Interviewing Family Caregivers: Implications of the Caregiving Context for the Research Interview
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What is This?
There is a wealth of existing academic knowledge about family caregiving and caregiver coping, yet the vast majority is based on interview research, much of it cross-sectional in nature. It has even been said that qualitative research now seems equated with interviewing (Atkinson, Coffey, & Delamont, 2003), as opposed to, for instance, observational research or the analysis of texts. Qualitative interviews tend to be particularly relied upon for the study of family caregiving experiences as well as coping; also, qualitative interviews are often the basis for developing quantitative measures of the ways in which caregivers cope or the strategies that they use to cope.

In this article we consider family caregiving as a research context, and examine the implications of interviews as a particular research method for understanding family caregiving. In particular, we argue that critical reflection on our ability to draw conclusions about caregiving, including caregiver coping, based solely on interview research, is needed. Our own experiences of interviewing family caregivers in different research projects will be drawn upon as examples. We conclude by questioning the ability to draw conclusions about caregiving and/or caregiver coping based solely on interview research, and call for greater integration of observational and longitudinal methods in family caregiving research.

Keywords: caregiving, informal; coping and adaptation; families, caregiving; interviews

Family caregiving tends to involve strong and often competing emotional experiences. Most of our knowledge of caregiving stems from interview research, much of it cross-sectional in nature. In this article we explore the implications of interviews as a research method for understanding caregiving. Specifically, we address difficulties in interpreting participants’ talk about caregiving when this talk is simultaneously an articulation of experience and an attempt to cope with that experience. Either uncritically accepting accounts as reflective of experience, without considering the role of coping, or making assumptions about the success of caregiver coping in this context, might be erroneous. Our own experiences of interviewing family caregivers in different research projects will be drawn upon as examples.

Background

Family Caregiving as a Research Context

Family caregiving has been the subject of much research, particularly as it applies to care for seniors and the terminally ill. Family caregivers represent a group that might be vulnerable to stress and burden. For instance, Gottlieb and Wolfe (2002) describe family caregiving for persons with dementia as “usually a chronically stressful experience that poses significant adaptive challenges” (p. 325). Another group of grounded theory researchers (Proot et al., 2003) identified “vulnerability” as a core category in their family caregiving research, concluding that “caring for a terminally ill person at home requires continuous balancing between care burden and capacity to...
cope” (p. 119). Other research indicates that providing care to family members can have negative implications, such as mental and physical burden (Proot et al., 2003), health problems (Kneebone & Martin, 2003), and depression (Gottlieb & Wolfe, 2002), although some individuals and groups are at greater risk than others.

What is it about family caregiving that contributes to heightened risk of negative health outcomes? Both primary and secondary stressors, such as difficulties both within and outside of the caregiving role, are implicated (Pearlin, Mullan, Seiple, & Skaff, 1990). One qualitative study (Proot et al., 2003) in particular explored caregiver burnout and fatigue as related to a variety of factors that contributed to feelings of vulnerability (a core category in their research), such as care burden, restrictions of normal activity, fear, insecurity, loneliness, facing death, and lack of support. Further, family caregiving tends to involve strong, and often competing, emotional experiences. Not only are family relationships—particularly parent–child—subject to feelings of ambivalence (Pillemer & Luscher, 2004) and power struggles, but the provision of ongoing and increasingly technical care and advocacy for chronically ill and dying family members often entails difficult emotional experiences and tensions. For instance, caregivers can often experience guilt (exacerbated by the moral imperative to care), burden, and at times loss of the quality of the relationship (Stajduhar, 2003). It is also speculated that factors more difficult to measure, such as the reawakening of unresolved emotional issues from childhood; the conflict between norms of reciprocity and solidarity (George, 1986); emotion work and perceived deviance from feeling rules, particularly for women (Aronson, 1992; Macrae, 1998); the mismatch or cognitive dissonance involved between caregiving expectations, ideals, and reality (Aronson, 1992; Brody, 1990; Groger & Mayberry, 2001; Hong & Liu, 2000); and the confusion of the caring about and caring for (Hooyman & Gonyea, 1995) also contribute to guilt and stress. For those with reduced resources, whether in terms of social support or socioeconomic resources, there can be additional hardship. For others, conflicts exist between work and caregiving, and stressors are involved in dealing with the health care system and/or other family members (Stajduhar & Davies, 2005; Stajduhar, Martin, Barwich, & Fyles, 2007). Although there are negative aspects in some caregiving and care-receiving situations, it is important to remember that these are not only private, individual problems of coping; they need to be linked to the macro-context of the availability and affordability of formal services, and structural constraints on women to care. In the context of family caregiving, coping involves the deployment of “a complex and dynamic set of cognitive, affective, and behavioural responses” to “regulate their emotions, solve or improve the practical problems they face, and maintain the psychological resistance and fortitude needed to stay productively engaged in caregiving” (Gottlieb & Wolfe, 2002, p. 325).

How Interviews Can Influence Coping

There is particular concern within the context of family caregiving research that interviewing itself might trouble caregivers further and otherwise disrupt their coping processes. For instance, Sinding and Aronson (2003) note ethical concerns around difficulties that emerged in their research, when participants’ experiences of the realities of caregiving for dying relatives did not fit with dominant ideals of “a good death” (p. 97), exposing a sense of failure and threat to identity for some participants within the interview context. As a result, particular caution is advised for researchers; they should attempt to help participants “control the degree of exposure or disruption they will tolerate, and to maintain valued narratives about themselves” (p. 110). Ultimately, this reflects awareness that what happens in interviews could potentially influence the coping processes of family caregivers. Other research more broadly speaks to the potentially harmful impacts of participating in qualitative interviewing (Clarke, 2006; Hewitt, 2007; Robson, 2001). However, as Corbin and Morse (2003) suggest, despite “evidence that qualitative interviews may cause some emotional distress, there is no indication that this distress is any greater than in everyday life or that it requires follow-up counselling” (p. 335).

In fact, there is growing support for the idea that interviewing, performed ethically and with sensitivity, can positively impact coping; qualitative interviews are often described as having therapeutic effects (Corbin & Morse, 2003; Hutchinson, Wilson, & Skodol Wilson, 1994; Kvale, 1996; Lowes & Gill, 2006), and indeed, some participants volunteer to participate for this reason (Hiller & DiLuzio, 2004), and report benefits of talking about their experiences (Lowes & Gill, 2006). Interviews are believed to provide opportunity for and facilitate validation, introspection and growth, self-acknowledgement and self-discovery, a sense of purpose, empowerment, healing, unburdening and
catharsis, a sense of helping others, and a means to make sense of experiences through speaking about them and refining thoughts through the interview (Corbin & Morse, 2003; Hiller & DiLuzio, 2004; Hutchinson et al., 1994; Lowes & Gill, 2006). For instance, “expressing the stress” or “unburdening” is described as an emotion-focused coping strategy (Lowes & Gill, 2006).

A Different Perspective: Interviews as Coping

In this article we adopt a slightly different angle on the debate: Rather than focusing on whether or not qualitative research interviews influence coping and well-being of family caregivers, we conceptualize what occurs during interviews as representing coping. In this section, we present this perspective.

Approaches to the conceptualization and interpretation of interview data can be grouped rather broadly (albeit simplistically) into three dominant paradigmatic approaches. These paradigms point to different interpretations of participant talk within interviews, and will be described here in broad groupings (with the exception of postmodern approaches) for the purposes of framing our discussion. First, a positivist approach tends to view interviews as a recording of actual events or behaviors that represent an objective reality; the aim is to collect information about an individual’s subjective experiences, and the influence of “social desirability” is hoped to be minimized. The focus of analysis is on the substantive information the interview provides about the realities of a participant’s life.

In contrast, interpretive or constructivist perspectives tend to view experience as social action and interviews as illustrative of the participants’ attempts to understand, interpret, and otherwise construct their social worlds and the meanings of their experiences through the use of cultural resources. Analysis focuses on what we can learn from the process of how meaning is constructed through talk—in particular, what we can learn about both the social or shared meanings that are enacted in talk, and about how the context of talk informs meaning. Interview data, from this perspective, are viewed as illustrative of the participants’ attempts to understand, interpret, and otherwise construct the meanings of their experiences, drawing on and re-creating shared meaning.

Finally, a critical approach to interviewing tends to view interview accounts as windows into taken-for-granted dominant ideologies. Like interpretive or constructionist approaches, a critical approach would also reject the idea of interviews as windows into the reality of a participant’s experience; instead, the analysis focuses on viewing talk as manifestations of dominant norms and ideologies within a society (or in some cases, as resistance to these ideologies).

To some extent, there might be, within interviews, evidence of all three types of information (the realities of experience; the meanings attributed to experience; and the ideologies at work in everyday lives). What these three approaches might miss, however, is attention to the role of psychological processes of coping within interviews. Indeed, we contend that much of what we hear in interviews with caregivers might also represent participants’ active attempts to manage and cope with difficulties and/or make meaning of their caregiving situation. We maintain that participants’ talk about their caregiving experience is simultaneously an articulation of experience that draws on broader ideologies, as well as an attempt to cope with perceived experience. Ultimately, they might even be indistinguishable. For instance, Sinding and Aronson (2003) note how participants in their interviews attempted to cope with the particular disjuncture between experience and ideals through accommodations such as “consoling refrains” in the interview (e.g., she didn’t suffer/everything possible was done). These consoling refrains functioned, for instance, to “narrow the distance between ‘the good death’ and the death research participants witnessed” (p. 103). Furthermore, Gottlieb and Wolfe (2002) note that “meaning making” (Affleck & Tennen, 1996) and social comparison (Tennen & Affleck, 1997) are themselves particular ways of coping; these processes are evident in many interviews. For instance, interpretive approaches to interviewing, although not discussing coping per se, do maintain that interviewees are not only trying to articulate their experience but also trying to show how their action makes sense; they are accounting for their feelings and actions and justifying them (Atkinson et al., 2003). Holstein and Gubrium (1997) speak of how respondents “simultaneously and continuously monitor who they are in relation to the person questioning them” (p. 122); Sinding and Aronson (2003) speak of how participants try to create “stories about loss that can be ‘lived with’” (p. 115); and Nunkoosing (2005) notes how in some cases participant digressions might serve to protect their egos.

If talk in interviews represents coping, we might wonder whether we could make assumptions about the success of coping through analyzing interview...
talk. In what follows, we present two illustrative case examples from our research that demonstrate how our interpretations of interview data might lead to erroneous assumptions about caregiver coping, followed by a discussion of the implications of our perspectives for the understanding of caregiver coping, the interpretation of interview data on family caregiving, and consideration of alternative methods for research on family caregiving.

Case Examples

The Case of Frank and Olive

The first illustrative example comes from a study examining the social context of home-based palliative caregiving (Stajduhar, 2003; Stajduhar & Davies, 2005). The primary sample consisted of 12 dying patients, 13 family members who were providing care for them, and 47 bereaved family caregivers who were purposefully sampled. After obtaining approval from the local university ethics board, data collection commenced and included 130 hours of participant observation in the homes of 13 palliative caregivers. Field notes were written to document observations and were validated with caregivers. In-depth interviews were also conducted with all family caregivers.

Frank and Olive volunteered to participate in the study after seeing an advertisement in the local newspaper. Frank was an 82-year-old man who had been diagnosed with multiple sclerosis 20 years prior. His disease had advanced to the point where recurrent leg and bladder spasms left him unable to walk and with severe pain that was unresponsive to treatment. Frank required extensive assistance with activities of daily living, including bathing and toileting. He was able to feed himself and was cognitively intact. He loved jazz music, having played in a band while in the army, and spent countless hours listening to music and watching comedies on TV in his rented hospital bed, which was located in the middle of the living room in the home he shared with his wife, Olive. Olive had been a psychiatric nurse for over 40 years and had just celebrated her 75th birthday. She had previously enjoyed traveling and volunteering, but caring for Frank was now a full-time job and she was unable to leave the home unless someone was available and could handle caring for Frank. Frank and Olive had two adopted sons and five grandchildren. Both sons were supportive and helped Olive with Frank’s care during the times they were not working or busy with their own family responsibilities. Olive and Frank’s involvement in the study included one formal tape-recorded interview and field notes from participant observation that occurred in their home over a 3-month period as Frank’s health deteriorated and he died at home. The second author (in this section referred to as “the researcher”) also conducted a number of follow-up visits to Olive after Frank’s death.

In the time that the researcher spent immersed in their family life, her impressions and that of the many health providers involved in their care was that of an incredibly supportive family who respected Frank’s wishes and desires to die at home. With the exception of one emotionally charged discussion that was witnessed between Frank and Olive, in which Frank was insisting that Olive assist him to die (through giving a lethal amount of pain medication), they seemed to be very happy together, and Olive was most attentive to Frank, who constantly needed assistance. The grandchildren visited frequently, and Louie, the family golden retriever, was a source of joy for everyone. By all accounts, this was a “happy family,” with family members who were supportive of each other during a trying time. Olive told the researcher in their interview and in informal discussions that she considered caring for Frank as a “final gift” to him, and her way of showing him and their children that “love is everlasting.” Frank died at home on a warm spring day, listening to jazz and looking out over the blooming tulips and daffodils that had sprouted from their garden. The researcher attended Frank’s funeral, at which Frank’s son Brent gave the eulogy and Olive spoke a few words about what a caring and wonderful man Frank had been.

Over the coming weeks, the researcher visited Olive and helped her sort through some of Frank’s belongings and pack up things that Olive thought should be sent to a charitable organization. As the two were sitting down in her kitchen to eat a lunch of tomato soup and stone wheat crackers (this had become Frank’s favorite meal as he was growing weaker and weaker), Olive said, “I need to talk to you about something.” The researcher replied, “Okay.” Olive asked, “Is this conversation still part of the research?” The researcher responded, “Only if you want it to be.” Olive said, “I do,” and proceeded to relate how she felt that she had deceived the researcher and the research over the course of the past many months. Olive revealed that not only was she not happy with Frank but that, in fact, Frank had been...
quite emotionally abusive throughout their marriage and had engaged in several extramarital affairs that had left her with little self-esteem and a lack of confidence. Olive proceeded to describe how during her entire caregiving experience, she wore a “mask” as a way to cope with the situation, explaining that she had to put on a “brave face” for the sake of her children and grandchildren. She said that much of what she had told the researcher about Frank and her caregiving was less about how she “truly” felt and more about her attempts to cope and to hide her true feelings. Olive said she shared this because “you need to know that in caregiving, what you see and hear from us isn’t necessarily what really is.” She indicated that she was glad that the researcher continued to visit her because it wasn’t until this point that she felt comfortable, safe, and even able to articulate how she was feeling.

Within the research relationship, disclosures such as this are highly sensitive. Olive had ongoing counseling support throughout her caregiving experience, and it was through this support that she decided to disclose her abuse. Even with this support in place, researchers need to be mindful of the ethical implications of such disclosures and be vigilant about preventing further vulnerabilities in caregiving participants.

The Case of Tom

Tom first heard about the first author’s dissertation research on responsibility for aging parents (Funk, 2008) late in 2004, through an e-mail forwarded to him by a colleague. The focus of that research was the interpretation of the meaning of filial responsibility in participant talk. A nonrandom sample of 28 men and women with one or both elderly parents living in or near Victoria, British Columbia, Canada, were included in the study, which had approval from the Human Ethics Review Board at the University of Victoria. Written informed consent was obtained from participants prior to commencing the research.

Tom contacted the first author (in this section referred to as the “researcher”) and they met for two in-person interviews about 7 months apart. The interviews were qualitative in nature and loosely structured; the researcher had a set of broad issues she wanted to discuss about a sense of responsibility for parents. Tom was in his mid-50s, divorced, with no children of his own. He enjoyed intellectual conversations, music, and was trained in counseling. In the first interview, Tom described a somewhat difficult relationship with his reclusive and depressed father, Harold, who was in his 90s and having particular difficulties with losing his sense of independence and privacy as his care needs increased. For a number of years Tom and his father had not been on speaking terms, but Tom described their relationship as having since improved. Harold and Sue lived in their own home in the community, and despite declining health, resisted bringing in paid help, although they needed and could afford it.

During the first interview, which took place in a university office, Tom expressed that he did not feel obligation or guilt in his relationship with this parents, and that he did not very often feel “irritated.” Tom had set limits on his filial responsibility, to protect himself: “It means that I don’t feel guilty on a Saturday that I HAVE to go over and accomplish chores.” In fact, what the researcher found particularly interesting was that Tom defined setting limits as part of being responsible; for instance, doing so involved not setting up false expectations, protecting his parents’ independence, and respecting their own responsibility for their decisions.

Tom strove for his contact with his parents to involve “real bonding,” and described a sense of satisfaction from helping his parents: “It’s just nice to have a good relationship with my parents, basically. One of the side effects of going over and helping them out with things is that we can just sit and talk as adults and enjoy each other’s company.” Although he enjoyed certain aspects of providing support, he clearly emphasized, “I don’t feel that it is my job to keep either of my parents alive; that is their job.” Tom, who himself came from a counseling background, appeared confident in setting practical and emotional boundaries around the provision of support to his parents.

In the second interview, Tom’s father’s health had deteriorated and Tom was providing more support. He had, however, successfully convinced his parents to hire outside help (such as a housekeeper). Although he was no longer able to maintain a quite limited level of involvement, Tom expressed that he felt a sense of control:

If I chose not to do it I would just simply choose not to do it . . . but I choose to do it and that is probably why I can do it positively I guess. Because I feel like it is all in my control. It hasn’t been forced on me.

Tom had taken on the role of accompanying his father to the doctor, and expressed that in fact, this
was an “easier” role because “there is a little better understanding of what I am doing, and why I am doing it.” Furthermore, Tom still placed limits on his responsibility, not only in terms of how often he checked in on his parents, but with regard to his emotional boundaries: “I never feel guilty about things that are going on for them.” He also still defined the provision of support as positive, particularly as his previous estrangement from his father had meant that “this is time that I didn’t really expect to have with my parents.”

Based on these data, Tom appeared to be coping well with increasing caregiving responsibilities for his ailing father. However, several months after the interviews were complete, events transpired that suggested that Tom had experienced considerable difficulty in coping; he experienced a traumatic health event linked in part to his caregiving. This was a shock to the researcher, given the absence of identifiable indicators in his interview accounts.

Tom’s emphasis on a sense of choice and control, his desire to respect his parents’ independence, and his rejection of the idea of feeling responsible had echoes in the majority of 28 adult children in the study. For instance, some participants spoke specifically to the need to have “a frame of mind” that viewed responsibility as a choice, that it was “the healthiest way to do it,” and involved approaching responsibility from a “more positive place” (Funk, 2008). By employing ideas such as this, therefore, participants were aligning themselves with a dominant cultural discourse of independence, but they might have done so to facilitate coping with parent care. Similarly, as reported elsewhere (Funk, in press), prioritizing parental independence and constructing filial support as done without obligation might also represent attempts to set boundaries and approach parent care with a positive attitude; that is, they can represent coping strategies.

Discussion

Implications for the Interpretation of Interview Data on Family Caregiving

The interview data collected in the above research examples would, from a positivist approach, be viewed rather uncritically as evidence of positive experiences with family caregiving, and perhaps as evidence of coping well. The subsequent, additional information obtained might lead to concerns about social desirability effects in the initial data collection. Interpretive and critical approaches might examine the interview accounts as reflective of broader social norms and ideologies such as familialism (“love is everlasting”) or individualism (“I choose to do it”) in participant accounts. However, the interpretation of these data might be enhanced if we adopt a perspective that views interview talk as simultaneously representing an articulation of experience and an attempt to interpret and cope with that experience (while drawing on social norms and dominant ideologies).

Therefore, we suggest a need to be wary of interpretations that view interview data solely as unmediated representations of actual experiences (Atkinson et al., 2003; Nunkoosing, 2005).

Uncritically accepting accounts as reflective of experience, without considering the role of coping—and therefore, for instance, making assumptions about the nature and success of caregiver coping in this context—might be erroneous. However, just as uncritically analyzing interviews as reflective of experience might be misleading, so might be uncritically analyzing accounts as reflective of normative ideals or dominant ideologies, without considering or acknowledging that interview talk is simultaneous with coping. For instance, when participants emphasize internal motivations and free choice in filial responsibility, there is likely an important psychological function at work; in the sense that perceived choice provides a sense of control, it might help protect their well-being, and thus participants might be motivated to define their responsibility in terms of a framework of choice. Distinguishing between psychological coping mechanisms and the deployment of normative and ideological discourses poses particular difficulties in interview research, because they are to a large extent indistinguishable.

Implications for Understanding Caregiver Coping

The above examples suggest strong caution is needed about generalizing about coping based on what we hear in interviews, because we have very little means of knowing whether the “truth” a person is constructing in an interview account is “working” for them in terms of their mental health and coping. Furthermore, coping within interviews is intertwined and perhaps indistinguishable from meaning-making, processes of social desirability, and responding to feeling rules. Finally, even if we ask specifically about
coping, these accounts are themselves part of the interpretive process, and might also be influenced by social desirability (Gottlieb & Wolfe, 2002). In addition, there are likely “more subtle, cognitive coping responses that are outside the caregivers’ awareness and other responses that they do not define as coping” (Gottlieb & Wolfe, 2002, p. 334).

Essentially, the issue might be one of whether we can locate a “truth” of coping in interviews. How do we tell if family caregivers are coping or not? Is it our responsibility to know? Not only is there difficulty in distinguishing coping from interpretation and social desirability, but coping success varies over time, depending on the nature of the stressor (Gottlieb & Wolfe, 2002). Thus, conclusions about coping should be made with careful consideration of these processes and their variation, a clear understanding of the perceived source of caregiving stress for the individual, and clear definitions of what constitutes “coping success.”

**Considering Other and Mixed Methods for Research on Family Caregiving**

Nunkoosing (2005) believes that because stories and accounts are not necessarily “true,” the interview should only occur at the beginning of a research process, and that researchers should seek confirmation through other methods. Similarly, Atkinson and colleagues (2003) argue that we need to reaffirm the equal importance of participant observation in terms of understanding the naturally occurring settings of social action. Observational research, with significant immersion in the field, combined with interviewing, might well be able to tell us more about how caregivers are coping than interviews alone. Observational research also tends to facilitate ongoing longitudinal collection of data, which might shed light on how caregivers perceive their experiences over time and might reduce issues of social desirability and reactivity as the researcher spends more time in the field and begins to develop trusting relationships with participants (Bernard, 1994). It is true, of course, that observations are filtered through our own interpretations; furthermore, tapping into caregiving coping might be difficult even with observation, because of the complexity of emotional, social, and cultural factors implicated in the process. However, our research experiences suggest that combining at least interview and observational methods in the study of caregiving, and particularly working with participants over a longer period of time, has greater potential to teach us more about the caregiving experience than interviewing alone.

Indeed, one rationale for mixed-methods studies (including mixing different qualitative methods) is methods triangulation (Denzin, 1978), which is argued to enhance research credibility through “comparing and cross-checking the consistency of information derived at different times and by different means” (Patton, 1999). However, mixing data collection methods alone (e.g., interviews and observation) might be insufficient; we need to consider integrating analytic strategies for data collected through different methods (Creswell, 2003; Tashakkori & Teddlie, 2003). In addition, although convergent results regarding caregiver coping might be welcomed, they can never fully prove the validity of results, as both methods might be biased in the same direction. Furthermore, a dilemma arises when findings are divergent: How should apparent differences in caregiver coping be interpreted and explained? There is as yet little guidance for qualitative researchers in this area. Finally, Sandelowski (2003) posits that the idea that mixed-methods findings will reconverge on one “true” understanding negates one of the key rationale for triangulation, which is that it provides a “fuller” or “more thorough” understanding. Indeed, perhaps the greatest benefit to mixing observations and interviews, and to enhanced immersion in the field over time, is that it might yield further insight into the complexity of caregiver coping (as opposed to making dichotomous assumptions about whether or not a caregiver is coping well). As such, research on caregiver coping needs to be accompanied by ongoing conceptual attention to the definition of “coping.”

**Conclusion**

Although the family caregiving context makes coping within interview accounts perhaps more salient and easy to identify, our perspective is that coping occurs within all qualitative interview accounts, because interpretation and coping are to a large extent synonymous. This perspective goes beyond the debate about the impact of research interviews on participant coping and well-being, to direct our attention to the ways in which individuals use talk and interpretation to cope. In addition, this idea has implications for clinical work in fields other than research; for instance,
social workers, educators, and psychologists who work with family caregivers should approach conclusions and assumptions made about caregiver coping based on one-time interviews cautiously. They should be attuned to fact that in the interview context, caregivers might be actively coping through meaning making, and seeking to maintain a sense of identity as someone who can and does cope well. Indeed, a fuller understanding of their coping might require ongoing involvement with the same specialist over time.

It is our view that the dominant paradigmatic approaches to the interpretation of interview data (positivist, interpretive, and critical) do not adequately address the phenomena of coping within interviews, although the interpretive approach perhaps comes closest to this by directing our attention to interpretation and sense making. However, we are not suggesting that the analysis of interviews focus only on participant coping strategies. Indeed, the particular ways in which individuals interpret their experiences are to a large extent culturally embedded, even as they are at the same time related to coping. Indeed, either uncritically accepting accounts as reflective of caregiver experience and interpretations, without considering the role of coping, or making assumptions about the success of caregiver coping based on interview accounts, might be erroneous.

In conclusion, participant talk about the caregiving experience is simultaneously an articulation of experience that draws on broader ideologies, and an attempt to cope with perceived experience. However, we also question our ability to draw conclusions about caregiving and/or caregiver coping based solely on interview research. Caution is needed in making assumptions about individual participants, as well as academic conclusions about whether family caregivers are coping well. The study of coping in family caregiving contexts is limited when interviews are the only methods used, and we call for greater integration of observational and longitudinal methods in family caregiving research. This must be accompanied by greater methodological guidance for researchers seeking to integrate results obtained through different methods of data collection, as well as a more nuanced and complex conceptual understanding of coping to guide analysis.

Note

1. Pseudonyms are used for all participant names.

References


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