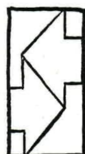
Grounding Research in Practice: Connecting Conversations

Nancy K. Brown, Ph.D., University of South Carolina

Practice should inform and be informed by research. In a reciprocal and reflexive process, these two dimensions of the helping process need to be linked. The author examines two events in practice that led to the development, implementation, and publication of research. Helping professionals should, by the nature of what they do, understand and engage in a grounded-theory process. This narrative examines how that might occur in clinical settings.

Grounded theory is all about conversation. It's about listening and hearing and the ability to organize what one hears into a framework that has credibility. Grounded theory uses detailed processes that result in substantive knowledge about a particular area of interest (Strauss & Corbin, 1998). The social work practitioner is, by the character of the work, a natural grounded theorist. Out of the counseling narrative comes thoughts about the meanings from both client and social worker. As the client speaks, the social worker notes, organizes, and then groups like ideas into a coherent understanding of the individual. Social workers are constantly forming "problem statements" throughout the course of the session. This paper describes two practice events that led to the development of research through conversations that occurred in the context of psychotherapy.



The therapist as researcher listens on multiple levels. The social worker uses the *content* of the session – "He said this, then I said that" – to lead the client into a more in-depth evaluation of the underlying mechanisms at work, the *process*. The social worker engages in a dance, with content being the dancer or dancers and process being the music. The other significant guest at the ball is the therapist who acts as the dance floor. As such, the therapist feels the shifting weight and moves of the client as a means to offer support while providing an absorbing medium on which to carry out the tango. This continues until the dance is finished and the partners return home.

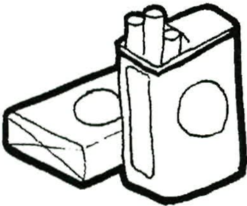
Occasionally, the client says something that makes the therapist take special notice and say something as simple as, "Hmm, now *that's* interesting!" Or, it may be something that represents a palpable disconnect between the client's belief system and the social worker's values. Both events should trigger a course of action in the social worker that begins a self–examination, not unlike the grounded-theory process. This paper is about listening to the small, interesting things that social workers hear in the context of their daily activities and the places to which they can lead us.

In 1993, while working at an alcohol and drug outpatient rehabilitation center, I was in charge of the women's recovery group. Women in the group, typically in recovery from crack-cocaine addiction, completed either a day treatment or an evening intensive program. Some had come from inpatient treatment to aftercare. As a primary social worker, I met with each woman weekly or biweekly to check on her progress in treatment. One incident, while appearing minor at the time, led to the development of a research

project that ultimately led to substantive theory in the area of women's addiction and recovery.

Maya was a 27-year-old woman who had been in the outpatient program for three months. She had entered aftercare and was attending the outpatient women's recovery group. During one of our individual sessions, she handed me a sheet of paper and told me that she needed my signature for her probation officer. I was surprised. Maya had a good job, had been stable in recovery, and had not been on probation when she came into treatment. I asked for details.

Maya reported that she had gone into a store one day and that a friend who accompanied her shoplifted some cigarettes. She encouraged Maya to try it. Maya also stole cigarettes and felt thrilled. As she described the event, I could see the excited look on her face. Despite the fact that this had brought terrible consequences, Maya, as she spoke, looked like someone who had experienced a thrill ride. Her face glistened and her eyes widened and brightened, the look of a physiological response to adrenaline.



Maya reported that after this event she began to shoplift on a regular basis. She said, "I really didn't need to do it, I had the money." She noted that it gave her a sense of power and well-being. She told me that recovery was everything to her, but sometimes the pressure of "all that" needed to be relieved, and she had found a way to do it. "Hmm….that's interesting," I thought.

The idea was planted. I began to listen in group and individual sessions to women in a new way. I had begun the grounded-theory process. I suspected that women in recovery did things, not because they were in relapse, but to relieve some of the pressures of being in a highly structured program that they were dedicated to. Other women spoke of events where they knew the outcome was dangerous or threatening to their recovery but for various reasons engaged in it anyway. More questions about the meanings of this process arose. By the spring of 1994, I had a seed of an idea and a plan to examine the phenomenon.

Many professional addictions counselors understood that high-risk behavior was a part of the recovery process, but none, as yet, had ascribed meaning to it. Counselors in a focus group offered to me their professional understanding of high-risk behavior in recovery. From that information, I developed an open-ended questionnaire and interviewed 30 women in recovery from crack-cocaine addiction, identifying an abundance of behaviors that could be categorized as high risk. From shoplifting to bingo to isolating through church activities, women engaged in behavior that had an impact on their recovery process. The impact was not always a negative one; often it led to stabilization in a shaky recovery process.

The study of women in recovery from crack-cocaine addiction and high-risk behavior led to the development of a theory of high-risk behavior in recovery, which was found not to be a linear process, but something that represented different dimensions of women's recovery. Examining addicted women's recovery processes helped to identify and challenge the meanings that certain behaviors may have for women in recovery and the purpose that these behaviors may serve. From grounded theory study, women could be characterized as either "*relapsing, running, or relieving*" when engaged in high-risk behavior in recovery.

In 1996, I began work as a social worker in a family-service agency. I often saw outpatient aftercare clients who needed to complete counseling for parole or probation. One individual was particularly memorable. Mark was a 33-year-old African American male. A crack-cocaine addict, he had just completed 18 months in prison for a drug charge. Mark had come from a middle class family. He had been drug free for two years. He was com-

mitted to recovery. Mark was stable, had a job and a family, and did not appear to have any secondary mental health issues to hinder his progress. He was intelligent and had attempted some college; he hoped to eventually complete his degree.

There are several models that would have been useful in working with Mark. The empowerment approach is an effective one with many individuals who are vulnerable or disempowered, and, in particular, for Mark. I believed that if I could assist him in making an attachment to community in both a civic and personal way, it would be a protective factor in his recovery. Along the course of treatment, we discussed ways in which Mark could be involved actively in his community, particularly in the area of drug-abuse prevention.

One day we discussed a community-wide anti-drug activity that he planned to take part in. Without much thinking, I was giving Mark a little pep talk about the positive effects that his activities could have on both him and his family. I said something like, "Think about what this models for your children. You are a force in keeping your kids off drugs." His response was, "You can't keep your kids off drugs."

Perhaps because I was a mother of a seven-year-old boy, perhaps because I was middle class, or perhaps because I was white, I had a visceral reaction to this. "What do you mean?" Mark believed that you could teach your kids all you wanted about drug abuse and addiction, but in the end, you really can't prevent it. My first thought was, "*I* can." As social workers, we need to be responsive to our reactions to clients. I recognized that I had reacted to Mark's statement, but I needed to process where my reaction came from. It could have come from many places. What did it mean that I, a white, middle-class mother, believed that I could positively impact and certainly *would* impact the initiation of drug or alcohol use in my son, and that Mark, a black, middle-class father and recovering addict, believed that he could not.

These types of disconnects in treatment demand attention. The social work student learns early that these types of events, which might be construed as "countertransference," can signal a bias or diminished cultural competence. It must be investigated, but not necessarily with the client. I recognized it as a personal reaction. While it did not become, nor should it have become, the focus of our work together, I tucked it away for future reference.

The recognition that there was a discrepancy between my sense of self-efficacy around the prevention of substance abuse in my child and the belief system of my client led to an investigation of literature on self-efficacy in prevention. What I found was that none of the literature specifically targeted recovering parents, the most vulnerable of all groups. Much of the research had been done on the general population and, in particular, parents of school-aged children. Parents with addiction are highly likely to have offspring that develop the same or related problems. The idea was worth paying attention to.

In 2001, I received a small grant to conduct research on recovering parents' self-efficacy in substance-abuse prevention. A questionnaire was devised that explored dimensions of parental self-efficacy. The analysis, which was done by someone other than I, revealed that parents who are in recovery have a strong belief that they are responsible for teaching their children about substance abuse, but they feel as if they have no control over their children's behavior around issues of drug and alcohol use. Parents who are in recovery, when referring to possible future drug use in their children, use the word "when" not "if."

At the same time this research was conducted, a survey was completed via the Internet with recovering parents and a control group. While the research has not yet

been published, an analysis has revealed a significant difference between the two groups. It seems that recovering parents, regardless of economic status or race had less self-efficacy than other parents. Although the analysis is not yet complete, the original idea, given shape in 1996, now has empirical substance.

Social work research often leaves the reader with questions about applicability at the practice level. Social work has struggled to find its voice and make its presence known among those disciplines that are typically identified with quantitative research with rigid methodology and limited applicability. Perhaps in seeking to quiet the ghost of Flexner, who declared in 1915 that social work was not a profession, we have inadvertently loosened the connection between practice and research.

Researchers have been frustrated that empirical findings often are not incorporated into clinical practice. When researchers have attempted to make their contributions more relevant to the practice of counseling, they have been disappointed by the lack of impact on or response from practicing professionals. One solution is to create research that arises from "practice wisdom."

It has often been said that social workers listen to their clients with a "third ear." I am suggesting that we listen with a "fourth ear," that of the qualitative researcher. Reestablishing a connection between research and practice will lead to an improvement in both practice and research. Creating a more direct connection between the two will strengthen the reciprocal and reflexive relationship between research and practice.

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