CHAPTER 7

THE UNSTRUCTURED INTERVIEW AS A CLINICAL TOOL

Of all the techniques which the student of abnormal psychology has at his disposal, the most direct as well as the oldest is that of the interview technique. Because conversation, the medium of the interview, is so common in everyday life, its potency in clinical investigations is often discounted while other techniques—like testing, questionnaires, and attitude scales—assume a much higher scientific status. It must be recognized, however, that conversation still constitutes the primary basis for evaluating the other techniques in the investigation of personality. In the particular clinical context, these techniques can be validated only by understanding the person under examination, and the fullest understanding that is now vouchsafed us is through verbal communication face to face.

There is no better way of finding out personal information than by asking for it. This is so obviously a truth that its import for clinical investigations is often lost sight of. To be sure, the person's reply has to be evaluated in light of all that is known about him previously, and the non-verbal aspects of his response (bodily movements, tones, etc.) must also be taken into consideration. But in the last analysis, abnormal behavior cannot always be inferred from externally observable behavior alone, since the affect or attitude of the patient may reveal itself (if at all) only to direct questioning. Mental disorders have an introspective subjective aspect, and the psychological judgments about how one feels, about one's attitude toward an event or an object, depend upon introspective reporting. This in no way lessens the scientific value of the obtained data, since even psychophysical brightness discrimination or flicker discrimination depends upon subjective reporting. We may want some day to use only external indications of brightness discrimination or flicker fusion independent of verbal reporting. Such non-verbal reporting for these phenomena has already been attained in animal experiments. Whether we shall ever be able to dispense with verbal behavior in determining how a person feels is very doubtful, but even if we could do so, the methods of attacking this problem would have to depend upon the results of interviewing as criteria for validation. The value of the Rorschach technique, for example, did not arise from any a priori significance attached to the responses made by a patient to inkblots. Its value depends on the fact that Rorschach observed mental patients and their behavior, conversed with them about their feelings and their cogitations, and then asked them to respond to the inkblots. As a result of his previous knowledge of the patients mental mechanisms, obtained by interview methods, he was able to relate inkblot responses tentatively to mental deviation. This basic primacy of the interview runs through all of psychopathology. Without the interview we would be unable to make progress in providing new tests or validating old ones.

It should be pointed out, however, that the medium of the interview, conversation, is still a primitive communication tool. In the early days of science conversation constituted the chief means of summarizing investigative work. Primitive man reported subjective warmth, for example, in conversational terms, referring his estimate to a rough consensual scale of warmth anchored between the coldest day of winter and the hottest day of summer. Estimates of height, weight, and time, too, were originally based on self-referred subjective standards publicized conversationally. Gradually conversational methods in physical measurements gave way to more precise instruments in which the subjective conversational factor was reduced to a minimum, pointers taking the place of verbal responses. Even in psychology, the conversational methods prevalent before Wundt gave way to more precise instruments for estimating or evaluating psychological

processes. But this holds true mainly of cognitive factors. Evaluation of affective, motivational, and volitional factors never developed beyond the primitive conversational method. The reason for this slow stage of development of techniques for evaluating the motivational, affective, and volitional components of mental life are many, not the least of which is men's own defenses against the invasion of his privacy. Cognitive functions have been removed from "the soul" long enough to subject than to measurement. Motivation, affect, and volition are the last functions that take refuge in the "soul." Modern psychopathology has, however, penetrated this stronghold by the brilliant insights of Freud and the empirical investigations of brain function following the somatotherapies. Despite the crudeness of our principal tool, conversation, we have made some progress. Now it is time to see whether we can make further progress by sharpening the tool.

Why does the interview retain such a central place in the investigation of abnormal phenomena? The answer to this question reflects a fundamental difference between observations of abnormal phenomena and of normal behavior. In general there are two types of questions which an investigator of abnormal personality wishes to answer. The first type deals with the basic causes or etiology of the behavior under observation. The second type deals with the reaction of the patient to the particular behavior he is exhibiting. The first type of question has been couched as follows: What unconscious agent makes this patient sick? How does it make him sick? The second type of question has been couched in these terms: What is the patient's reaction to the disease process? How does the patient respond to this sickness, and how does it affect his total personality?

Information about the events leading up to the illness and the "causes" that presumably produced the illness can be obtained from many sources. First, the life history in the form of documents, vital statistics, available records of schooling and vocational career, and other information available from official sources which indicate the patient's general background. These can often be obtained impersonally or from the patient or his family. Second, the reports of friends and relatives. Third, the clinician's observation of the patient himself and his performance in free or structured situations, the way he dresses, the way he approaches people, and his general manner of self-expression. This may also include psychological tests, rating scales, and questionnaires. It is quite apparent that the interview technique transcends these other methods in tapping the patient's attitudes, if not in eliciting the basic information necessary for understanding him.

Information about how the patient feels or his attitude toward his illness can be obtained only from him, directly. This is why the interview is so important. It is the only method now available for determining first-hand the patient's response to his illness. Thus, three patients might be suffering from somewhat similar recognizable digestive disorders, such as recurrent vomiting. One goes to the doctor, complains about his difficulty and is found to have an organic basis for his vomiting, accepts it as the correct explanation, and, after proper treatment, improves. The second is found to have no organic basis for his condition, is told that it is due to tension, does not accept this as an explanation, and shops around until he finds a doctor who discovers a possible organic basis. Treatment is given, but the patient finds no relief. A third patient regards the vomiting as due to magnetic currents induced by the electric wires in the house, requests that the electricity be turned off and reverts to gas lighting, but finds no relief from his condition. In each of these three cases, somewhat similar overt behavior exists, but the attitude towards this behavior (which may itself be part of the disease process) is the one factor which differentiates the three conditions diagnostically.
Another example is afforded by a handwashing compulsion. In what way does the behavior of a patient with a handwashing compulsion differ from the behavior of the dentist who washes his hands in between patients? There may be no difference in frequency but there certainly is a difference in motivation and in attitude. Compare the result of a sudden water stoppage on the behavior of the two. The dentist would probably solve his problem in some ingenuous way, by utilizing some substitute, for example. The patient is likely to perform the lavation ceremony without benefit of water.

Perhaps the most striking evidence in favor of the hypothesis that the attitude or response to a given event may be more important than the event itself comes from the somatic therapies. Both under electroconvulsive therapy as well as under insulin therapy, the patient retains his earlier habits, hallucinations, compulsions, emotional memories, but his attitude towards them has changed. They no longer disturb him and no longer overpower him. This is found to be equally true after psychosurgery for relief of psychosis and for the relief of intractable pain. The psychosis is still present but it no longer overwhelms the individual; the pain is still there, but it is no longer intractable.

Sometimes the interview helps in determining the presence of complications not revealed by the objective indicators, since many diseases depend upon the patient's own recognition of his illness before any objective evidence can be obtained ( ). For example, some types of early cancer cases at the present time are not detectable in any way other than through the report of the patient himself. In such instances interviews with a patient who complains of some vague ailment may sometimes lead to a discovery of a disease which otherwise would be missed. In the field of mental disorders, where the objective indicators are few, the interview technique assumes much greater importance. For these reasons, the primary technical procedure in psychiatry and in abnormal psychology for eliciting information from, and understanding of, the patient, is the interview. It is not an infallible method, but is the most trustworthy method now available.

Another possible reason for the importance of the interview in psychopathology is the fact that it is a sample of the way the interviewee reacts to interpersonal relationships. If mental disease is essentially a disturbance in interpersonal relationships, the interview technique may be counted on to reveal such deviation.

How the clinical interview developed

The use of the interview method in medicine and psychopathology dates back to the dawn of history.1 Probably the very first physician or medicine man had occasion to question his first patient and this probably constituted the first interview or history-taking for healing purposes. Celsus ( ), a layman of the first century, described in detail optic or visual hallucinations, which were no doubt obtained by interviewing of patients. One of the first intimations of the use of the interview with mental patients is given by Soranus ( ), who formulated rules for approaching patients during their convalescence. He recommended

1According to the Shorter Oxford English Dictionary the word "interview" was first used in 1514 to designate a meeting of persons face to face, especially for the purpose of formal conference on some point. In 1869 it was used to designate a meeting between a representative of the press and someone from whom he seeks to obtain statements for publication. The two essential elements in both of these definitions are that there be a face to face meeting, and that information be elicited by one person from the other.
that a laborer should be engaged in conversation about the cultivation of the fields, and a sailor in a discussion of navigation. If the patient was grossly ignorant he should be approached with only very general topics or with simple calculations. He concluded: "It is possible in fact to arouse the interests of all kinds of persons, but care should be taken to encourage the patients by complimenting them when possible."

Historically, as one investigates the rise of the interview technique, one must bear in mind that each period had its own philosophy and its own approach to mental illness. For example, during the Greek period mental disease was regarded as due to either perversity, being possessed, or being drugged. The procedures for treating these causes were to use physical force against the perverse one, to leave the possessed one to the priests or other religious leaders, and to regard the drugged patient as one whose humors had been disturbed physiologically. The hallucinations and delusions which characterized such patients were regarded as nothing more than the reflections of their drugged condition. Interviewing of patients seems to have had little or no place to this period.\(^2\)

During the Moorish period, psychodiagnosis used mystical and intuitive approaches. Whatever the patient uttered was interpreted by the seers in terms of mystical criteria rather than in terms of the patient's needs and difficulties. During this period, however, interest in the patient's attitudes and beliefs increased because of the preoccupation with man's soul.

The Western Caliphate, especially in Seville and Cordova, began to be concerned with the problem of personal responsibility, and emphasized the personal interview. During the Spanish Inquisition it was against the law to condemn a non-Christian for heresy, and only the heretics, upon whom the devil had prevailed to desert their religion, could be punished by death. Where convictions were desired, interviewers were appointed to question each prisoner to determine the degree of influence which the devil had had upon him. This gave rise to a new type of interviewing such as that recounted in the records of the Inquisition \(^3\) in which reports are given of how old inquisitors trained new inquisitors in the art of interrogation to establish the presence of heresy. By easy stages the accused were led to reveal their beliefs and their attitudes, and special techniques were prescribed for overcoming the artful ingenuity of the peasant in order to obtain confession.

With the rise of the idea of personal responsibility, implying that only those who are mentally competent can be punished, there arose a need for interviewing the patient in order to determine how he actually felt and thought. Bacon, in the early 17th century, used certain test questions, inquiring, for example, whether the patient knew how old he was and what his name was. Thus he

\(^2\)To be sure, there were such questions as whether the person suffering from hallucinations and delusions should be kept in a dark room or whether he should be kept in the light. Those who locked the patient up in a dark cell felt that by thus reducing stimulation, the tendency to perceive hallucinations would be reduced. On the other hand, those who believed that every object had its emanation and that objects are continually sending forth these emanations in the form of images favored placing the patient in a light room since it would permit the person to overlook the emanations and prevent them from interfering with his normal perception. \(^3\)Hence, asking the patient whether or not he had hallucinations or delusions perhaps was important, but that is as far as their interview approach could have led the physicians of that day. The rest was a matter of controlling the hypothetical source of these hallucinations.
initiated psychological interviewing with regard to time and personal orientation. Though this trend spread, it was incorporated into law rather than into medicine.

About this time Waynor (1) demonstrated the importance of seeing patients as they actually are, of recognizing the inner independence of their personalities, and of looking at them and observing them as a naturalist without shock at what he discovered and without flinching at the incongruities and conditions of human beings.

The observation and interviewing techniques developed during the 17th century are exemplified by the following occurrence. A young man whom Foppand (2) knew to be a cheerful, energetic person, came to him very sad and depressed. A change of his environment, recommended to remove the melancholia, only made his condition worse. But one day while Foppand was palpitating the young man's pulse, a good-looking young girl happened to enter the room, carrying with her a lamp. Foppand noticed that the pulse of his patient at once became irregular, his face grew pale. He guessed where the trouble lay and the patient, upon being interviewed, admitted it. The family objected to marriage as the solution to his trouble. But Foppand took charge of the boy and obtained a successful cure. From that time on, Foppand devoted a great deal of energy to the study of similar disorders. Some people, he said, treated melancholias and other manias caused by love in the same way that they treated other melancholias in madness, without considering the true cause and seat of the disease.

Perhaps one of the most recordings of the subtleties of their methods in eliciting attitudes is found in Carvantes (1547-1616) Don Quixote. In a delightful description of a three-way conversation between the curate, the barber, and Don Quixote, the technique of eliciting the hero’s temporarily latent attitude towards knighthood is detailed with great finesse. (de Carvantes, Miguel, The Incomparable Gentleman Don Quixote de la Mancha: Seill’s revision of the translation by Peter Motteux; the Modern Library, New York, Randon House, Inc. 1950 (paper bound) Part II Book III, 1. What passed between the curate, the barber, and Don Quixote, concerning his indisposition, p. 444-447.)

Another example of subtle interviewing is given by Dostoevsky (Crime and Punishment) in the discussion between Raskolnikov and the Inspector. The final development and the confession and the feeling of relief coming after the confession is one of the most unusual examples of the processes which sometimes occur in therapeutic situations.

There was a time when the life or death of a mentally ill patient depended on the outcome of an interview. For example, in Koenigstein in 1636, a man proclaimed that he was God the Father and claimed that all the angels and devils and the Son of God recognized his power. He was interviewed, forthwith convicted, his tongue cut out, his head cut off, and his body burned. Interviews today do not often lead to such dire results but it is interesting that convictions then often depended merely on the self-admission of an individual. (4)

Johann Christian Reil (1759-1813) developed some interesting approaches to eliciting communication from patients during interviews. For example he tried the effect of placing them in an absolutely dark and quiet cell and letting them talk. He also wanted to have a special theatre in a mental hospital in which employees would play the roles of judges, prosecutors, angels coming from heaven, dead men coming from out of their graves, and similar roles, which might bring forth responses from various patients in accordance with their needs and fantasies. When- (Footnote continued on next page)
Recent history

With the rise of the phenomenological approach to mental illness, exemplified in the first place by Charcot and culminating with Freud, the interview became the center of the psychodiagnostic process. Here began certain modern attitudes toward interviewing which proved important in the handling of the normal as well as the mentally ill. It is to Pinal, however, that the invention of the case record must be credited. He introduced the taking of psychiatric case histories and the keeping of careful records. At first the majority of those records were Pinal's personal notes made for his own use. Gradually, however, the principle of record-taking became established and it proved to be the cornerstone of modern psychiatric research procedures. Much investigation would have been totally impossible without the permanent systematic case records which are now the measure and the identifying mark of a good mental hospital.

The system of animal magnetism introduced by Mesmer, which later developed into hypnosis and into various forms of suggestion therapy, relied heavily on the reports of patients. Here the interviewing of patients was both essential for understanding the basic difficulties of the patient and important in the cure of the patient's condition. The introduction of persuasive therapy must certainly have utilized interview techniques intensively. Sometimes, to be sure, the method worked in reverse; for instead of the patient's telling about himself, the physician narrowly told the patient how to live more normally.

The next step in the development of the interview occurred with Josef Breuer, a general practitioner in Vienna, who had been working with hysterical patients between 1880 and 1882. This was before Freud went to study with Charcot. Breuer introduced the following innovation: he let the patient, usually a woman, talk under hypnosis and tell him what it was that troubled her. The patient as a rule talked freely under these circumstances and while doing so displayed intense emotion. Upon awakening from the hypnotic state she was relieved of some of her symptoms. Freud was impressed with Breuer's method and findings, and communicated them to Charcot, who appeared rather indifferent to them. Upon his return to Vienna, Freud resumed his friendly contact with Breuer, and eventually - for a time - used Breuer's method only. No suggestions were made to the patient; hypnosis was used to permit the patient to speak spontaneously and to discharge a considerable amount of emotion connected with the fantasies or the memories which the patient was relating while in the hypnotic state. Because of the regular discharge of emotional tension, the method was called the cathartic method. In 1893, a joint paper by Breuer and Freud ( ) appeared, and in 1895 their book, "Studies in Hysteria," Freud very soon discovered that he could dispense with the hypnotic state as easily as he had with suggestion. Allowing the patient to talk at random he found that the patient eventually overcame the inner obstacles which stood in the way of remembering. The therapeutic results of this method were found to be more efficient than those obtained by the earlier methods. The new method was called "free association," and the method of analyzing and interpreting what

(Continued from page 7-5) ever necessary, prisons, lions' dens, places of execution, and operating rooms should be represented on the boards of this psychotherapeutic theatre. This was based on Reil's conception of non-injurious torture as a means of exorcising the illness ( ). It is interesting to compare the psychodramatic method of Moreno with this procedure of more than 200 years ago. Reil was extremely interested in the patient's introspective self-observations, that is his ideational content, which he elicited in his interviews with the patients.
Perhaps the highest development in the use of the interview technique in psychotherapy is due to Adolph Meyer (1) and his school of psychobiology. The interview was utilized by him for obtaining information regarding the development of the individual, from his early childhood up to the time when the illness began. The purpose of this interview is an attempt to discover the various forces which interfered with the normal development of the individual. Finally, during the war, the brief interview technique was developed, being used primarily as a screening procedure in discovering the emotionally unfit; and the non-directive interview technique of Rogers (2) emerged as the primary method in one type of psychotherapy.

Outside the psychological and psychiatric fields the interview is also utilized quite extensively, especially in medicine, anthropology, sociology, law, criminology, and in confessional in the church. An analysis of the auricular confessional interviews, with their complete frankness and self-revealing aspects on the part of the interviewee, and the anonymity and relatively impersonal role played by the interviewer would provide important psychological information on the various factors operating during an interview. Such analyses, however, would probably be difficult to undertake.

What the interview differentiates

At this point it might be well to examine the factors that differentiate the clinical from the non-clinical interview. The focus of the interview, in its clinical form, is on the person being interviewed, and the interviewer is in a sense only incidental: any other interviewer, provided he had the training, would no doubt be equally acceptable. In this type of interview (including counselling, guidance, employment) the interview is most often requested or initiated by the patient or client or candidate, who feels a definite need for help. There are, of course, certain kinds of interviews that deal with clinical matters which the informant does not request — for example, in forensic psychiatry, required counselling for school underachievement, etc. In these cases it is a moot point whether or not the transaction itself can be called a "clinical" interview. In the non-clinical interview per se, such as a sales promotion, traffic survey, public opinion poll, etc., the interview is usually initiated by the interviewer, and any other informant, provided he was a member of the sample of the population under investigation, would be equally acceptable. As a result of this non-reciprocal relationship between the two interlocutors in the two kinds of interviews, the resulting transactions take on quite different tones.

6 Even in the non-clinical interview, however, the apparent personality characteristics of the interviewer may prejudice the results. Jewish-appearing interviewers with Jewish names obtain totally different responses to questions about antisemitism than do non-Jewish appearing interviewers. Thus, in one study in which the question was: Do Jews have too much power?, 25% of the respondents said yes to a definitely non-Jewish looking interviewer, 16% said yes to an investigator who was Jewish but did not mention his name, and only 5% said yes to a Jewish investigator who gave a very characteristically Jewish name. In surveys of labor relations, the dress, manner and appearance of the interviewer, whether he looks like a pro-union or anti-union man, etc., will influence the outcome. Intellectual factors, aside from personality, may also influence the results. In health surveys, a positive correlation was found between the number of illnesses reported and the IQ of the interviewer. In addition to the appearance and biases of the interviewer, the anxieties he exhibits may also influence the response.
In view of the importance of the interview technique, it is surprising that so little attention has been paid to its structure, content, and the factors underlying it. It presents a classical pattern of cultural lag, having been relatively unaffected by the techniques which have served to improve the adjacent areas of tests and rating scales. Only recently has it been lifted from the framework of common, everyday conversation and become an object of study by psychologists, psychoanalysts, and students of information and communication theory. 

The main characteristics which together set off the interview from other types of human encounter are as follows (1): 1) it is a meeting of individuals face to face; 2) it is directed to a particular purpose; 3) it employs conversation; and 4) the relation between the individuals participating in the interview is non-reciprocal, in the sense that one usually is the interviewer and the other the interviewee.

Each of these factors makes its contribution to the unique experience which constitutes the interview. The face-to-face relationship permits both the interviewer and the interviewee to utilize the subtle non-verbal cues which are very important in our understanding of each other. They are entirely lost in written recordings of the interview and at least partially lost even in voice recordings. The facial expression, the body movements or postures, the postural attributes, steadiness or lability of demeanor — in fact, all the gestural aspects of conversation — constitute an important avenue of communication, the nature and characteristics of which have hardly been touched by scientific investigations (2). The face-to-face situation is, of course, important in everyday casual conversation, but its effect in the interviewing of mental patients is probably even greater. The interpretations (and misinterpretations) of the cues arising in a face-to-face situation are made by the patients as well as by the interviewer. The unconscious floating gestural expressions of the interviewer may interfere with communication and, by the same token, a purposeful, controlled use of such gestures in the service of role-taking might be helpful in eliciting the attitudes of the patient.

The purposive nature of the interview differentiates it from most spontaneous conversations, though not from all. In the clinical interview, need and goal are made consciously identified. In situations where the patient comes willingly for help, the purposes of the interviewer and informant have a common goal, though each is satisfying a different need — the patient, a need to get better, and the interviewer, a need to find out what the trouble is and how best to provide help. In the case of the patient who comes unwillingly, brought in by others, the goals of the patient and interviewer may be contrary. (Once regard the resolution of the differences in goal between the interviewer and the interviewee as the purpose of psychotherapy.) The analysis of the reasons why the patient came to the interview are of importance in the diagnostic process. Whatever the reason, recognizing the double purpose in the interview permits one to analyze the progress of the conversation and determine a natural beginning and end to the interview or series of interviews.

The non-reciprocal relationship between the interviewer and the informant sometimes permits the interviewer to take the lead in directing the course of events whenever necessary by removing obstacles to the free flow of conversation, or sometimes, in imposing such obstacles as the strategy might dictate. This, too, permits experimental investigation of the effect of a given intervention by the interviewer.

Considering the clinical interview as a means for evaluating personality in
mental patients, two broad types of clinical interview may be differentiated: the diagnostic interview and the therapeutic interview. Although the two types have much in common they differ in their purpose.

In therapy the chief aim of the interview is to utilize verbal expression for the relief of symptoms and cure of disease. Diagnosis, on the other hand, is concerned with why the patient seeks help, what his difficulties are, and his attitude towards these difficulties. The diagnostician, who is not concerned with the therapy itself but merely with determining the kind of therapy most suitable for the patient, can feel freer to utilize a variety of techniques for eliciting the information which he is seeking regarding the source and nature of the patient's difficulties. How he proceeds in eliciting this information is a difficult process to analyze. The basic question in the analysis of the interview process is simply this: what is it that permits an interviewer, without previous acquaintance with the interviewee, upon a particular occasion, within a limited time period, to arrive at a more or less reliable assessment of the personal problem of the interviewee? In other words, upon what does the interviewer's judgment depend; or what particular type of behavior displayed by the patient constitutes the basis for the evaluation?

The uncovering of attitudes

The essential element which differentiates the interview from other techniques is that it deals with the patient's attitude towards his ailment. To be sure, the patient sometimes reveals objective information not available through any other source (vis., hallucinations, delusions, worries), and the skill of the interviewer is reflected in the ability to elicit this type of information. More often than not, however, this information is closely interwoven with subjective attitudinal factors which may have prevented it from being communicated previously. Apparently, revealing even this kind of information also exposes certain attitudes and feelings. This is the key to the riddle. It is the patient's attitude towards his difficulty which the interview can evaluate more directly and more successfully than other methods can. Examples of the importance of attitude in other types of behavior are not difficult to find. In the courtroom, for example, not only the fact of the murder but the intention must be present for obtaining a verdict of guilty.

Another aspect of the attitude towards an event needs to be mentioned. The subjective importance that is attached to a certain event may identify it clinically as psychopathological behavior. Sometimes, conversely, failure to realize the importance of an event marks it as psychopathological.

How does the attitude of the patient display itself? Does it come spontaneously, or does it require manipulation on the part of the interviewer to elicit it?

First, what is meant by attitude? Generally speaking, "attitude" means the expression of feeling and the emotional "set" regarding some idea or event that comes up in the course of the conversation. How is this attitude evaluated? There are two divergent opinions on this matter ( ). The first hypothesis is that attitudes are directly demonstrated, and even though they may be misperceived by the interviewer or there may be a delay in their perception, they nevertheless are direct and undelated and do not depend upon inferences for their perception. The second hypothesis is that attitudes are inferred from certain cues observable in the patient. Probably both of these processes, direct perception and cue perception, contribute to the correct evaluation of an attitude. Thus interviewing is essentially a perceptual transaction in which the attitudes
of the patient are perceived either directly or through inference by the interviewer and evaluated at the same time. The correspondence between the interviewer's evaluation of an individual and his "true" personality may be very slight or very great. It is probably never perfect, and the degree to which it approximates the "truth" is dependent upon the personality of the interviewer, the degree of readiness of the interviewee to reveal himself, and the degree of experience that the interviewer has had previously in eliciting such information.

How the interview works

What is the process of interviewing, what does it consist of, and how does the interviewer elicit the information with which he evaluates the personality of the patient? Generally, the patient who has sought out the clinician for help is ready to communicate whatever the clinician wishes to know, and is able to do so provided it is not too deeply defended against. This readiness to confide is not available immediately to interviewers in other fields. But even in the clinical field, the clinician must be careful to be frank and direct in enlisting the patient's help to determine the puzzling cause of his mental anguish. Usually evoking the attitude of cooperative effort is sufficient to enable the trained clinician to attain his goal. In some cases, however, he has to plan more carefully in advance in order to elicit the required data.

Since the primary purpose of the interview is to evaluate attitudes it is necessary that the attitudes be displayed. (If a patient tells his story forthrightly and readily and responds to the inquiries of the examiner in the usual conversational manner, there may be no need for strategy, since conscious strategy needs to be resorted to only when the conversation lags or breaks down.) But if they are not spontaneously exhibited, the interviewer must undertake to arouse latent feelings and attitudes by means of either direct or indirect stimulation. In such instances, however, it is desirable to manipulate the factors that have brought about the impasse, so as to be able to regain the forward momentum of the conversation. But what are these factors? The problem of analyzing conversation and finding its components, both verbal and non-verbal, is not essentially different from the one which faced mankind in its attempt to analyze the constituents of the atmosphere. Although everyone is surrounded by air from the moment of birth, it took a genius to discover its existence at all. Once its presence was discovered, the analysis of air proceeded at a rather slow rate because of its apparent homogeneity. Similarly, although the existence of conversation has been recognized for millennia the analysis is hampered by the lack of a proper framework. There is a need for conceptual models to help guide the observations that have been made or are still to be discerned.

The interview medium: the Skinnerian model

It is not surprising to find that the number of psychological formulations that have been attempted in the past are not very numerous. Philologists and students of literature have formulated many schemes for analyzing the formal aspects of language but there are very few analyses of conversation as a form of behavior. Skinner has attempted such an analysis. He has defined verbal behavior as he does non-verbal, as emitted behavior which is contingent upon a stimulus (known or unknown) and upon reinforcement. Reinforcement in verbal behavior may differ from reinforcement in non-verbal behavior, however, insofar as it requires the mediation of another organism. For this reason, the speaker is less certain of the reinforcement he expects to obtain than he might be in a non-verbal situation where the mediation of another organism is not required. The energy with which he speaks bears little or no relationship to the effect produced, a situation which is not so common in non-verbal behavior. The basic datum in
verbal behavior is not the response, but the probability that a given response will be emitted under specified conditions. 'Slips of the tongue' are examples of the probabilistic nature of the emission of responses; when a 'slip of the tongue' occurs, a concatenation of circumstances has raised the probability of a response to the point where it goes against the trend of the rest of the responses and appears as a maverick. Thus, verbal behavior is a dependent variable, contingent upon the assumed presence of motivation, conditioning, emotion, etc.

Skinner has divided the elements of verbal behavior into five major categories in accordance with the nature of the differential stimulus involved in the emission and its relation to the reinforcement process. These are 1) the man, 2) echoic and textual behavior, 3) intraverbal, 4) audience conditioned, and 5) the tact. The man refers to the type of verbal behavior which in many communities is characteristically followed by certain reinforcing consequences - e.g., Wait! Ssh! Cut! This type of response is under the control of the drive behind the verbal response. Thus, if there is an attractive object outside of the room, the response "out" will be increased in vigor and urgency. If the attractive object is brought into the room, the response "out" will be extinguished - fall below "threshold" because of the lowering of drive. A man, then, is a speech utterance that makes demands upon the hearer and brings reward to the speaker when the hearer complies.

Some types of verbal behavior are not under the direct control of special drives. Two of these are the echoic and textual responses, which consist of the repetition of previously heard or read speech. The echoic tendency is strong in children and is probably an important factor in the development of language. A third type is the intraverbal behavior exemplified by the word-association technique where the stimulus work evokes a different (non-echoic) word in the respondent. So strong is the echoic tendency however, that in order to obtain intraverbal rather than echoic behavior, a special injunction against echoic behavior is required in the directions for the word association test.

A fourth type of verbal behavior is that which is controlled by the character of the audience. A given audience will reinforce one type of response rather than another, even if it consists of nothing more than a change from slang to more conventional usage, or vice versa. The fifth type of verbal response is the "tact," which refers to a verbal response in which the form is determined by a particular object or event which stimulates the speaker directly prior to the emission of the response. Thus, the presence of an object might be responded to by naming it, the presence of a lost friend by a sudden outburst of inquiries about his whereabouts, etc.

Skinner, however, points out: "Our variables might be said to generate the materials from which verbal behavior is composed, but the act of composition is another matter. Before we may consider the processes which forge this material into the larger samples of verbal behavior which we are familiar with, we must examine one other fact about our variables. They do not act one at a time. Verbal behavior is usually the product of multiple causation.

"A simple way to demonstrate the effectiveness of multiple causation in verbal behavior is to accept the engineering task of evoking a given response in a given speaker at a given time. The devices to be used will depend upon the response specified, upon the speaker's history, and so on. But in a selected case our procedures demonstrate our faith in the combined action of multiple variables. For example, suppose we are to evoke the response, pencil, in a naive subject. (If the subject is not naive, he is already under the influence of variables affecting the result and we should have to stop to deal with these variables first). Proceeding step by step in retracing our analysis,
we first create a strong drive. For example, we make sure that no pencil is available, then hand the subject a pad of paper appropriate to pencil drawing, and offer him a hundred dollars if he can draw a recognizable picture of a cat. The mand pencil will certainly acquire strength. Secondly, we set up a stimulus for the tact pencil by putting a very large or unusual pencil in an unusual place — say half submerged in a large aquarium, within sight of our subject. We strengthen the response intraverbally by having a phonograph repeat pen and —, pen and —, pen and —, or by posting large signs reading PEN AND — on the walls. We get the echoic response pencil with a phonograph saying pencil, pencil, alternating with the first phonograph, and we could get the textual response pencil with signs saying PENCIL, interspersed among the other signs. Lastly, we supply the audience of several obviously English-speaking people whose pockets are bulging with pencils with which they will presumably reinforce the mand pencil. If, under these circumstances, our subject does not say pencil, does not in fact fairly scream it, we shall be inclined to agree with the logician after all that pencil is simply a word used as a sign for a thing called a pencil and that to call it a verbal response is an impertinence."

Skinner's analysis is fraught with much significance for the understanding of conversation in general, and doubtless offers the outlines at least for a systematic method of analyzing the interview. If the interviewer could develop the technique of inducing a mand or a tact by controlling the pertinent variables, many of the problems in interviewing would be solved.

Skinner has distinguished two kinds of supplementation which are useful in the evoking of verbal behavior — the prompt and the probe:

"If we know in advance what behavior we are to evoke, our variables can be fairly specific. Supplementation of this sort we may call prompting. On the other hand, if we know merely that there is behavior in strength which it is important to uncover, but not what the behavior is, our choice of variables must be less specific. The engineering task will be different. This kind of supplementation we may call probing."

The probe is already well established in psychodiagnosis. Any technique for strengthening verbal behavior, such as a picture, an inkblot, or even a mere "mm," is a probe when it sets the occasion for "talking."

Recent workers in the field of clinical psychology and experimental psychopathology have renewed the investigation, following Skinner's general method, of the verbal behavior going on in the interview. For example, Salzinger ( ), working within the general framework of reinforcement theory, has outlined a system which can be roughly expressed in terms of the following statements:

1) The stream of verbal behavior can be divided into units objectively distinguishable from each other:
   a) responses which can be grouped into response classes. Frequency of occurrence of members of a response class will be used as a measure of the strength of that response;
   b) reinforcements which can be grouped into the following two classes: a positive reinforcement (e.g. agreement)
will be any unit of behavior (verbal or non-verbal) emitted by one speaker after the response of another speaker which causes a subsequent increase in the frequency of utterance of that response class; a negative reinforcement (e.g. disagreement) will have the same effect as a positive reinforcement except that it will increase the frequency of utterances by its removal following the speaker’s response; c) discriminative stimuli (e.g. staring, question) which can be grouped into classes. The first class will refer to stimuli (verbal as well as non-verbal) in the presence of which a given response class will be reinforced while the second class will refer to stimuli in the presence of which the response class will not be reinforced.

2) The behavior going on in an interview will vary as a function of the above variables, e.g.,

a) the greater the frequency of reinforcement the greater will be the number of responses occurring;

b) the schedule of reinforcement (e.g. a reinforcement delivered after a given number of responses, or a reinforcement delivered after particular time intervals) will affect frequency of response in different ways;

c) the longer the delay of reinforcement (the longer the period intervening between a response and the reinforcement) the less will be the increase in frequency of the reinforced response.

Provocative as Skinner’s and Salzinger’s analyses are for all future experimentation in verbal behavior, any single attempt to analyze the interview from Skinner’s point of view at this stage of development would be too atomistic. In the last analysis, he provides the specific tactics to be utilized in gaining a definite end, but the wider strategy of eliciting hidden or suppressed or repressed attitudes is still to be worked out. Conversation, from the point of view of the interview, is best treated at the present time from a more molar point of view. For this wider horizon it is necessary, at least at present, to turn elsewhere.

Interview dynamics: the Newtonian model

In representing the process of conversation, the model of physical motion propounded by Newton seems to be attractive and suggestive for further research. 7

7For a short popular description of the Newtonian model see Perkins ( ).
The specific concepts which seem most pertinent are those of inertia (mass), force, acceleration, and friction. The specific laws which Newton formulated in 1687 are as follows:

1) Every body continues in its state of rest or uniform motion, in a straight line, unless it is compelled to change its state by (the action of) impressed forces.

2) Change of motion is proportional to the impressed motive force, and takes place in the direction of the straight line in which that force is impressed.

3) To every action there is always an equal and contrary reaction, or, the mutual actions of two bodies are always equal and oppositely directed.

In the application of these concepts to the process of conversation, motion may be equated with the process of conversing which goes on between the two interlocutors; inertia with the inborn or acquired natural obstacles to communication (varying from individual to individual in the same way that mass varies from substance to substance) and friction and other forces impeding the movement with the "resistance" concept, as evolved by Freud and his followers, indicating the degree of difficulty in communicating a given set of information (to be distinguished from inertia, which is a parameter of the two individuals rather than of the topic); force, with the drives and needs leading to the conversation. Physicists distinguish between two states of rest: 1) the state in which a body is at rest simply because of its inertia and the absence of any force sufficiently strong to overcome it, and 2) the state of rest resulting from balanced forces acting on the body. In conversation too, there may be an absence of communication, either when the drive to communicate is insufficient or when there are contrary drives at work inhibiting conversation.

By applying the laws of motion to conversation, the following formulations are obtained:

1) Every pair of persons in the face-to-face situation continues in a state of quiescence or continuous uniform conversation leading directly to the purpose at hand unless the pair is compelled to change the conversation by the action of drives or needs arising from within or from without.

2) Change in conversation is proportional to the operating drives and takes place in a direction which is the resultant of the drives operating in the two individuals.

3) If the conversation is to continue flowing, every change in attitude in one interlocutor produces a corresponding change in the second interlocutor. Specifically, mutual role-taking during the conversation must be related in a reciprocal manner; thus, if one interlocutor assumes an aggressive attitude, the other must assume a corresponding attitude (submissive or attentive) if the conversation is to continue smoothly.
Following the model, it may be postulated that conversation is engaged in only when a sufficient stimulus is present, in the presence of an interlocutor who is attentive, and when sufficient drive to communicate exists. The absence of communication between two individuals who meet face to face (such as occurs in the subway) is attributable either to the absence of a need for communication, or to the presence of two equal but contrary needs, one to communicate and the other to avoid being too forward. Next, it may be postulated that conversations once begun continue to flow until their natural stopping point is reached — when the goal or point of the conversation is attained, or interest or time runs out. Only when certain forces, analogous to friction, interfere with the progress of the conversation is there a need to resort to conscious strategy in order to keep the conversation flowing.

What damps up a conversation? Theoretically, at least, a conversation between two persons, or a group of persons, regarding a given topic should go on to completion unless certain attitudes, hidden or overt, are aroused or strengthened, which then stand in the way of the progress of the conversation. Usually, in order to keep social conversation flowing smoothly, the socially sensitive hostess will disregard irrelevant side remarks or, alternately, welcome them as offering a new channel. She may herself either change the course of the conversation by an adroit remark, or welcome turning the topic in some other direction in order to bring more people into the conversation. Long silences are always socially taboo, to be avoided at all costs. Interjections to clarify a point, interruptions to inject a bit of humor, and even the prompting of slightly halting remarks of a participant often add to the enjoyment of the group.

Interview techniques

Such conversational behavior, however, often proves as ruinous to a clinical interview as the clinical attitude does to a social conversation. The verbal habits and proprieties demanded by good social conversation may interfere with interviewing, though the truly sensitive conversationalist may be flexible enough not to spoil a clinical conversation. The momentary disturbances to smooth flow of the social conversation which are glossed over in the parlor are focused on in the clinic. The irrelevant asides which we note in a patient's conversation are "irrelevant" to us because we do not understand them; they are not irrelevant to the patient. To him they mean something, if nothing more than a way of justifying or explaining his behavior. The wise clinician, far from neglecting irrelevant talk, will try to ask himself: to what question is this apparently irrelevant talk an answer? In this way, the mental content which precipitated the "irrelevant" talk can perhaps be ultimately discovered. Shifts in the topic of conversation are similarly important for the light they may throw on feelings and attitudes. These shifts may be occasioned by a recollection of parallel events which the patient considers similar to his own, or may be a reflection of the patient's fear that he is telling too much. In other events, the clinician, by paying attention to these subtle factors, can gain a deeper understanding of the patient's feelings and attitudes. The periods of frozen silence which are anathema to the hostess are often welcomed by the clinician as an indication that something pertinent has been touched on or is about to be uncovered. The clinician pays special attention to the words used by the patient and the specific meanings they bear for the patient, not only in situations involving neologisms but even in everyday affective terms. By placing together such "incomprehensible" events, an understanding or evaluation of them can be reached in the same way that the surveyor can estimate distances by triangulation.

Since the patient has come with a specific goal in mind — to obtain relief from his pain or anguish — any point in the conversation at which halting,
change of pace, sudden shift of topic, or loss of direction, occurs is probably a "loaded" point as far as the patient is concerned. Such an event ought to serve as an indication to the diagnostician that the patient's attitudes, sets, interests or fantasies have interfered with the smooth progress of the conversation, and that these particular points might well serve as a cue for further investigation. If the patient has glily expressed an attitude or related an event which was apparently a focus of discomfort or annoyance, the diagnostician might utilize some of the following conversational techniques ( ) in an attempt to elicit relevant data: 1) amplified agreement, 2) disagreement, 3) surprise, and 4) change of tempo or tone. Whichever the interviewer goes beyond the statement made by the patient and overextends it, the patient will either correct the amplification, let it stand unnoticed, or accept it, and in this way his attitude toward the matter at hand is revealed to the observant interviewer. Disagreement will also evoke additional responses which may be important. Similarly, an exciting surprise or adopting a challenging tone may evoke a response that may lay bare attitudes thus far hidden. In this respect the clinical interviewer has an advantage, since he can utilize critical or challenging remarks to put the patient on the defensive, a procedure which might terminate interviews of the non-clinical variety. The rationality of the patient's ideas may be doubted or his voracity questioned, but in doing so certain losses in the interpersonal relationship may be suffered which may not be offset by the gains for diagnostic purposes. If the diagnostician, however, is not to conduct the subsequent, therapy his freedom is not curtailed as if he had to depend on the patient's future cooperation. It is, of course, understood that these radical approaches for uncovering attitudes are to be entertained only if the more usual methods fail. A change of tone, from seriousness to humor or from frankness to aloofness, may be helpful at strategic moments. The basic information which the patient provides may also help to confirm or disconfirm the existence of certain suspected attitudes. The strategy of the interview thus consists of a series of hunches and hypotheses played like a game of chess.

The pain and anguish which a diagnostic interview may sometimes cause in the patient as a result of this type of probing has a counterpart in the pain brought about by probing for somatic injuries. The diagnostician does not hesitate to probe a physical wound in making a physical examination; in fact, in certain situations, it might be negligent not to probe. Under proper conditions the psychopathologist need have no hesitation to probe even if it momentarily disturbs the patient, provided the ultimate purpose of such probing is his welfare.

The ease with which the interviewer can capitalize on his own attitudes and emotions will depend on his own development. In his first interviews, everyone is more or less tentative in playing such roles; only with experience does one feel free to probe, to use surprise or change of tempo and the other tactics and techniques which may facilitate interviewing. Even the fear of causing pain diminishes in time. Psychoanalysis is one of the methods which serve the purpose of freeing the interviewer from his own limitations. But even successful analysis does not remove all the interferences with freedom, and a good interviewer must always be on the lookout for blind spots in his own approach. If his blind spot seems to coincide with a blind spot in the patient it is all the more difficult to perceive it. 8

8A story is told of the influence of unconscious tensions in the interviewer: in a sodium amytal interview the patient began to discuss sexual problems when he suddenly dropped off into sleep. The interviewer had unwittingly pressed harder on the syringe giving the patient a sufficient dose to put him to sleep.
It might be of interest to examine the question whether conscious role-
playing is more effective than spontaneous unconscious role-taking in unco-
vring the patient's attitudes. There are investigators, especially in the field of
social work, who maintain that it is undesirable to have the interviewer become
so absorbed in the material and content of the interview that he cannot retain
his objectivity and his ability to manipulate consciously the factors in the
interview. In such instances, it is alleged, the interviewer presents either a
garbled or biased picture of the interviewee. There are others who maintain that it
is highly desirable for the interviewer to get involved on this level with his
interviewee. Only research comparing the outcome of the two methods can throw
light on this question. Perhaps the answer will depend on the personality type
of the interviewee and the interviewer.

Freud has approached this problem in the following way ( ). He asked: Can
we, without restricting the activity of either of the interlocutors, refine the
procedure (conversation) to such an extent and in such a direction as to make it
generally useful to psychology (in addition to its specific therapeutic value)?
Bion ( ), following Freud, has regarded the psychologist as a catalytic
agent in the conversation for releasing the patient from the obstacles that in-
hibit the progress of the interview, when the conversation progresses in the usual
fashion, no catalysis is needed, but when it meets a stumbling block the analyst
must set in motion certain forces that eliminate the blocking. The patient's
blocking is then usually followed by what Bion designates as the "confession" —
the lowering of voice, gesturing, and experiencing of action accompanied by
certain physiognomic patterns. Experimental studies of the non-verbal expressions
of blocking and the verbal as well as non-verbal behavior accompanying the release
of blocking include not only active measures but also passive measures, in which
the patient works on his own salvation under the positive effects of non-
interference on the part of the analyst.

Within the context of the physical model of motion, the achievement of rapport,
the resistances which are manifested, and the lowering of resistances which
takes place during the interview can be dealt with in a more precise (if
artificial) fashion. Furthermore, the methods for dealing with resistance can be
experimentally tested and empirically validated. Only after such experimenta-
tion will care control and prediction in the interview situation. Whether the principle
of action and reaction (Newton's third law) has a parallel in the interview
situation is not yet clear. Perhaps the conversational correlate of action and
reaction will be found in the mutual and reciprocal responsiveness and initiative
which must take place if the conversation is to continue.

It has been suggested that the good interviewer should possess an intro-
spective habit of mind and should gain practice in perceiving changes in his
own attitudes. During the interview he must think and act in terms of the
attitudes expressed by the subject. He should not attend so much to what the
patient says but notice more the way he says it. He should not be so much con-
cerned with making a "correct" remark as with adopting a proper attitude, for
then his words will form themselves naturally. Furthermore, he must be able not
only to uncover attitudes, but also to evaluate them in psychological terms.
The would-be interviewer must take every opportunity of cultivating the art
of human relations in general and conversation in particular. These skills are
of a high level and are, accordingly, subject to deterioration through disuse
or misuse. It is clear that there is a great need for studying the interviewer
himself not only as the receiving but the evaluating instrument.
In conclusion, it should be pointed out that the interview is really borrowed from life insofar as it depends upon conversation between two people with the usual expression, arousal, and perception of attitudes and the formation of judgments which go on in everyday conversation. There is hardly a situation in which more than one person is involved which does not include almost all the elements of the interview technique that we have described. Since it is so common a part of life, it may perhaps be very difficult to disentangle the underlying variables that require study. Another difficulty is the lack of proper terms for describing the various phenomena that are involved. The analysis described in this chapter is based on the hypothesis that attitudes toward the illness are the principal data to be elicited during the interview, rather than information on the illness itself. The latter can be obtained either from direct observation or case history taken by others, etc. There are two specific aspects of the attitudes, namely their arousal and their evaluation, which go on simultaneously during the interview. Certain techniques may be utilized in the uncovering of attitudes; although it is possible to outline these devices, because of their pervasiveness they have never been analyzed and, hence, no general principles can now be deduced from them. Another difficulty arises from the fact that the actual personality framework into which the evaluation of the attitudes is placed is still very poorly developed. Thus, we have on the one hand a poorly defined situation, the interview, and on the other a poorly defined framework of personality traits and their constellations. The result must often be disappointing at present.

We have already indicated that the interview technique suffers a social lag with regard to the application of scientific methods for its evaluation. While tests and rating scales have forged ahead and become more and more scientific, the interview has been arrested in development and has made little progress. What are the reasons for this lag? It has already been pointed out that the training everyone gets in social conversation is a handicap in clinical conversation. The ease with which one can overcome the effects of early social training and acquire the new technique varies considerably from person to person. Furthermore, from early childhood on we utilize speech and conversation primarily to impart information or to initiate communication. (In fact, such training in "verbal communication" as is afforded in our schools is in the area of public speaking or drama.) Perhaps we should provide instruction in our schools, not only in the methods of public speaking but also in the methods of eliciting information.

In addition to the theoretical analysis of the elements involved in the interview there are also certain physical aspects of the interview that need to be examined. Questions arise as to the advisability of taking notes in the presence of the interviewee, for example, and similar factors need to be investigated in the evaluation of the outcome of an interview. The initial moments of the interview may be critical in establishing rapport. This is the moment when the interviewer and the interviewee take each other's measure in the face-to-face situation. Special care must be taken to avoid giving the interviewee any mistaken notion that the interviewer is not interested in him. Telephone calls, intrusions by other patients, a desk piled high with material or a mind preoccupied with other matters are bound to interfere with good rapport. The final moments of the interview are also of great significance. They may be more revealing and informative than the earlier part. The patient may have been nursing himself up to the point of telling the most important matters; he may try to "buy" more of the interviewer's time by holding his attention with what he thinks the interviewer is after; or he may suddenly assume the role
of a non-patient once the interview is over. For this reason interviewers should
make a special point of deliberately closing the interview just before time is up
so as to permit the latent material to emerge.

As a model for the interview, the laws of motion in physics have been sug-
gested. According to this formulation the following characteristics of the inter-
view process constitute the important variables that intermesh in the production
of interview material: (1) The inertia of the interviewee (his normal resistance
to communication of any kind, which varies from person to person); (2) the need
or drive for communication (force); (3) the resistance to communication arising
during the course of the conversation from within the interviewee or arising in
response to the interviewer (friction); (4) the release of tension when a resis-
tance is overcome and the conversation proceeds smoothly again (the opposite,
if not equal, reaction). According to this model, a person will be at rest
(sent-sent-tovering) unless a need arises which is sufficiently strong to overcome
his inertia to communication. Once his need overcomes the inertia, he will
continue his conversation until he either exerts to its natural end (satisfaction
of need) or meets with certain obstacles from within or without. The problem of
the interviewer is to anticipate and avoid these obstacles or remove them so that
the conversation can go on unhindered. This model immediately suggests certain
experimental investigations. Some of them are reviewed in the next chapter.

SUMMARY

The interview technique is historically the earliest method used for
eliciting information from another. It is still the basic method for obtaining
information regarding the inner makeup, feelings, and attitudes of an individual.
It is the critical situation in which the results of all indirect probing of
personality can be validated. The interview occupies a central place in psycho-
pathology because it affords the only certain method for determining the
patient's attitude towards the events that disturb him. Information of this more
subjective kind can be obtained best by interview. For this reason, it is
important to study the underlying processes involved in the interview and the
potential biases that may distort the interviewer's evaluation. The processes
involved in the interview involve the strategy of everyday conversation between
individuals. Unfortunately these interpersonal processes are still not too
well known. Experienced interviewers report that the diagnostic interview con-
sists of eliciting the expression of attitudes from the patient by such means
as over-agreement with his point of view, disagreement, surprise, alteration of
tone, and other techniques which constitute the essence of good conversational
procedure. Those mechanisms require further study. In order to study them
effectively, models for the interview must be constructed in which the various
factors underlying the interview are represented. From such models certain
inferences about the interview can be made and the role of the various factors
in testing those inferences can be determined. By systematically varying these
factors, the tenability of the hypothesis under investigation can be determined.
Two such models—one based on reinforcement theory (Skinner) and one based on
Norton's laws of action have been suggested. Only further experimentation
can determine whether these models prove adequate.


