

Clinical Sociology Review

Volume 13 | Issue 1

Article 9

1-1-1995

The Dangerous Listener: Unforseen Perils in Intensive Interviewing

Tracy X. Karner
University of Kansas

Carol A. B. Warren
University of Kansas

Follow this and additional works at: <http://digitalcommons.wayne.edu/csr>

Recommended Citation

Karner, Tracy X. and Warren, Carol A. B. (1995) "The Dangerous Listener: Unforseen Perils in Intensive Interviewing," *Clinical Sociology Review*: Vol. 13: Iss. 1, Article 9.

Available at: <http://digitalcommons.wayne.edu/csr/vol13/iss1/9>

This Article is brought to you for free and open access by DigitalCommons@WayneState. It has been accepted for inclusion in Clinical Sociology Review by an authorized administrator of DigitalCommons@WayneState.

The Dangerous Listener: Unforeseen Perils in Intensive Interviewing

*Tracy X. Karner
Carol A.B. Warren*

*Department of Sociology
University of Kansas
Lawrence, KS 66045*

ABSTRACT

We suggest that interviewers become dangerous by the simple act of listening. In dangerous listening, there is a looking-glass effect through which the listener deflects the new or repressing self and reveals the old. The heart of danger is the interviewee's self reflected back from the interviewer's relationship to the past self. The data are drawn from two sets of intensive interviews, one with female mental patients-to-expatients in the 1950s in California (see Warren, 1987), and one with ex-Vietnam veterans on a trauma ward at a Veterans' administration hospital (see Karner, 1994). In listening, the narrator and the interviewer become participants in witnessing a violation of a social or personal norm. After such an accounting, the listener is seen as the symbolic repository for the narrator's troubled past, constituting a threat of judgment or exposure. These dangers of listening are not only those special biomedical and social dangers involved in the rhetoric of human subjects regulations, they are dangers of an everyday life world in which selves change, and change again.

Human subjects legislation over the past ten years has framed social science research, like the biomedical, as potentially dangerous. What

such legislation frames as dangerous is the interview or questionnaire topic, or the way questions are posed, particularly for vulnerable respondents. What we propose is that in the intensive interview, the act of listening, thus the listener her- or himself, may become perceived as dangerous. The conditions under which this danger arises are those in which a past, suppressed or forgotten self emerges in the interview, and becomes associated with the listener. We suggest that mental patienthood, and the events and relationships that preceded and led to it, may be one such set of circumstances.

Our data are two sets of intensive interviews, one with female mental patients-to-expatients in the 1950s in California (Warren, 1987), and one with ex-Vietnam veterans on a trauma ward at a Veterans' administration hospital (Karner, 1994). In the first study, referred to as the "Bay Area" study, seventeen women were interviewed at intervals ranging from one week to three months for a period of 36 months between 1958 and 1961 (Sampson, Messinger and Towne, 1964). In the second, in the Midwest in the 1990s, 15 men were interviewed one to four times each, and were observed in a variety of hospital settings by Karner. In addition, Karner interviewed hospital staff, and had access to autobiographies written by the veterans as they entered the hospital.

We suggest that the interviewer becomes dangerous by the simple act of listening: when the speaker has put on the mantle of a new self seeking to bury the old self in an unmarked grave, yet must confront the presence of an interviewer who has knowledge of the past self. The listener is also dangerous as a participant in the retelling of the past by a respondent who feels unable to escape from that past and the self constituted by it. In both kinds of dangerous listening, there is a looking-glass effect through which the listener deflects the new or repressing self and reveals the old. The heart of danger is the interviewee's self reflected back from the interviewer's relationship to the past self.

"Narratives of the past inflect the construction of identity in the present" (Ganguly, 1992: 36). For both the Bay Area women and the veterans, narrating the past reintroduced a self that was what Herman (1992: 94) refers to as a "contaminated identity." It was one that they wanted to transcend or transform into the new self, untarnished by previous experiences. However, their personal history continued to constitute the present through both remembered and retold events and relationships.

Central to the Bay Area women's narrated experiences while they were in the hospital were relationships: their lives and identities and housewives and mothers in the 1950s. For the veterans, the Vietnam war was the one catalytic event that shattered their identity into frag-

ments of a past self, a combat self, and a post-war self. Of course the Bay Area women's lives were eventful and the veterans relational as well: the women experienced death, sickness, bankruptcy and childbirth (and some violence, see below), while the veterans struggled with issues of trust, intimacy, and friendship with their families of origin and their own wives, girlfriends and children. The themes of events and relationships, and the interrelationship of these to notions of identity and selfhood, wove through both these sets of narratives.

For both the women and the veterans, the medicalization of their experiences had become a salient part of their biography, affecting expressions of the self. The women were patients and then ex-patients, with diagnoses of schizophrenia; the veterans were current patients diagnosed with post traumatic stress disorder. The therapeutic milieu provided an assortment of social resources for constructing a new self and reinterpreting one's past. Medicalization has its own language: of schizophrenia, depression, anxiety, stressors, flashbacks, that gave names and understandings to their experiences. A medical diagnosis furnished both the Bay Area women and the veterans with a complete set of explanations legitimated within the broader psychological discipline. Most importantly perhaps, medicalization relieves the patient of blame, shame and immorality, and reconstructs him or her, through illness, as a blameless victim. Herman asserts that once the patients "recognize the origins of the psychological difficulties in an abusive childhood environment, they no longer need to attribute them to an inherent defect in the self" and thus she continues, a way is opened for the creation of "a new, unstigmatized identity" (1992: 127). Hence the constituting of the listener as dangerous demonstrates the limited triumph of the therapeutic in these people's lives.

The situation of the ex-patient, however, is different from that of the patient. Once medicalized, the self can be framed as cured, a new self, different and transformed from the old self. Or, alternatively, as returned to the old self prior to all the troubles that led up to hospitalization. Both self-views occurred among the Bay Area respondents, and both resulted in the listener's presence as dangerous. In contrast, the veterans were only interviewed during their current patienthood, which for many was not their first time in treatment. Thus some of the veterans had previously been through the "transformation" of therapy; finding that their "treated" self had remnants of the old "untreated" self, returned to the hospital. For these therapeutic veterans, the listener was not only dangerous, but suspect since their listening had not worked or "cured" them thoroughly before.

Listening As Witnessing

Listening to narratives of extreme pain and great emotional depth removes the passivity from the act of listening. In Hochschild's (1983) words, listening, as well as telling, becomes a form of emotional labor, although not a labor tied to the capitalist economy. As Laub (1991) explains, the "listener to trauma comes to be a participant and a co-owner of the traumatic event." Since often such memories are not held by the cognizant self, they unfold and become known during the acts of telling and listening. Thus Laub conceptualizes traumatic life memories as events that have yet to come into existence:

The victim's narrative—the very process of bearing witness to massive trauma—does indeed begin with someone who testifies to an absence, to an event that has not yet come into existence, in spite of the overwhelming and compelling nature of the reality of its occurrence. . . . The emergence of the narrative which is being listened to—and heard—is, therefore, the process and the place wherein the cognizance, the "knowing" of the event is given birth to. The listener, therefore, is party to the creation of knowledge *de novo*. The testimony to the trauma thus includes its hearer, who is, so to speak, the blank screen on which the event comes to be inscribed for the first time (Laub 1991: 57).

As a blank screen, the listener becomes the symbolic repository for the narrator's problematic and traumatic past. The fact that the past situations have not been "known" prior to the telling is also testament to the current self's desire to repress and disassociate from the past self. Most of the recent literature on traumatic retelling and listening as witnessing is deeply influenced by Holocaust testimonies (e.g.; Langer 1991; Felman and Laub 1991). Such extreme experiences as those told by concentration camp survivors provide a conceptual model for understanding trauma and survival as well as their impact on issues of selfhood and identity.

Herman (1992) has expanded the models derived from the Holocaust studies to incorporate other contemporary traumatic experiences, such as rape, domestic violence, incest and combat atrocities, that many survivors find difficult to narrate. She contends that "certain violations of the social compact are too terrible to utter aloud: this is the meaning of the word *unspeakable*" (1992: 1). Herman posits that the desire to hide and escape from one's past "unspeakable" experience, which she labels "construction," is a symptom of post traumatic stress disorder. Individuals who have lived through such problematic experiences often

will “go to great lengths to avoid” remembering; the recollection of such memories is experienced as “reliving” the traumatic event (1992: 42). Indeed, Laub (1991: 67) goes so far as to state that “the price of speaking is *re-living*; not relief, but further re-traumatization.” According to Herman (1992: 46), some people narrow their consciousness, attempting to “numb” themselves psychically—pushing all the pain and horror as far distant from themselves as possible, while others selectively lose problematic parts of their past resulting in a “truncated memory.”

In his work on the debates over representing the Holocaust, LaCapra (1992) explores “transferential relations to the past” that vary according to the subject position one finds oneself in, be it victim, victimizer, or observer. He suggests that we “rework and invent” our subjectivity by denying certain features and enhancing “our own desires for self-confirming or identity-forming meaning[s].” Thus in the telling of our historical selves, individuals construct an appropriate self from a “selective schedule of preferences.” Indeed, “the identity of an individual and the identity of a group consists of the construction of a narrative, internal and external: the narrative construed *by* and the narrative construed *about* the subject” (Funkenstein 1993: 23). Consequently, selves are constructed historically as well as narratively; the listener as “witness” functions as the blank screen upon which personal history is inscribed.

The Self As Listener

Before one can narrate a past, it must exist somewhere in one’s psychological memory. The process of remembering traumatic experiences differs from the structure of regular memory. Memories of traumatic events are thought to be similar to childhood memories in that they are retained by the mind in pre-verbal imagery and bodily sensations that are both vivid and haunting. Nontraumatic experiences are encoded in a verbal, linear narrative sequence that is assimilated into one’s ongoing life story. The absence of a verbal narrative in traumatic memory creates an inability to fully comprehend the event, or to integrate it into one’s existing life narrative. Thus, a fragmentation of self occurs where the traumatic event is held separate from the nontraumatic life experiences (Herman, 1992: 37-42). This rupture of self is at the heart of the Bay Area womens’ and veterans’ life trials. And their inability to verbally recount their stories—locked in vivid, wordless images—maintains the emotional crevasse between life before the event and life after.

In the stories we tell about ourselves, we are also listeners. Ganguly (1992: 29) proposes that retellings and recollections serve as the “active ideological terrain on which people represent themselves to themselves” and consequently may be more about telling self-images to the self than to others. Self stories, Ganguly continues, are “fabrications” that focus on “shoring up of self-understanding” rather than historical “truths.” If a recollection is a story we don’t want to hear, we may “forget” about the past relationship or event, or bury it deeply under layers of other stories so that it rarely comes to mind. Repressed narratives do not have to be told to others nor forgotten ones to the self; there need be no dangerous listener. But the point of both psychiatric treatment and research interviews is the recalling and retelling of the past. Thus, in the inpatient phase of the moral career of the mental patient, the Bay Area patients and the Vietnam veterans were instructed to remember (and the Bay Area patients, as we shall see below, also to forget).

Traumatic Memory

Remembering can be further problematized when the event is perceived as being unique and far from the realm of ordinary experience, as traumatic memory often is. Langer (1991) in his study of Holocaust testimonies, discusses this in terms of two kinds of memory: deep and common.

Deep memory tries to recall the Auschwitz [traumatized] self as it was then; common memory has a dual function: it restores the self to its normal pre- and post-camp routines but also offers detached portraits from the vantage point of today, of what it must have been like then (Langer, 1991: 6).

Langer is able to identify the binary dilemma of a contemporary self attempting to narrate a past, traumatized self that seems “too unbelievable” to have happened. In the safety of the hospital, participating in gratuitous violence in Vietnam or thinking of killing ones’ children is indeed hard to acknowledge, especially within the context of “common memory” of normal routines and life situations.

Thus to narrate, to oneself or to another, there must be some expectation that the listener can accept the uniqueness of the story. “The absence of an empathic listener, or more radically, the absence of an *addressable other*, an other who can hear the anguish of one’s memories and thus affirm and recognize their realness, annihilates the story” (Laub, 1991: 68). If the person is going to narrate, and undergo the “reliving”

of the horrific event, a listening witness is needed to affirm the story as believable so that the narrator can too believe what s/he is hearing. To narrate in the face of denial or disbelief adds to the confusion of the deep memory, but may also bolster the construction of the new self. Therapeutically, denial is seen as problematic as it does not allow for an integration of the old self with the new. For the research interviewer, disbelief will often curtail the narrative, thereby thwarting the quest to hear.

Contradicting Mythological Selves

What was forgotten or repressed in the lives of the Bay Area women were events related to their current marriages, and (often later in the inpatient career) their families of origin. The relation of these women's treatment to memory was, however, complicated by the use of electroconvulsive therapy with ten of the seventeen women; a treatment whose "side effects" involve memory loss. Thus, the recalling and retelling characteristic of verbal psychiatric treatment and intensive interviewing was interrupted and curtailed by ECT.

These 1950s wives and mothers were part of a culture in which family, womanhood and motherhood were shrouded in what we of the 1990s see as a genteel mythology. This mythology hid from view such supposed "anomalies" as child abuse, women's thwarted ambition, male violence toward their wives, and the possibility of things being different, relegating such tales to the realm of "unspeakability." Thus, the discontents that led up to their hospitalization, and formed the content of their delusions, hallucinations, and bizarre behavior, were seen even by the women as socially illegitimate, and appropriately medicalized. For some of these women, the possibility of forgetting their own deviation through the mechanism of electroshock therapy (which they thought was intended by benign psychiatrists to erase memory) had an enormous appeal. Reminders by family members, therapists or interviewers of their past behavior—their old self—were unwanted:

I asked (respondent) if she was actually no longer depressed, since she had said so and requested that ECT be stopped. She laughed and said she was no longer able to remember the "things that she had been moaning and groaning about."

The Vietnam Veterans, prior to their entry into the hospital, had patches of forgetfulness about major events that occurred in Vietnam. They retained remnants of the experience—hazy images or pieces—or they might be able to remember the overall context of their experience

with some of the significant elements left out. One veteran said that he could not remember anything but seeing stars on an enemy lapel and he thought he had strangled him with his bare hands, but he could not remember any details.

It was common in these interviews for the veterans to allude to the scope of the event that occurred, but hesitate to tell crucial details. Since the core of experiencing an event as traumatic seems to be that it creates a rupture between the imagined and real self, there is a logic to keeping it hidden from others even if it is impossible to keep it forgotten or repressed. A unit psychologist who led groups devoted to combat traumas, or “war work” as some of the veterans called it, identified this pattern:

Some of these fellahs were high functioning guys before going to Vietnam and being exposed to certain kinds of things or doing things that they were asked to do were so contrary to their way of looking at how life was supposed to be and what kind of person they were supposed to be that there was no place to put that. It didn't fit . . . The traumas usually have to do with one or two things—experiences where they felt tremendous guilt for having done something or experiences where there is tremendous shame for having done something . . . for the most part, those are the things that are remembered the most with some degree of bother by the veteran.

For example, Ramsey unfolded his story in opposites; he mentioned what had happened, then expressed his disbelief that he could have done that.

I should've if I was like somebody else that was brought up different than me and didn't have any feelings about human life, then I would have come back bragging and said, “Oh I killed somebody today.”

Ramsey recognized that he had repressed the past:

What happened to me [was over] very quickly. Oh I blocked it out, because I didn't want to see myself doing what I did.

Ramsey illustrates the process by which the narrator comes to hear himself speak of a past ‘truth’ that takes shape only in the telling and becomes inscribed on the listening witness. Thus the spoken past is given to the witness; it is this role as a “keeper” of the “unspeakable” that constitutes danger. In a therapeutic context, this danger may be mediated in part by the promise of secrecy, whereas the researcher *will* retell the past promising the narrator only anonymity.

The Listener Who Knows The Past

Some mental patients are, or become, hyperaware rather than forgetful or repressive concerning the relationships or events that brought them into the hospital. They may, however, up to the moment of an interview have kept this information to themselves, and not shared it with others, particularly not significant others. As Bill said, "I mighta got drunk one night and told a girl" despite his overall strategy of not telling. Ironically, the themes of rapport and trust in the literature on interviewing, predicting and producing a closeness between respondent and interviewer, could also produce a sense of significance rather than strangeness, and thus a reluctance to tell.

What is it about past events or relationships that cannot be told without endangering the self through the looking glass—or, more aptly audio-tape—of the audience? The past events which were forgotten, repressed, or the subject of hyperawareness for veterans such as Bill were themselves hyperreal and unbelievable: the brutality, alienness and death of Vietnam. Their family of origin and marital relationships, while they might have been somewhat problematic prior to Vietnam were only ordinarily so; after Vietnam, hyperreal events of combat became inextricably intertwined with present and future relationships. Often the social stigma of the Vietnam war reinforced any fears of failed manhood that seemed to underlie their life troubles (Karner, 1994). Lack of employment, status, and satisfying relationships also bolstered a sense of inability to act and succeed as men which was often rooted in problematic combat situations where they had not measured up to their perceived masculine role.

The Unspeakable Self

The balance of events and relationships was slightly different for the Bay Area mental patients, whose hospitalization had been precipitated, in part, by failures in the ordinary roles and relationships of 1950s wives and mothers (Warren, 1987). These women did not have a social event like Vietnam to embody their troubles. They had episodic events anomically interspersed with daily routines, and were isolated from any structured community like the military. Approximately half of the Bay Area women had engaged in unconventional acts prior to hospitalization, such as fire setting, breaking household items, wandering around, and placing a wedding ring on the church altar. Two had made one or more suicide attempts, and three had tried to kill their children; one was

a suicide-murder attempt. Intake and subsequent descriptions of these women's mental status combined psychiatric with stigma rhetoric:

Bizarre behavior, hallucinations, preoccupied. History of illicit love affair and conflict on attempting to terminate same (Certificate of Medical Examiners).

. . . a history of frequent infidelities, hallucinations and illusions [sic]; she was described as having flattened aspect [sic] and being withdrawn. The final diagnosis was schizophrenic reaction, paranoid type (A summary sheet from another hospital).

During hospitalization, the women talked in general terms about the various episodes that precipitated hospitalization. There was, however, resistance to retelling the details of these events. The patient who had been admitted to the hospital for delusions, illusions, and marital infidelity initially answered the interviewer's questions as follows:

I asked her why she was here in the hospital. After a pause she said, "Because I was mentally disturbed." "In what way?" She laughed weakly and said, "A good question—oh—I cried too much—that's about as much as I know about it."

But later she added: "I fell in love with my brother-in-law four years ago, and that's it."

An interviewer's notes on another patient, a woman who had set fire to her house reads as follows:

Interviewer: You were talking a little earlier about sort of being here for correction . . .

Respondent: Correction to me means like a child does. You correct it, you know, when he does something bad. I set a fire, so, and that house belonged to the state, so, here I am. . . . on the order of punishment. In other words, paying for what I did. Like I set the fire and it wasn't my house, it was a state house, so here I am.

Interviewer: (Pt. resists retelling how she set fire)

Respondent: It's not even fresh in my memory anymore except that I know I am paying for it.

One woman had tried to choke her daughter and commit suicide. At one point she said to the interviewer:

. . . the burden I put on my little girl, she's not going to forget—she'll carry it the rest of her life. A person must be sick to do something I did . . . I was too scared to live, that is what prompted my action I guess.

This patient (who believed that the interviewer knew about the murder-suicide episode, which he did), was one of the few who did not, during the hospital phase of research and especially at the beginning, want to talk to the interviewer. The perception of knowledge denoted danger, even prior to her narration. She said,

Why should I help you?—to be rude, and I'm not usually that way. . . . He (husband) wants a divorce. . . . How do I know he did not hire you to talk to me? Who do I trust and who don't I trust? Who's to say you are who you say you are?

The two women who had tried to kill their children without an associated suicide attempt did not at any point mention this event to the researchers, who knew about it only through the medical records. This ultimate social violation, a mother attacking her own children while leaving herself unscathed, could not be told. Their stories remained "unspeakable."

In order not to seem the self evoked by past behaviors and events, these female and male mental patients kept the past to themselves in front of any significant listener who did not already know about it. The Bay Area patient's volunteering her love affair with her brother-in-law was unusual, and may have been precipitated by her feeling that all the listeners around her knew her business. Among the veterans, Ramsey said that he "never did tell nobody," not his wife nor his friends, about his flashbacks until he went to therapy,

I didn't want to lose no friends or anything, and I didn't want to lose no girl friends you know if I told somebody I was crazy.

Flashbacks signal craziness and a medical frame; Vietnam events signal an evil and a moral frame. Killing, in particular killing deemed gratuitous after the fact, was not to be told, because if told, it would bring with it an identity: murderer. Ramsey, who had forgotten events until he began telling them, said that

I'm really starting to remember . . . it makes me want to cry . . . if you would call it murder or kill I don't know for sure, at times I call myself a murderer . . . underneath the face I am, I am someone—I know I'm a killer.

Ramsey viewed anyone who listened as a potential judge of his behavior and his murderous self, able to expose the past and likely to reprimand the narrator. Chris also sought to avoid a sense of judgement:

I'm not going to bring myself out and just lay me out on the table for you to analyze who I am, because that's just not me, that's not the way I do things. . . . You wouldn't like what you saw.

Similarly, anticipating his turn to speak, Bill recounted his avoidance of the psychologist who led the therapy group in which the veterans recounted their combat experience:

I evaded her in the hallways even because she was the factor that was going to hurt me. . . . She was going to hurt me so I stayed away from her.

Therapeutic Talking

The task of the therapeutic listener is to persuade the patient to talk about precisely that event or relationship that casts discredit upon the self. The VA hospital staff were well aware of their role as dangerous listener. One described the object of the therapy group:

The object is they can talk about it. For the most part they will talk but they can't talk about it out there with other people because they would look at them like they are crazy. . . . We have had guys who could not talk through their experiences but they're the exception to the rule. A lot of times it takes a full three months just to get them talking.

Once talking, the therapeutic listener becomes dangerous; the research listener may do so also. Ramsey said of the research interviewer:

I have to look at you every time I walk down this hallway and I know you'll be seeing me again . . . I don't even know if I'd want you to know what happened.

This listener was dangerous because not only did she know the past, her mere presence would evoke it as well.

The Listener Who Evokes The Past

Unlike the veterans who could focus their difficulties on Vietnam, the Bay Area women saw their dilemmas symbolized by their hospitalization. After their release from the mental hospital what could not be told was ex-patienthood, not only because of the stigma attached to it by society, but also because of its reflection of a self from which the ex-patient wanted to remove herself. While some of the Bay Area ex-pa-

tients regarded the interviewer as a type of therapist, and wanted her to continue interviewing as a therapeutic process, others had determined that the self exemplified by their stay in the mental hospital was to be erased. These women wanted to see themselves as their old prehospital selves, restored pristinely to the status quo ante, or as a new, reborn self: Phoenix rising from the ashes.

For the self who wishes to erase the past, the listener who evokes that past is dangerous. The researchers in the Bay Area study found that, for the most part, the women respondents welcomed the interview during the period of hospitalization. The interviewer represented contact with the outside world and with her family, a source of information to be tapped, and a listening ear when most of the professionals around her did not listen.

A few of the women continued to welcome the interviewer during the ex-patient phase of the interviews, generally in the context of continued feelings of trouble that the woman wanted and needed to communicate to someone. But most of the women sought, virtually immediately, to terminate the interviews or to turn them into something other than an interview. The techniques they used to accomplish interview-conversion included treating the interview as a social occasion (offering refreshments), role reversal (the respondent asking, "how are you?") and a sullen attitude of recalcitrance. In the first post-hospital interview, one ex-patient demonstrated the process by which the interviewer might be rendered less dangerous if he became simply a social other, un-privy to the past self:

She repeated on several occasions, "How are you?" "What have you been doing?" These questions, I believe, were an attempt by her to establish an equalitarian relationship . . . For this reason . . . I commented on my own experience in neutral areas. . . . For example, when serving coffee [the respondent] commented that she does not like sugar in her coffee. I informed her that I also do not like sugar in my coffee.

The change in the respondents' treatment of the interviewer and feelings about the interview reflected her new sense of self and the danger of a former listener to this present sense of self. Most of the Bay Area respondents had left the mental hospital resolving that the mental patienthood episode and its self would be left behind, obliterated. Some resolved to be their old selves, the people they had been before hospitalization; the people they had been prior to the marital troubles that had precipitated hospitalization, such as the woman's dissatisfaction with the domestic role. Others resolved to be new selves, arisen from the

ashes of the old, pre- and hospital self, to begin anew in relation to husband, children, and the world. The interviewer was dangerous to these old and new selves as embodied reminders of the biography the women sought to bury.

Safeguarding the New Self

The Bay Area interviews both evoked the past—reminded the woman of Napa State Hospital—and knew about past events and actions that the woman now sought to disremember. One of the original interviewers said of a respondent that she felt

an entitlement to normality. Probably her evident desire to desire to decrease the frequency of interviews . . . should be so headed. She has indicated that she has to talk about many things that trouble her in the interviews.

The interviewer characterized this same patient as “reaching out to a new life” by attending Alcoholics Anonymous. In fact this was an old life and an old self, since throughout hospitalization this patient had insisted that she “really was” an alcoholic and not a mentally ill person after all. This patient said to the interviewer toward the end of the series that (presumably despite his continued attendance on her) “the hospital is beginning to seem ‘unreal.’”

Similarly, the veterans had attempted to distance themselves from their troubles by denying their veteran status and combat experience after returning from Vietnam. Larry reported having his first conversation about Vietnam in 1986 when he went into therapy for PTSD. He was silent for almost twenty years. Larry’s attitude is common among the veterans. Kurt explained, “the only time I ever mention Vietnam in here is when I’m in trauma [group].” Like Kurt, Larry only speaks of Vietnam when he is in treatment. Larry has one veteran friend at home that came back with him, “he’s my brother-in-law now, but we don’t talk about it.” David also says he has never spoken of his tour. “I mean I never talked about nothing until I came here, to nobody,” David revealed. Chris spoke further about trying to avoid his experience:

I wouldn’t wear anything that said I was a Vietnam veteran. I never wore a hat that said anything about Vietnam, I never had a tee-shirt that said anything about Vietnam and I just found myself avoiding anything that had anything to do—Everything that had anything to do with Vietnam.

Chris adds, "I'm protecting me." By not identifying with veterans he has tried to erase his former self through avoidance and silence. Tommy had Vietnam symbolically inscribed on his body with multiple flesh wounds. He took steps to hide these markers of war from others.

I never talked to nobody about Vietnam for God knows how long. I'd just keep it bottled up inside me . . . I'd always wear long sleeve shirts. . . . I never go shirtless 'cause I didn't want nobody asking me.

Tommy's scars are continuous reminders of his actions and experiences. At times he is prompted to disbelieve that Vietnam could have been real—"I look at my body and I know different." His physical wounds maintain Vietnam as a constant presence that at times he can erase from his emotional memory—"And then I look at myself in the mirror and see my body, and then I think about how I've treated people, we were cold, you know." By keeping this from others, he protects them from the confusion of his actions and any moral ambiguity they may feel, but also, like Chris, he is protecting himself from further external judgments. In general, these veterans had remained silent about their combat tour—not talking or displaying any remembrance. Like the Bay Area women attempting to dissociate from their hospitalized selves, the veterans endeavor to evade the symbol of their previous selves, Vietnam.

Therapies Of Forgetting And Remembering

The importance of memory and of the listener in the construction and maintenance of the self is recognized as important in the practice of psychotherapeutic treatment. What is interesting about these 1950s-1960s, and 1980s-1990s approaches to patients and their past is the importance of therapy in forgetting, on the one hand, and remembering, on the other.

Talk therapies of various kinds are, par excellence, the therapies of memory, while electroshock or other convulsive therapies are the therapies of forgetfulness. Those psychotherapists who espouse remembering and thus "dealing with" repressed memories have both theory and practice on their side: a whole set of theories which relate repression to ungovernable behavior and uncontainable feelings. Those therapists who practice ECT operate without much theory. They do, however, consign the memory loss associated by many with ECT to the disclaimed category of "side effects," thereby distancing themselves from the patients' belief that memory loss was the purpose of the treatment.

The VA hospital therapists believed that the resumption and retelling of memory, the facing of the old self, was crucial to the reconstitution of a new, healed self. One staff psychologist said that the veterans had to remember and retell in order to

go through a forgiveness process. Number one they need to let themselves have the awareness that they did it and then come to terms with the fact.

Coming to awareness, retelling, and coming to terms with the fact involves the therapist as a dangerous listener, as these VA therapists well knew. Thus part of the therapeutic discourse is a reframing that shifts the danger from telling to secrecy. Staff try to persuade the veterans to remember and to tell, and to see danger not in the listener but in the consequences of not telling. This same staff psychologist said that

What we encourage them to understand is that by trying to stay away from people and trying to stuff your feelings when you have them, you actually make it more likely that at some point some little thing will happen and there'll be enough powder stored, that something is going to blow.

The Bay Area psychiatrists of the 1950s and 1960s also attempted to persuade their patients to retell the troubles in their past in order to overcome them. But they also provided the therapy of forgetfulness, ECT. While memory loss was generally framed by psychiatrists as a side effect of the treatment, some ECT adherents did value the brain- or intelligence-damaging effects of ECT in altering the behavior of mental patients.

One of America's most respected psychiatrists, Abraham Myerson, wrote in 1942 "these people have for the time being at any rate more intelligence than they can handle and...the reduction of intelligence is an important factor in the curative process. The fact is that some of the very best cures one gets are in those individuals whom one reduces almost to amentia" (Farber, 1991: 95).

Certainly the Bay Area patients themselves believed that ECT was intended to make them forget their troubles; indeed, one woman wondered why she was being required in psychotherapy to remember and deal with her past while with ECT she was being forced to forget. In forgetting the troubles that had brought them to the mental hospital in the first place, the women were enabled to forget the selves responsible for the troubles. They did not then want to be reminded by the presence of the interviewer of that old, inpatient self.

Therapeutic remembering also delves further into biography than those troubles that eventuated in mental hospitalization: further back than Vietnam and its post-trauma, and further back than marital troubles and the burning of houses. Therapists encourage patients to recall and retell—often to reconstitute—their pasts within the family of origin. For both populations of hospital patients, therapists associated their present troubles not only with the recent past, but with the far past. For both the Vietnam veterans and the madwives, tales of childhood physical and sexual abuse, alcoholic fathers and mothers, took their place alongside stories of killing innocent children in Vietnam or attempting to kill one's own in the kitchen.

Separating Selves

For those patients whose pasts did not generate retold selves and families, the danger inherent in the more recent past was all the greater. For some of the veterans, the contrast between the self that killed in Vietnam and the Christian, virtuous self that went to Vietnam was intolerable. This complete disjunction was at the root of many of the veterans' crisis of the self. Like John's statement below, Ramsey expressed the impossibility of reconciling radically different selves. Ramsey also mentioned during the initial interview that he had "kind of went off the deep end, the extreme opposite of being a very sheltered Christian—I went to the extreme opposite!" Expressing his disorientation, he gave closure to each problematic event narrated by withdrawing from the aggression and willfulness of the event. He would mention what happened and then conclude with "I feel so guilty." In a later interview, Ramsey mused, "I didn't perceive myself as being someone who could kill somebody and then laugh about it and feel good about it." He paused briefly, then added, "I didn't." Still later, he admitted to his enjoyment and euphoria in Vietnam, being able to kill at will. Ramsey's narration was much more convoluted than John's, yet they both contain the same moral dilemmas of integrating experienced with idealized selves. John, a Vietnam veteran, expresses the dilemmas of past and present that constitute the self endangered by being listened to:

I had my life as a kid growing up in (Midwest) and then I had my experiences in Vietnam which was totally out of character with the John (1) that grew up, okay? And due to my experiences in Vietnam I am now the John (3) that is here today, okay? Now them other two Johns (1, 2) is back in the past and every now and again, one of them will flare up. . . . The John (3) today has trouble com-

prehending what the John (2) in Vietnam has done . . . [And] at the time, that John (2)—the one that's in Vietnam, has a hard time understanding where he's at and doing the things that he's doing, according to the upbringing (1) that he had. You know I mean religious beliefs and everything else. And the John (3) today is still having trouble comprehending what these other two Johns (1, 2) have done. And while I was growing up and in Vietnam and how to come to grips with that and accept that being part of my life . . . Basically because it goes against my beliefs, like my Christian upbringing, 'thou shalt not kill' and all this. And it conflicts with the fact that the John (3) today is sorry for the things that he's done in the past. The John (2) that was in Vietnam kinds of feels like he's unpardonable for the sins that he's committed over there are not forgiving type sins. Am I making any sense? 'Cause I don't know how to live with myself because of my actions in Vietnam and [I] have that guilt and I can't seem to shake it to get on with my life. I'm still hung up, still basically and mentality . . . at the war in Vietnam in my own mind, and I don't know how to get it out, you know? [the numbers have been added for clarity].

It is not an easy task for therapists to persuade the injured self to remember and retell a time of even greater injury. For one thing, therapists may be dangerous listeners if they listen and thus constitute a witness, but patients are often not sure that their voices are heard at all. One of the Bay Area patients, awaiting the outcome of a conference on her case in which staff were deciding whether or not to release her, was faced with her physician's forgetfulness:

Dr. H emerged from the conference room and a patient who had been seen earlier yelled, "Am I going home?" He stopped to think, and then said, "I don't remember." The patient, with what was supposed to be mock indignation, exclaimed, "you doctor! you doctor! And after I've been sitting here since one o'clock. You know, I only saw you once and I remembered your name." The patient turned to me and said, "We're just like ants in a hill to him."

But if the therapist and the interviewer do listen, and persuade the patient to talk about the past, the self is in danger of being witnessed or misunderstood—Can the listener truly understand? Many of the veterans believed that only another Vietnam veteran could appreciate their stories.

I could talk about being in a firefight or someone getting blown away but you don't experience [it] unless you been there. I mean like the effect it has on you and people just don't know or realize, so I never really [would] talk about it unless its another vet.

This doubt may in part be due to the lack of social support for the telling of war stories. These tales are “unspeakable” to the broader society and their narration is usually segregated by gender and historical era (Norman 1989:139-141). In actuality, veterans may have difficulty talking among themselves too. Mangum explains,

There’s two other guys, only time we talk about Vietnam is when we get together drinking and its just one phase we talk about that [is] when we got in a firefight that we turned around, our boats turned around and went off and left them, now that’s as far as it go right there.

He says he can only talk with other veterans about general things like where he was stationed or his job assignment. “I can deal with that, but when you start to get too close,” Mangum warns, “I’m gone.” There are some stories that can not be told, even to others who “should” understand.

Thus there are several levels of resistance to the retelling demanded in therapy. Bill said that he “never told nobody till I got here,” and objected to the demand to tell by the ward staff. He said,

They want you to remember it where you’re trying to forget about it. . . . I ain’t going to open up all the way ‘cause it’s none of their business. . . . I don’t know if anybody needs to know . . . some of the real hardcore stuff I can’t get out. I haven’t even been able to get it out with you.

Chris, similarly, said of trauma group that he has

. . . told people what they wanted to hear, I’ve told them what I wanted to give them, but I haven’t told. I’m not going back into that pain again.

But sometimes the veterans found that speaking helped. Mangum said, “Remembering it brings a lot of pain and talking about it, like I said, it feels good to get it out. . . . It’s something that I’ve had to let go inside of me and you just can’t discuss with anyone.” Others, like Marty, had been in therapy before and returned with a specific agenda of telling more.

I got two things that I still haven’t told those people, I lied. I told them, but I didn’t tell them it was me, you know, [in] my autobiography. The story’s there. . . . They’re there, but I didn’t tell them. . . . That’s the main reason I’m up here—to get rid of those two things, to tell somebody.

For Marty and Mangum, the listeners may still be dangerous, but they are also these veterans’ confessors. When the past becomes inscribed on the listener, the narrator no longer owns it by him or herself.

Living In Between Selves

In the aftermath of the war in Vietnam, the reception afforded the returning veterans reframed them as perpetrators of violence, as murderers, rather than as the heroes they had anticipated. Therapy, and the 1980s sociocultural recastings of Vietnam, have enabled them to redefine themselves (should they choose to tell this story) as victims (of the government, of the antiwar movement, of their own tormented childhoods). Many of them, however, may—like Frank¹, of documentary fame—remain poised uneasily, as Lutz (1995) puts it, between pride and shame, “caught between two ideologies, two moralities, two emotions.” (p. 14). Whichever path is chosen, memories and feelings must be shaped and reshaped to fit the emerging self.

For the madwives of Napa, there were neither dramatic events nor feminist cultural discourses to shape and frame their feelings about themselves. All they had (most of them did) was a “golden age” of youth when they were active, vigorous, and, above all, equal to the boys. The processes of mental hospitalization and therapy contained the cultural ideologies of both patriarchy—of self-abnegation in motherhood and wifehood—and therapy—self-discovery and fulfillment. Some of the Napa women remained caught between these two ideologies, two moralities, and two emotions. Others chose to bury their old self, and its golden age, within a renewal of wife- and motherhood. Two women strove toward a new self, free of the old bonds.

For those stuck between two moralities, emotions and identities were the object of continual shuffling and reshuffling, consideration and reconsideration. For those who sought a new identity, the emotional and cognitive work of redefinition involved the repression of memory. But a sociological, rather than a psychological repression: the repression of memories in talk, together with a vivid awareness of those same memories within the mind and imagination. Our study tells us that for those who seek to escape the past, what is best forgotten is least forgotten.

Listening And Social Relationships

Danger in listening is part of everyday life. There are times in which we forget what we have done, repress something else, or tell something to someone which we then regret. We are henceforth embarrassed to see or be with that person because we know that the self they now see us as, is not the self we prefer to present.

The implications of listening are different, however, depending upon the presence, degree, and type of relationship between speaker and lis-

tener as well as the self and event being narrated. The main audiences for self-revelation are strangers, intimates (and every gradation in between), and the professional audiences of therapist or interviewer. Like Bill who told the "girl in the bar" about some of his Vietnam experiences, the stranger whom we will never see again may be the least dangerous listener. The self revealed to them is immaterial, one with which we will have no future relationship. By contrast, the self revealed to the intimate—wife, husband, lover, friend—is part of a social relationship of some permanence, and a revelation can affect it permanently.

For the Vietnam veterans, retelling Vietnam among intimates was confined to those who already knew—fellow veterans. The intense—if sporadic and superficial—relationship between Vietnam veterans, based upon getting drunk and loosening repression, fostered the closed retelling of combat tales. By contrast, many veterans did not tell the same stories to their wives, children, or workmates. Although Marty had told his wife some details of Vietnam, he had refrained from telling other associates about:

. . . war work—things that you never told anybody your whole life, you know, for twenty something years, you never told.

Not only could the horror of Vietnam not be told, it did not suit a Christian self, but also the terror and fear could not be told, because it did not suit a real man, as Walter explained,

I don't have no John Wayne story or nothing you know. And you know, I tell the fear, about scared.

One of the functions of the trauma and therapy groups at the veterans' hospital was to enable the veterans to admit to fear as well as horror, something that was certainly unmanly to do with their veteran buddies. However, the VA did try to capitalize on the "shared fantasy" that often develops between combatants that "their mutual loyalty and devotion can protect them from harm" (Herman 1992: 62). Speaking of his squad, Chris illustrates how the context of combat brought men closer, and yet maintained stereotypic rules about not sharing one's emotional life.

Oh, we told each other everything, everything. I mean they were my buds, you know. I could tell them anything and know that they wouldn't be judgmental and know that if I had a problem that I had to work through that I could value what input they had, but as it turned out you know they were my sounding post just as I was their

sounding post and it was, one or the other of them would come to me and be upset, or boohooing about a girlfriend calling and I'd tell him all shut up and go to work. I mean you know I don't want to hear this shit. . . . Yeah, but then again if I did the same thing, they would tell me the same thing. I told them leave that shit back here because I don't want you to try to cover my ass thinking about your girlfriend back in Ohio.

Thus Chris began by expressing closeness in the totality of their communication, but then illustrated that emotional topics were not appropriate because they might interfere with one's ability in combat. Larry also recalled similar "talking rules".

When you was over there you was a macho figure, that was all you was taught to be a macho figure, you know, nothing can hurt you, you're scared of nothing, no feelings, no pain, you know, just kill okay? And everybody has got that feeling so you don't relate to the next guy. 'Hey man, you know I'm really scared that this is happening,' you know what I'm saying, that this is happening, you know. You don't say that to the next guy because in return he would probably laugh at you, you know, or call you a wimp or puss or whatever and then it gets around and everybody points a finger at this guy, you know, well he's a wimp or he's a puss or queer or whatever . . .

Interviewers and Therapists

Therapists, as professional listeners whose purpose is to relieve suffering by listening, are in a different position than that of buddy. They are not strangers seen once on a plane, and they are not intimates whose lives are enmeshed with that of the mental patient. They are listeners to whom a tale unfolds over time; the speaker may feel relieved by speech, or endangered, and may come and go from therapy (if voluntary) according to these feelings.

The interviewer is also in a different position, and one which depends upon whether the interview is (like the encounter with a stranger) one shot, or (like the encounters with a therapist) continuing over time. The embarrassment occasioned by a revelation during a one-shot interview may cause a momentary pause to the self, but it is not relived by subsequent encounters and can be short-lived. Both the studies we refer to, however, involved more than one interview occurring over time, making them more similar to the encounter with a therapist than with a stranger.

The fact that an interviewer's professional interest in the respondent is based on the interviewer's disciplinary rather than the respondent's

emotional interests is generally lost on the respondent; both therapist and interviewer can evoke both danger and catharsis. One Bay Area respondent said to the interviewer:

I was depending on you all those months, even though you told me, you know, that wasn't your function . . . yet I used it for what I wanted to and I really did depend on you . . . going to the [outpatient] clinic now, I feel like I transferred. . . . if that study hadn't come in there, I really don't know if I would have found my way back, you know that.

An interviewer of another patient commented from his perspective that:

I had intended to cut down the frequency of my interviews, but decided to postpone doing it . . . it seems to be her feeling that she must not complain if she is to avoid the risk of being rejected and disapproved of by other people, and I didn't wish her to interpret reduced frequency in this way.

In the VA study, the distinction between the therapist and interviewer was even more confused by the lack of individual attention afforded the veterans. The majority of veteran contacts with staff members was in groups: the only private audiences they had were five to ten minute medicine checks with the psychiatrist. This was a stark contrast to having the interviewer's undivided attention for one to two hours. Ramsey made this overlap between roles of therapist and researcher most pointedly with a request to be reassigned to the interviewer for therapy. This "therapeutic misconception" seems to arise from both the respondents misunderstanding and the interviewers' lack of communication (Warren and Karner 1990). Bensen et al. (1987: 182) assert that the absence of cultural familiarity with the role of researcher and a knowledge of patient role also enhance this confusion of roles.

Professional Listening

Intensive interviews done as a series with the same respondent over time reveal the constructed nature of the interaction: it is a social negotiation that can only be understood in social and historical contexts, not only of the broader environment, but also of the selves involved as well. Most people have some memories which when narrated evoke powerful emotions. Certain kinds of these recollections will fall into the category of the shame or guilt filled "unspeakable" trauma or horrific event. These are the tales that beget danger.

In listening, the narrator and the interviewer merge into a dual witnessing of a violation of a social or personal norm. After such an accounting, the listener is seen as the symbolic repository for the narrator's troubled past, constituting a threat of judgment or exposure. These dangers of listening are not only those special biomedical and social dangers involved in the rhetoric of human subjects regulations, they are dangers of an everyday life world in which selves change, and change again. Even after a one-shot interview, the rhetoric of human subjects can be marshalled to neutralize what has been to the respondent an unseemly display of an unwanted self. A colleague of ours, engaged in interviews concerned with ethnic identity, had two respondents withdraw as respondents after the interview had been completed; one said, "this was not an interview. It was just a conversation."

In Practice

The historian, Paul Thompson (1988: 159), admonishes interviewers that certain "memories are as threatening as they are important, and demand very special skills in the listener." He suggests that interviewers can learn from a sensitivity to psychoanalytic theories in exploration of the diversity of ordinary experience. The psychoanalytic is not without its own problems and debates; however, Thompson's call for an increased awareness of the power of emotional memories and process of trauma seems fitting for social scientists venturing into the dangerous terrain of listening.

Listening, therapy, and interviewing are all aspects of everyday life; therapy and interviewing are, however, set apart from listening heuristically by their disciplinary, professional, temporal, or financial characteristics. They are not separable epistemologically, however; therapy and research share the interactional features of everyday listening and speaking. Retelling Vietnam violence to a stranger in a bar or to a one-shot interviewer, or hiding a culturally unmaternal past from a therapist, fiancée, or repeat interviewer share similar structural and emotional characteristics. What they all share is different dimensions of danger and safety to the self that the speaker wishes to present, maintain, and preserve within the social context. This interactive dynamic warrants further discussion in relation to practitioners as well as interviewers.

Interviewers, surrounded by the ethical and institutional warnings of human subjects regulations, are only too well aware of danger, although they might not be quite so sure what precisely it is that is danger-

ous. In the traditional human subjects text, what is dangerous to the respondent is not so much the listener, but the questions asked by the listener. Our research shows that the listener her- or himself may pose a danger quite apart from that of the questions, or of the risk of public exposure.

For the therapist in practice, no one warns of danger, except perhaps within the counter-transference process. The therapist-client relationship is posed as one of benign, healing talking and listening, together with a process of trust-development (and even transference) over time. Our research indicates that there are pitfalls within these assumptions, pitfalls recognized by Goffman (1963) in his discussions of "exs" (ex-mental patients, ex-addicts, and so on) and their identities. First, an "ex" may wish to repudiate all reminders of what s/he once was, including the interviewer or therapist who has heard too much about the old self. Second, the development of trust and intimacy over time may curtail, rather than liberate, personal revelations. If an old self is painful and a new one covers that pain, the listener—the therapist as well as the interviewer—may become dangerous. And may have to go. The ultimate power of the new self is to take itself away, into new contexts, and away from the dangerous listener.

ENDNOTE

1. *Frank: A Vietnam Veteran*, produced for public television and originally broadcast in May of 1981.

REFERENCES

- Bensen, Paul R., Loren H. Roth, Paul S. Apelbaum, Charles W. Lidz, and William J. Winslade. (1987). "Informed Consent and the Regulation of Psychiatric Research." in *Research in Social Problems and Public Policy* 4:151-91. Greenwich, CT: JAI Press.
- Farber, Seth. (1991). "Romancing Electroshock." *Z Magazine*, June: 92-99.
- Felman, S. and D. Laub (eds.). (1991). *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*. New York: Routledge.
- Funkenstein, Amos. (1993). "The Incomprehensible Catastrophe: Memory and Narrative" pp. 21-29 in *The Narrative Study of Lives*, R. Josselson and A. Lieblich (eds.). Newbury Park: SAGE Publishers.
- Ganguly, Keya. (1992). "Migrant Identities: Personal Memory and the Construction of Selfhood." *Cultural Studies* 6:27-50.
- Goffman, Erving, (1963). *Stigma: Notes on the Management of Spoiled Identity*. Englewood Cliffs, NJ: Prentice Hall.
- Herman, Judith L. (1992). *Trauma and Recovery*. New York: Basic Books.
- Hochschild, Arlie Russell, (1983). *The Managed Heart: Commercialization of Human Feeling*. Berkeley: University of California Press.

- Karner, Tracy X. (1994). "Masculinity, Trauma, and Identity: Narratives of Vietnam Veterans with Post Traumatic Stress Disorder." an unpublished dissertation: University of Kansas.
- LaCapra, Dominick. (1992). "Representing the Holocaust: Reflections on the Historians' Debate." pp. 108-127 in *Probing the Limits of Representation: Nazism and the Final Solution*, S. Friedlander (ed.). Cambridge: Harvard University Press.
- Langer, Lawrence L. (1991). *Holocaust Testimonies: the Ruins of Memory*. New Haven: Yale University Press.
- Laub, Dori. (1991). "Bearing Witness or the Vicissitudes of Listening" pp. 57-74 in *Testimony: Crises of Witnessing in Literature, Psychoanalysis, and History*, S. Felman and D. Laub (eds.). New York: Routledge.
- Lutz, Catherine. (1995). "Warring Emotions: The Cultural Contradictions of Emotion in Modern Warfare." *Social Perspectives on Emotion*, 3: 15-31.
- Norman, Michael. (1989). *These Good Men: Friendships Forged From War*. New York: Crown.
- Sampson, Harold, Sheldon L. Messinger, and Robert D. Towne. (1964). *Schizophrenic Women: Studies in Marital Crisis*. New York: Prentice Hall.
- Thompson, Paul R. (1988). *The Voice of the Past: Oral History*. Oxford: Oxford University Press.
- Warren, Carol A.B. (1987). *Madwives: Schizophrenic Women in the 1950s*. Rutgers: Rutgers University Press.
- Warren, Carol A.B. and Tracy X. Karner. (1990). "Permissions and the Social Context." *The American Sociologist*, Summer: 116-135.