DeSantis, 1980:79). In the research interview, in addition, the participants negotiate a "research bargain" by which each gets his or her needs attended to.[4] While researchers generally seek access to truthful and valid data, respondents' desires are as diverse as their life situations (Douglas, 1976).

The Bay Area respondents were in a life situation of marital disruption and, in the case of the wives, of mental patienthood. They were given little if any information about diagnosis, prognosis, or treatment, and thus were in a state of considerable uncertainty. Not surprisingly, in these circumstances, the Bay Area respondents attempted to press the research interviewers into service as information-, opinion-, and advice-givers in both the marital and medical spheres. In addition, they asked the researchers for small personal services, such as the bringing of slippers from home to hospital; with these sorts of request the researchers generally complied.

The respondents saw the interviewers as mental health experts (which was true in six out of eight cases) and as connected with the state hospital (which was only somewhat true); therefore, they turned to them for clinical information not provided by the hospital staff. The interview transcripts demonstrate various points of negotiation or struggle between the interviewers and respondents over the provision of clinical information and medical or marital opinions and advice. The respondents did not understand, and often resented, the interviewers' evasions of their direct questions:

> Eve Low asked the interviewer to give her advice about leaving her husband, which the interviewer refused to give. Eve complained that her [outpatient] psychologist would not give advice either, and "I don't want to do anything until I get some advice."

As Eve Low's experience indicates, both the clinical and the research models of interviewing discourage the provision of specific advice to respondents, and even opinion or information giving may be suspect. However, in the Bay Area interviews the interviewers were sometimes tempted or pressed into giving the respondents what they wanted:

> (Mr. Sand 6.25.58) During this talk with him I was debating in my mind whether or not I should tell him that his wife was being discharged from the hospital that day. I figured that he would find out about it eventually and that if I didn't tell him now this would aggravate [him]. However, in view of the fact that . . . the news . . . was likely to provoke a strong reaction, and lead to some possible action on his part, I refrained from doing so.

> Interviewer: "Did you tell the ward nurse about your discharge plans [for his wife]?"
> Mr. Quinn: "Yes, sure I did—I thought they would be very—well, in fact you told me to do that."[5]

Seeking therapeutic opinions and information from the research interviewers was, as indicated, one by-product of the lack of information provided by the mental hospital. Respondents wanted the Bay Area interviewers to tell them what they themselves thought of the women's mental status, and to pass on what the Napa psychiatrists thought. Again, the interviewers attempted to avoid giving therapeutic opinions or information, usually by claiming a lack of expertise or knowledge:

> Mr. Quinn then proceeded to ask me what I thought about his wife's condition, how long I thought she would be there, and what I think about the prognosis. I told him I can't answer his questions because I just don't know. He then said that I must have an opinion. I told him all I can say is that patients vary considerably, and I would have no way of predicting in his wife's case. After a little more pressure from Mr. Quinn, I finally suggested to him that what he's really concerned about is that whether she will get out of the hospital and give him trouble—that he's afraid he may find himself in the same unpleasant situation. His response at first was to say that he hadn't thought about it that way, and then after a pause said I was probably right.

Dyads and Triads

Special information-negotiation problems result from the separate interviewing of members of a dyad, as Mr. Quinn's comments indicate. Like marriage counselors, the Bay Area research interviewers were faced with the issue of being a third party to an ongoing, often problematic dyadic relationship. Unlike marriage counselors, the research interviewers' purposes were related not to conjoint therapeutic interventions in the dyad, but to separate data gathering with respect to it. As a consequence of this interview structure and/or of the respondents' life situation, individual spouses attempted to obtain both therapeutic and life-activity information about the other spouse from the research interviewers.

On those occasions when the Bay Area researchers did do joint interviews with the spouse they sometimes took on the functions of marital therapist:

> (Joint interview, the Whites) I would like to note . . . that several times during the interview both patient and husband remarked to each other to the effect that they hadn't realized the other had held the view just expressed.

On this occasion, the interviewer adopted the relatively benign clinical role of the facilitator, neither giving opinions nor advice but allowing the spouses to communicate with one another. At other times, the researcher-respondent interactions took on some of the less benign qualities described by Simmel (1950) in his analysis of the conflict attendant upon the expansion of dyads into triads.

In interviewing husbands and wives separately, the Bay Area interviewer sometimes found him- or herself in the situation of the *tertius gaudens* (Simmel, 1950), a third party who—quite unclinicianlike—profits from, and thus foments conflict in the marital dyad. Despite the allure of digging data out of such conflicts, none of the Bay Area researchers seemed willingly to play the role of the *tertius gaudens*. However, some found themselves placed, generally despite their intentions, in such a role. In the following example, this occurred simply because of a refusal to pass on information:

> Mr. Sand . . . told me that he didn't see any point going on [with the interviews] . . . He asked me if I had talked to his wife that day, and when I did not answer at once he repeated the question and I finally told him that I did . . . He told me that . . . I knew things about what was going on at the hospital with his wife, and I didn't tell him a thing about it. He brought this up a few times . . . saying that a person isn't much of a friend if he hides important things like this [his wife had been having an affair with a fellow-patient, which the interviewer did in fact know about] from someone.

At times, one spouse would attempt to ally him- or herself with the interviewer in a joint interview, again casting the interviewer into the *tertius gaudens* role:

> The husband was in a way coaching his wife as to what to bring up for a discussion with me and as to what to say. He would frequently tell her, "Tell Dr. C about such and such," or "Didn't you want to say something about this?" or "There was a question you wanted to ask Dr. C." I would see some of the frustration that Mrs. White had in dealing with her husband . . . I also feel that part of Mrs. White's increasingly negative attitude toward psychiatry, and thus, I assume, me, at this time, was fostered by the fact that her husband tried to move in the direction of some sort of alliance with me. At least he seemed to try to protect me at times from her more negative comments about psychology.

Another type of dyadic coalition was that between the husband and his wife's psychiatrist. Mr. Vick, for example, behaved like a sort of clinical aide for the psychiatrist, collecting and interpreting material about his wife's family in order to "help" with what he called her "case." Since Mr. Vick also saw the Bay Area interviewer as a psychiatrist, he attempted to align with him in what Goffman (1961) calls an "alienative psychiatric coalition" against his wife. At one point he compared his own therapy with a social worker to the research interviews, and commented:

> (Mr. Vick 2.4.58) "Oh, that . . . It's a different thing. With her we work on me, but with you we work on Rita [his wife]."

Interpretations and Interventions

As data analysts, the Bay Area research team was interested in making various psychodynamic as well as sociological generalizations (Sampson et al., 1964). However, they were instructed not to communicate the results of their interpretive work to the respondents. From the professional therapist's point of view (which the Bay Area team seemed to accept), such verbalized interpretations—while they are the very stuff of clinical interviewing—might be antitherapeutic and even harmful when done by research interviewers.

However, from time to time, the Bay Area interviewers performed this sort of emotional-interpretive function, in what was, from a purely clinical point of view, a somewhat ad hoc manner.[6] In one of the interviews quoted above, for example, the interviewer ventured to suggest to Mr. Quinn the "real meaning" of his search for the researcher's opinion concerning his wife's prognosis. The interview continued in the same therapeutic vein:

> There was another pause and then Mr. Quinn leaned forward intently and said something like, "I guess the fact is that I don't want her to get better. That's an awful way to feel, isn't it?" I shrugged my shoulders and said something to the effect that well, we can't always feel the way we would like to feel. He then said something like, "No, but that's immoral, isn't it?" I again shrugged my shoulders and said something intended to be neutral, but which was probably more permissive of his feeling than otherwise.

The Bay Area interviewers referred occasionally to intentional therapeutic interventions. These interventions were not related to communicative content in the way that advice, opinions, information-giving and interpretations are. Instead, they took the form of ad hoc modifications of the length, frequency or format of the interviews; modifications done not for data gathering but for clinical purposes.

> (Joyce Noon 4.3.59) I had originally anticipated that I would stop the interview after about one tape, but since Joyce seemed to be getting some benefit from talking to me and expressing her feelings, I went on for another tape to give her further opportunity to do so.

From the Bay Area respondents' point of view, the therapeutic function of the interviews themselves—their existence and timing, as over against their content—was dependent upon a number of factors related to the patient's current life situation. Most of the women welcomed the activity of being interviewed while they were in the mental hospital, since it gave them the opportunity to have their communications taken seriously by someone. In the ex-patient phase, however, the interviewing process functioned, for some of the women and their husbands, as an unwanted reminder of the hospital episode:

> June Mark again tells me that she cannot fully participate in the research simply because the research in itself signifies the stigma of deviance which she is struggling to avoid . . . "I don't like being a guinea pig . . . you keep asking a lot of questions . . . things I want to forget about . . . It's not normal, my talking to you . . . It's just that I'm reminded I'm a patient. If you're a patient, you're always a patient."

A number of ex-patients rejected outpatient therapy, even though it might be helpful to them, on the same grounds. By contrast, women who had significant emotional needs in the ex-patient phase of the moral career tended to welcome the research interview on therapeutic grounds:

> I had the feeling that Irene James was desperately trying to gain some control over her feelings and thoughts by talking about them to me, but unfortunately I did not feel that she was very successful in the attempt. Irene says that when I arrive for the interview, that seems reassuring.

Transference and Identification

As Laslett and Rapoport (1975) note, their team research project was concerned with psychodynamic processes of transference and countertransference as aspects of method. They refer to transference as:

> A somewhat neglected methodological concern. It refers to the way in which the respondents' feelings about the interviewer, derived from the former's past experience, irrespective of the latter's current behavior, may shape the answers that are provided . . . An even less recognized phenomenon in the standard interview situation is *counter*transference. Countertransference refers to the feeling and responses which the interviewer (or, in the therapeutic situation, the clinician) has in response to the interview situation. (Laslett and Rapoport, 1975:970)

The Bay Area interview transcripts provided evidence of both transference and countertransference processes between researchers and respondents. Transference phenomena symbolically linked the interviewer with the respondent's familial or psychiatric significant others:

> Mr. White mentioned that his wife thought I was disappointed in her last week. This was perhaps, she thought, due to her not taking her medicine.

> Mrs. Quinn also told me about a number of strange ideas that she had when she first went into the hospital, and she stated that I am the first person she has told this to. As one example she mentioned the fact that the first time I took her out on the grounds, she "associated me with" a psychiatrist she used to work with. She stated that I look something like him. Apparently she had the idea I was the same person.

In some sense, countertransference may be seen as the psychodynamic equivalent of the qualitative interviewer's *verstehen* method. But, as Laslett and Rapoport (1975) describe it, countertransference involves an empathy based on

the researcher's own life context rather than one based on the respondent's. Thus, one of the consequences of countertransference is that the researcher may inadvertently intervene in the respondent's life events:

> Rita Vick asked me, with an anxious look, if they would come and get her (she has gone AWOL from Napa after a ten day home visit pass) if she didn't return. I replied that I didn't know, but I doubt it. My feeling at that time was that I was wanted to be of some help . . . since I empathized with her negative feelings about the hospital . . . I automatically reacted as though anything I said which would make it easier for her to stay out of the hospital would necessarily be helpful. That this was a mistake became clear very quickly as Mrs. Vick began to express her own strong feelings that she is still sick and ought to return.

In addition to psychodynamic transference and countertransference, the Bay Area interviews illustrated parallel social-psychological processes which is referred to elsewhere as identification and disidentification (Warren and Mauldin, 1980). While the transference phenomena involve emotions connected with significant others (often parents or spouses) identification mechanisms refer back to emotions related to the generalized other: what sort of person one has learned that one ought to be, or not to be like. Mental patients, as Goffman (1961) has shown, are in a special position with regard to the generalized other. While wishing to identify with a properly moral, in-control self, they have been publicly identified as mental patients, and thus as not morally appropriate at all. Thus, for mental patient or ex-patient respondents, the research interviewer tends to "stand for" the generalized other in the social process, just as the clinician "stands for" significant others in the psychoanalytic process.

The appeal of identification, then, is to the generalized other or social standards which are held in common and in equality with the interviewer. Since the Bay Area interviewers attempted to remain reasonably uninformative about their own private lives, their respondents' attempts at identification remained at the same superficial level encountered in brief visits to mental hospitals or courts. Comments directed at the interviewer's clothing, hairstyle or behavior in relation to the patient's own were the most common identification expressions:

> En route to the receiving suite, I mentioned that I was late because I'd gotten myself locked out of my car. Eve Low said, "Oh my, that sounds like something I'd be likely to do."

Occasionally, biographic intimacy proceeded enough in the reverse direction for, say, female patients or ex-patients to make identifying comments about a female

researcher's pregnancy or childcare problems. Interestingly, although the Bay Area patients occasionally triggered countertransference, they did not promote identification on the part of the researchers. From the point of view of the generalized other, the researchers were in the normative and the patient respondents in the counternormative position. Although the respondents did not "rub the noses" of their respondents in this fact, so to speak, they also did not identify with them at the social-psychological level.

Conclusion

Analyzing the Bay Area interviews indicates that the clinical and research functions of interviewing tend to overlap, despite the interest of sociological researchers in avoiding clinical interpretations or interventions. These interviews also indicate that being therapeutic is often as much a matter of function as intention; as much an issue of being cast into a role as taking one on.

What is also clear is that the social context in which the interviewing takes place affects the relative balance of clinical and research processes. The topic of the interviewing—in this case mental illness and mental hospitalization—is undoubtedly quite salient to the issue, as Dr. H noted in the planning stages of the Bay Area research. The lack of clinical information, and during the hospital phase the lack of contact with one's spouse and family, are also relevant. Under circumstances of uncertainty, any and all apparent "experts" or contacts are likely to be pressed into advisement service.

Finally, the meaning that the interviewing process has in the lives of respondents is interesting in general, and for its illumination of the clinical aspects of research interviewing. Both for the purposes of understanding the ways in which the method of data gathering influences the data, and for understanding the psychodynamic aspects of the interview process itself, an examination of the interaction of the clinical and the pedagogical enterprises in sociological research can be instructive, the more so as the clinical and research agendas of our discipline come to overlap.

NOTES

1 The pseudonyms used in this study are the same ones used in the original Bay Area research publications (Sampson et al., 1964)

2. Other interviewers studying the "mentally ill" do report countertransference or counteridentification. Barry Glassner (personal communication) comments that in his interviews with manic depressives he came to the conclusion that they "behave normally and the rest of us don't " More generally, as Glassner notes, such counteridentification is what "going native" is all about.

3. Barry Glassner, personal communication, August 1985.

4. For a summary of the research bargain literature and my criticism of it, see Warren (1984b). The analogy for a clinician-client research bargain might be summarized as. The client wants to obtain

insight and better life satisfaction, while the clinician expects to gain an income, and perhaps also a sense of professional satisfaction.

5. To be fair to the interviewer in question, there is no evidence from the transcripts that he advised Mr. Quinn in this manner

6. A clinician's judgment of the appropriateness of research interviewers' therapeutic interventions would probably be based on the degree of clinical training the research interviewer had received. Thus, Rubin's (1976) interventions would be seen as appropriate, as would those of the Bay Area interviewers, six in number, who were clinically trained either as psychiatrists, psychiatric social workers, or marriage and family counselors

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