

Article

Transitioning from Clinical to Qualitative Research Interviewing

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Abstract

In this paper one aspect of the transition that must be made by experienced clinicians who become involved in conducting qualitative health research is examined, specifically, the differences between clinical and research interviewing. A clinician who is skillful and comfortable carrying out a clinical interview may not initially apprehend the important differences between these categories and contexts of interviewing. This situation can lead to difficulties and diminished quality of data collection because the purpose, techniques and orientation of a qualitative research interview are distinct from those of the clinical interview. Appreciation of these differences between interview contexts and genres, and strategies for addressing challenges associated with these differences, can help clinician researchers to become successful qualitative interviewers.

Keywords: clinical interview, graduate studies, health care professionals, interviewing, research interview, supervision

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Introduction

Interviews are a common, successful, and fairly adaptable strategy to collect information. Clinicians routinely use data collected during patient interviews to compile a history, contribute to establishing a diagnosis, assess prognosis and develop a therapeutic plan, and monitor progress. Individual interviews are also a primary data source in many qualitative health research studies, a field to which clinician-researchers make significant contributions (Britten, 1995). Given their familiarity and expertise with clinical interviews, clinicians new to qualitative research interviewing face a challenge that they might not anticipate or recognize. Experienced clinicians who become involved in conducting research interviews may take for granted that their clinical interview experience will provide them with the requisite skills and knowledge to be excellent research interviewers. This idea, that clinical interviewing and research interviewing require the same skill set and approach, and the underlying assumption that these activities are guided by similar goals and understandings, is a source of potential difficulties for clinicians new to qualitative research (Britten, Jones, Murphy, & Stacy, 1995; Tod, 2006).

While the challenges involved in transitioning to the needs of qualitative interviewing exist for clinicians from all health care disciplines and specialties, the ways in which this issue will manifest will be influenced by both the particular types of clinical interviews employed in a given practice and the types of qualitative research interviews which practitioners will conduct. Some clinicians may feel that “interviewing is as familiar as breathing” (Thorne, 2008, p. 78), however, interviewing in one context does not necessarily translate to facility or effectiveness of interviewing in another. Being very comfortable with interviewing in a particular setting might even be an impediment to transitioning to the needs, concerns and goals of a new interview type. A sense that one is an expert clinical interviewer will be an obstacle to adapting to research interviews to the extent that differences in interview genres are not recognized and if corresponding adjustments are not made. There is a possibility that individuals who are familiar and comfortable with one type of interview will persist in that mode of interviewing, even when they are interviewing for a new purpose.

The authors of this paper are health care providers (Lisa Chan and Anita Mehta are nurses, Matthew Hunt is a physiotherapist) who returned to graduate school after practicing as clinicians. Our dissertation projects consisted of qualitative studies using interviews as primary data sources (Lisa Chan carried out a focused ethnography, Anita Mehta conducted a grounded theory study, and Matthew Hunt used interpretive description methodology). The inquiries we conducted in our doctoral research were oriented by a naturalistic paradigm. Within this paradigm, realities are understood as socially and culturally-based, and contingent in form and content on the persons who hold them (Lincoln & Guba, 1985). This exploration of qualitative interviewing is influenced by the perspectives of a naturalistic paradigm.

It was in retrospect, discussing and writing about our experiences of being health care professionals using qualitative methods (Hunt, Mehta & Chan, 2009), that we identified shared challenges in moving from clinical to research interviewing. Some of these challenges related to the nature and techniques associated with research interviewing. Other questions arose in considering our dual roles as clinicians and researchers. When we began our projects many of these challenges were unexpected. We identified some

of the necessary adaptations early in the process of data collection. Other challenges were not fully apparent until data collection was well underway, or until after our projects were completed. In particular, it took time to fully apprehend how our experience as clinical interviewers was intricately bound up in the ways we conducted our research interviews.

Clinical and research interviewing

Clearly, there is considerable heterogeneity within both of the broad categories that we are considering in this article: clinical interviews and research interviews. For example, diagnostic interviews are substantially different from therapeutic ones. Similarly, there are differences in the nature and style of research interviews across qualitative methodologies (Wimpenny & Gass, 2000) and different epistemological conceptions that underlie approaches to qualitative interviewing (Roulston, 2010).¹

Interviewing is a core method employed in many qualitative research methodologies (Gubrium & Holstein, 2002). Eliciting participant experiences and perspectives through an effective interview is a key means for researchers to collect data to enable them to develop analyses that illuminate a phenomenon of interest. The importance of interviewing in qualitative research is illustrated by the number of books dedicated to this topic (Gubrium & Holstein, 2002; Kvale & Brinkmann, 2008; Rubin & Rubin, 1995). However, the particular issues experienced by clinicians who take part in research interviewing are rarely addressed in detail in such texts.²

For Patton (2002), research interviewing is “based on the assumption that the perspective of others is meaningful, knowable and can be made explicit” (p. 341). Likewise clinical interviews involve engaging verbally with people in order to gain access to their particular perspective and experience. Interviews and interviewing in both clinical and research domains are also shaped by disciplinary and theoretical perspectives. Different paradigms influence the practices and approaches of practitioners in qualitative research and clinical practice (for example, positivist or constructivist in research or psychoanalytic or behavioral in clinical practice) (Craig, 2005; Guba & Lincoln, 1994). In this way, clinical and research interviews are both influenced by the theoretical models that underpin the research project or the clinical approach (Hutchinson & Wilson, 1994; Roulston, 2010). These theories influence the types of questions asked, the interview process, as well as how data are interpreted and analyzed (Craig, 2005; Hutchinson & Wilson, 1994). Thus, what constitutes a successful qualitative research interview, and the goals of the interview, will vary between methodologies. Qualitative research interviews, however, also share common features that distinguish them from clinical interviews.

While many skills required of the clinical interviewer are transferable to the research setting (such as the use of open-ended questions and attention to non-verbal communication), the overall orientation of the interview is different (Britten et al., 1995). At a fundamental level, the purposes of clinical and qualitative research interviews diverge. Broadly speaking, this distinctiveness holds whether the clinical interview is diagnostic or therapeutic (or another form of clinical interview) and whether the qualitative research interview is conducted within a constructivist or realist paradigm. For the purpose of illustration we will contrast a diagnostic interview with a face-to-face grounded theory qualitative research interview. Britten (1995) describes how a physician’s diagnostic interview has the primary goal of fitting the patient’s experience into a particular category. In order to obtain the necessary information to formulate a diagnosis, the interviewer focuses the content of the interview, is directive and sometimes probing in seeking information related to the issue of concern (Britten et al., 1995). In such an interview, the clinician is the one who is the director of the exchange that occurs. Due to the constraints of clinical practice this interview is often streamlined and its focus narrow. Consistent with the primary goal of identifying patterns and eliminating competing explanations for the patient’s signs and symptoms, the diagnostic interview begins broadly and then quickly becomes more focused as the clinician narrows

possible explanations for the patient's history, symptoms and clinical presentation.

In contrast, the objective of a grounded theory interview is exploration of the respondent's experience of a particular phenomenon, whether an illness experience or some other experience of interest, with the ultimate goal of learning about the phenomenon. The interviewer aims to create opportunities for the participant to identify and discuss aspects of the phenomenon that are important to her or him. To do so, the interviewer seeks to avoid overly directing the interview, and typically has an extended period of time available for the interview (Britten, 1995, Rubin & Rubin, 1995). With the objective of going "beneath the surface of ordinary conversation," the grounded theory interviewer uses strategies that include requesting further detail or explanation, clarifying points to check for accuracy, validating the participants' "humanity, perspective or action," and expressing appreciation for taking part in the research process (Charmaz, 2006, p. 26). This approach involves an appreciation for participants as experts regarding their own experience and allows them to express thoughts and feelings that might not be acceptable or encouraged within other spaces of conversation or dialogue (Charmaz, 2006).

Structural aspects of qualitative research interviews also differ from clinical interviewing. In qualitative research interviews, there is typically an interview guide created specifically for the research study being conducted, and questions are designed to open opportunities for the participant to reflect on and engage with the topic of interest. A single interviewer conducts the in-depth research interview.³ There may be a single interview, or multiple interviews may be planned. In contrast, clinical interviews are rarely 'stand alone' events.⁴ The interview conducted by a single professional is often integrated within an extended conversation between the treatment team and the patient, the record of which is contained in the patient's medical chart. For many patients in hospital settings, particular exchanges are situated within a broader set of conversations and formal interviews by multiple clinicians. In the case of a hospitalized patient, the clinical interview may be conducted at multiple times as the patient and family meet with members of the treating team.

Recent discussions of clinical encounters have focused on partnerships between clinicians and patients, patient-centered care (Stewart, 2001) and shared decision-making. These approaches seek to address the power differential between patients and clinicians. However, there remains an inherent asymmetry of power in clinical encounters. Clinicians remain the 'health experts' by virtue of their training and prior experience, though patients remain 'experts' regarding their own experiences and needs. In research interviews these dynamics are significantly altered: the role of the interviewer is to discover and explore the experiences of the participant by providing opportunities for them to reflect upon and discuss their experiences. The ultimate aim of the clinician engaged in interviewing a patient is to provide tangible assistance to the patient. The qualitative interviewer, in contrast, approaches a participant as the expert, indeed a volunteer expert, who can teach them about the phenomenon that is of interest to them.

Strategies for successfully transitioning from clinical to research interviewing

Learning to conduct effective research interviews is a basic skill for qualitative inquiry. Whether conducting an ethnography, grounded theory, phenomenology, or most other qualitative studies, the ability to gather data through interviewing is crucial. There are many types of qualitative interviews including unstructured, semi-structured and structured interviews (Gubrium & Holstein, 2002; Tod, 2006). In addition, informal interviewing is also used in tandem with participant-observation in some methodologies (Bernard, 2002; Fontana & Frey, 1994). To support clinicians new to qualitative research we propose five strategies and approaches that can assist experienced clinicians to conduct successful research interviews (as defined within a particular methodology or tradition). We recommend that clinicians acknowledge and reflect critically on their prior interview experience, prepare carefully for research interviews, maintain awareness of power dynamics within the interview, pay attention to the use of language and verbal cues, and evaluate their own progress on an on-going basis.

1. Acknowledge and reflect critically on prior interview experience

As we have discussed, there are challenges associated with transitioning from one style of interviewing to another. For the clinician-researcher, it is important not to simply assume that a strong clinical interviewing background directly translates into skill and success as a research interviewer. However, previous experience as a clinical interviewer is a source of considerable benefit when the differences between interview genres are acknowledged. Like clinician-researchers who conduct research into questions that relate to their own fields of clinical expertise, it is neither possible nor desirable to put aside one's professional background, or to 'bracket' previous knowledge, skills or experience. Clinicians have first-hand experience of the usefulness of 'talking to the patient' as a means of accessing facets of health experience best understood by the person experiencing it (Thorne, 2008). In addition, the communication skills honed in clinical practice, such as active listening, responding in a sincere, open manner and attending to non-verbal communication are essential aspects of successful qualitative interviewing.

Reflexivity is another process that is essential in research and in clinical practice (Hutchinson & Wilson, 1994; Koch & Harrington, 1998). McNair, Taft and Hegarty (2008) emphasize the importance of reflexivity by clinicians new to qualitative research interviewing as a means of promoting analytic rigour. They employ transcript excerpts to demonstrate challenges related to how a clinician interviewer may control the flow of an interview, over-interpret participant statements during an interview, use inappropriate probing and make assumptions based on 'insider' clinical knowledge. Reflexive practice also entails paying attention to how one is feeling and reacting to the participant, and the impact of these responses on the interview process and the rapport between the interviewer and the research participant.

As previously mentioned, qualitative research (within a naturalistic paradigm) entails epistemological and ontological understandings distinct from clinical practice. It is particularly important for the healthcare provider who has been newly introduced to philosophical, sociological or anthropological theories to investigate the theoretical foundations of planned methodological choices, as well as to reflect on theoretical distinctions underlying clinical practice and research. This process can include examining epistemological issues including the extent to which findings are locally situated and socially constructed, and what truth claims and generalizations can be justified based on interview data within a particular paradigm (Hutchinson & Wilson, 1994). New researchers may also be well-served by taking time to explore related subjects, including researcher positionality (Rosaldo, 1993), negotiating insider-outsider relationships (Allen, 2004) and ethics (Gerrish, 2003).

Critical reflection on one's degree of comfort and preparation for conducting a research interview is crucial. This process can help to identify aspects of the research interview that may prove challenging. In this vein, Thorne (2008) asserts that clinicians need to "undo" aspects of their clinical approach and communication techniques. While the clinician-researcher is likely to have clinical knowledge or experience that relates to the area of inquiry, this background cannot be applied in the research interview in the same way that this insight would be used clinically. This reality reflects the fundamental shift from being someone whose expertise is being sought (the clinician), to someone who is an inquirer (the researcher) seeking out the experience of others in order to better understand a phenomenon.

One implication of this difference relates to the examination of sensitive topics. In clinical practice the interviewer may be justified in probing a sensitive topic or returning to a line of questioning that was uncomfortable for the patient if this line of inquiry is necessary to gather relevant data on the patient's health and circumstances and to determine the most appropriate treatment or care plan for them. The purposes of the research interview, and the role of the participant as a volunteer contributor to the research process, establish more restrictive boundaries for examining sensitive topics. The participant is a volunteer in the study and this creates expectations and limits that differ from the clinical context (Clarke, 2006). Charmaz (2006) asserts that a participant's comfort level always takes priority over obtaining data.

Researchers should be attentive to the discomfort or hesitation of participants, and ensure the participant's willingness to discuss particular questions.

2. Prepare carefully for research interviews

Before beginning the first interview, researchers should prepare for the exchange. In most research interviews there is a set of topics or facets of the area of inquiry that the researcher wishes to cover. To ensure that these topics are addressed, the researcher may script specific questions in advance or may formulate loose questions, and follow up probes. Typically, researchers develop an interview guide, though recognizing that the questions will likely evolve over the course of the research project based on what is learned in earlier interviews. In creating an interview guide, a researcher reflects on what questions she or he wishes to explore with the participant and how to frame questions that will enable this exploration. In particular, a careful plan for broaching sensitive topics, and framing difficult questions, can be very helpful. Planning questions in advance is a process that encourages researchers to reflect on their own knowledge and presuppositions about the topic.

It is also helpful for novice researchers to receive feedback on the interview guide from a variety of sources. Colleagues or mentors with research expertise, in particular those who have used the specific methodology of the project and those with knowledge of the subject matter, as well as clinicians who are familiar with the phenomenon to be studied, might all offer valuable advice. Some researchers also delay establishing the interview guide until they have spent time in the field using other methods of data collection (such as participant observation) (Allan, 2006).

Another opportunity for refining the interview guide and improving interview technique is the process of pilot or test interviews. Evaluating the experience of a practice interview, and receiving feedback from the interviewee, can promote the ability to ask questions well and support the "art of listening" (Munhall, 2007, p.185). Practice interviews will also reveal the kind of spontaneous prompts and verbal feedback that come naturally to the interviewer, and offer an opportunity to consider whether these are the most appropriate or effective in a research interview. Practice interviews might be videotaped to facilitate self- and peer-critique (Taylor, Kermode, & Roberts, 2006). Video will enable the researcher to consider and discuss her or his own body language and demeanor during the interview.

Another preparation strategy that could be considered is role-play. Role-play can be used in a class or training context for novice researchers to practice how they would respond to challenging scenarios such as if a participant becomes distressed, angry or very quiet, or when a participant wanders in telling their story. A particular scenario that could be role-played and that is very pertinent for clinician-researchers is when a participant requires or requests clinical assistance from the researcher.

A final strategy that might be employed is to observe interviews conducted by an experienced researcher and to discuss observations with the interviewer (and perhaps even the participant) afterwards.

3. Avoid mixed-messages and maintain awareness of power dynamics within the interview

Clinician-researchers must decide if (and how) they will present themselves to research participants as health care providers, as well as researchers (Thorne, 2008). In Canada, the Tri-Council Policy Statement advises that researchers having potentially dual roles as care providers and researchers be sensitive to how this situation may create "conflicts, undue influences, power imbalances or coercion" (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2010, p. 95). According to the Canadian Nurses Association, a researcher should avoid being in a dual role situation; that is, nurses should not be both caregiver and researcher for a patient/subject without compelling reasons for doing so (2002).

Where research is conducted in a healthcare facility in which the researcher also practices as a clinician, it is important to consider potential non-verbal cues related to the dual roles of researcher and clinician. For example, the researcher should consider whether to wear a hospital ID badge, scrubs, a pager on her or his belt, or a lab coat as these are symbols of the clinician role. In conducting the interview, the researcher might choose to reveal that she or he is a clinician however this information should be presented with attention given to clearly communicating responsibilities and not creating a power imbalance. At the beginning of an interview, for example, the researcher might introduce herself as “Angela Lewis,” a researcher and physician. This approach would be preferable to introducing herself as “Dr. Lewis” who is conducting a research project. Emphasis that the researcher is a clinician, especially one with clinical responsibilities in the department or unit, might evoke uncertainty or tension for some participants. For example, a participant might question whether information revealed to the researcher will be relayed to the treatment team or included in her or his medical chart. Mixed messages might also be a barrier to creating rapport between the researcher and participant. Researchers should address such concerns and reassure participants about the parameters for protecting confidentiality and anonymity in the study.

In all settings, the process of negotiating informed consent to participate in a study presents an opportunity to clarify the voluntary role of the research participant and distinguish the research process from clinical care. In carrying out the informed consent process, researchers can help clarify the nature of the participant’s role in research by acknowledging the participant as an expert, and their own desire to learn from the participant.

4. Pay attention to language and verbal cues

Researchers, and particularly novice clinician-researchers, will benefit from paying attention to the use of language, terminology and verbal cues during interviews. A fairly obvious example is that clinicians should avoid reference to research participants as patients. They should also be careful to avoid unnecessary use of medical jargon during interviews and should verify the meaning of terms used by participants and not “assume that interviewees use medical terminology in the same way that they do.” (Britten, 1995, p. 252).

It is also useful to consider the prompts and cues that are a normal part of interpersonal discourse, but which are often unnoticed. The implications of these cues in the research context are different from other settings, including clinical interviews. Even with a tightly scripted interview guide, spontaneous verbal cues are an important aspect of every interview. Thorne (2008) asserts that the use of value laden prompts such as “that’s good” or “I agree” should be avoided as they imply to participants that certain types of data will be received positively and that other types of disclosure may not be (p. 115). In addition, she suggests thinking of ways to encourage the participant to elaborate on the topic, other than saying “I understand” (Thorne, 2008, p. 115). Such a response might indicate that the researcher already fully understand the experience that the respondent is describing. There are multiple ways that researchers’ questions and prompts have the potential to “structure a person’s story” (Munhall, 2007, p. 184) by leading a participant in certain directions or valorizing certain types of responses and not others. Evidently, orienting an interview in these ways should be avoided.

As in the clinical interview, paying attention to non-verbal cues and body language of research participants yields valuable insight. It is also helpful for the interviewer to notice which terms are employed by a participant as they discuss a particular phenomenon and to incorporate this phrasing in the construction of subsequent questions.

Finally, the duration of a research interview is usually sufficiently long to allow for silences and to avoid the need to hurry a participant’s response. Pauses and silence can be an important part of the interview. Such silences can be uncomfortable but the researcher ought to practice restraint and avoid rushing to fill them (Munhall, 2007). Silences allow participants to collect their thoughts and to reflect on the question

and their own experience. Charmaz (2006) also suggests that researchers attend to long pauses and reflect upon whether they might signal a “struggle to find words” (p. 33).

5. Evaluate progress on an ongoing basis

Reflection and evaluation of the interviewing process is best thought of as an ongoing activity that continues throughout the research project. Various activities can support continued attention to interviewing quality. Writing field notes after each interview provides an opportunity to reflect on and chronicle the interviewing process. This is in line with Bernard’s (2002) assertion that researchers ought to write methodological field notes to chart their “growth as an instrument of data collection” (p. 374), in addition to descriptive and analytic field notes. Such notes are different than those usually made by clinicians following interviews. Clinicians need to adapt their note taking approach – field notes differ in scope, content and purpose from the familiar tasks of taking clinical notes or charting in the medical record.

Reviewing interview transcripts is not only essential for data analysis, it is also valuable for evaluating the broader interview process. Reviewing a transcript provides another vantage point from which to evaluate the exchange that took place. For example, scanning printed transcripts will give an impression of the ratio of talk between interviewer and participant. If there is a greater amount of talk by the researcher than is anticipated, this can stimulate reflection upon what was happening in the interview. A range of questions could be asked: Were many prompts required? Was the participant reticent to discuss a particular topic? Was the interviewer too verbose or too quick to fill silences?

Listening to audio-recordings of an interview, while reviewing transcripts, is an important quality control mechanism. Taking the time to listen to the taped interview also provides a valuable feedback loop for how questions were framed, verbal cues used, and silences allowed or resisted. Listening to tapes can also provide insight into whether the participant was able to express her or himself fully before the next question was asked. The step of reviewing transcripts or recordings with supervisors or mentors can provide an additional and valuable source of feedback.

Conclusion

There are important differences between clinical and research interviewing. Clinicians who become involved in qualitative research might encounter unanticipated challenges in adapting both to the context and needs associated with research interviewing. In this paper, we argue that the differences in interviewing between the clinical and research domains should be acknowledged and addressed prior to embarking on a qualitative project, and attended to throughout the study. This is an important topic that should also be addressed by supervisors and mentors. We recommend the following steps for clinician-researchers: critical reflection on prior interview experience, careful preparation for research interviews, attention to power dynamics and mixed messages during the interview, awareness of their own and their participants’ use of language and verbal cues, and evaluation of progress on an on-going basis. Identifying and seeking to address points of divergence between different genres of interviewing will help clinicians new to qualitative research become successful research interviewers.

Notes

1. For example, the interview used in an institutional ethnography is loosely structured and set questions are not identified in advance (DeVault & McCoy, 2002). In some other methodologies, a tightly scripted interview guide that includes pre-established questions and follow-up prompts is required. We acknowledge that in treating research and clinical

interviewing as broad categories there is a risk of over-generalization. However, our focus in this article is on the dominant set of practices within each category.

2. Two methodological texts where this topic is addressed are Hutchison and Wilson (1994) and Thorne (2008). Hutchison and Wilson's analysis focuses on theoretical and epistemological differences between clinical and research interviews. Thorne discusses these issues within her presentation of interpretive description methodology (2008).
3. There may be multiple interviewers in the case of group interviews.
4. There are exceptions, of course. In some clinical contexts such as the emergency department or walk-in clinic, 'stand-alone' interviews may be common.

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