

I'VE GOT THEM IN MY BLOOD: REFLECTIONS ON THE IMPACT OF COUNTERTRANSFERENCE ON THE PROCESS OF BECOMING A SOCIAL WORK RESEARCHER

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Poor minority women are the fastest growing group diagnosed with AIDS. As a seasoned social worker, the author conducted a research study that explored why a sub-population of these women, those in substance abuse treatment, continued to engage in AIDS risk sexual practices. Here, the author reflects on the impact their stories and experiences had on her. She learned that even as a seasoned social worker, knowledgeable in clinical countertransference, she struggled with her new role as a researcher.

Poor, primarily African-American and Latina women are the fastest growing group diagnosed with the human immunodeficiency virus (HIV) (DHHS, OMH, 2005). Most have been involved in drug use, though increasingly they are acquiring the disease as a result of heterosexual transmission (DHHS). Therefore, addicted women now enter substance abuse programs receiving not only drug treatment, but also AIDS¹-prevention education services.

In the mid-1990s I became interested in minority women's risk for AIDS when running a 24-month substance abuse treatment program and, as a licensed clinical social worker, providing psychotherapy services for some of the program's clients. During that time, several of the women became pregnant, even though since the early 1990s the program also provided AIDS-prevention education groups for its clients. All were required to attend the groups at least monthly for the entire time they were enrolled in treatment. Nevertheless, within one 12-month period, some of the women became pregnant—a clear indicator of lack of condom use. Unprotected sex, of course, also increased their risk for AIDS and other STDs. In talking with these women, I was told that they wanted to get pregnant. This both shocked and pained me for several reasons. Most already had several children in foster care, for whom long-term arrangements had yet to be made. All of these women were having unprotected sex with partners who were intravenous drug users or engaged in other risky behaviors. Also,

many said the reason they wanted to have another child was to “prove” they could have a baby born drug-free; none indicated to whom this needed to be proved.

As a result of what I was hearing from these women, I conducted two pilot studies involving five African-American women in recovery, some of whom were clients, and some of whom were drug-treatment employees. I discovered that during their recovery, ranging from six months to three years, a number of them had previously or still engaged in risky sex. One reported having unprotected sex with her husband whom she described as promiscuous. Another, clean and sober for 16 months, continued to prostitute, though not for the money. Two others, AIDS educators, were having unsafe sex. A former client, sober for more than five years, engaged in unsafe sex with a man whom she knew to be promiscuous and suspected of using drugs.

I wanted to discover what contributed to their risky sex behaviors and do something about it. I was concerned about the women I'd learned about and others like them. What they were doing alarmed me. Why, I wondered, would women who were seemingly taking control of their addiction risk contracting AIDS? I did not question my being alarmed; it seemed appropriate. In fact, the emotions these women generated in me motivated me to conduct social work research in the area of minority recovery women's continued AIDS risk. I had a clear purpose and goal; I knew I would not lose my way (Maxwell, 1996).

I used primarily quantitative methodologies to study an availability sample of 44 women in a variety of drug programs to address my global research question: What are the factors that contribute to the continued AIDS risk of minority women who are in recovery in substance abuse treatment? The qualitative portion of the study (not appearing in study's final version) provided personal, descriptive stories of their risky behaviors, detailing their relationships and the situations or contexts in which they occurred. In retrospect, I think it was the qualitative dimensions of the study that initially interested me. I prepared for the study while actively involved in clinical work with women much like the ones I planned to study, listening to their tragic and traumatic stories almost daily. By the time I began interviewing the participants, however, I was no longer working directly with women in recovery. As far as my clinical relationship with recovering women was concerned, I considered myself appropriately decathected; that is, I was clinically emotionally detached.

When I began interviewing the participants, I focused on them only as research subjects rather than as clients. I would still be of help to them, I thought, but indirectly, as a researcher. I would disseminate my findings to other AIDS educators who, in turn, would help them directly. It is clear I was deeply involved in these women's realities. It was, after all, my viscerally responsive concern that led me to immerse myself in this emotionally volatile arena. Being a researcher, however, was new to me. I didn't know the extent to which my inexperience and inadequate understanding in this new role would disarm me, causing me uncertainty in my old role as a direct practicing clinician.

My inexperience and lack of the knowledge and breadth of the researcher role led me to believe I would relate to the women only "objectively" as research participants. But, I began readily acknowledging the impact I would have on them (Mishler, 1986; Weiss, 1994). I knew I needed to remain aware of how and in what ways I was affecting them during the interview. Unfortunately, I left behind too many of my erstwhile clinical skills, neither giving much thought to, nor preparing myself

for, how such interviews with highly vulnerable and traumatized women might impact me. Despite many years of psychodynamically oriented clinical social work, countertransference in the research interview process did not occur to me. I had no inkling of how these women, their stories, and their interview responses might force me to alter the course of my research. Only upon completing my study have I begun to think more deeply about the role differences between social work clinician and social work researcher, and to untangle the variety of experiences I had conducting this project. What follows is a narrative reflection on what was a difficult and complicated process.

The Social Worker as Researcher: The Future is Nigh

I mount the very steep steps of Harambi House, a woman's substance abuse treatment program, on a quiet inner-city street. The steps are so steep that I am convinced there cannot be physically handicapped women inside. I ring the bell and hear women's voices behind the door signaling my presence. I've already interviewed some women here, so they know me and I get in right away.

Mary* is waiting at the top of the stairs leading down to the interview room. We greet and banter with one another in an Afro-centric style that clearly puts her at ease. Mary is quite talkative and personable. Her affability belies, however, the evident toll that her life of drug abuse has taken on her body. She has scars across her eyebrows and several missing teeth, looking like a veteran undercard boxer, a look not uncommon on frequently battered women. The ravages of her hard life, like too many others I've interviewed, have left their permanent marks on her—she's only 35, but looks almost 50. I find that continually having to look at the results of these women's physical trauma is increasingly becoming hard for me to bear. Sometimes they are almost too hard to look at and to hear. Their stories are disturbing, the ones about their risky sex practices becoming ever more difficult to listen to. This difficulty flits through my mind, an as yet inchoate feeling that I find myself loathe to acknowledge. I watch as Mary completes



*All clients names are pseudonyms.

her questionnaires and I ready myself to ask her open-ended interview questions. One of the first questions I ask Mary is whether there have been times in her life, including recently, when she has been in a relationship with a man and not felt in control of their sexual relationship. She replies that it was occurring with her current boyfriend. (At the time of the interview Mary had been in treatment for several months. She had been in this relationship with her boyfriend, though, for *three years* before she entered treatment.) "Yes, yes," she answers, almost eagerly. She continues, "I feel, first of all, I feel violated, helpless. It's like, it's because, I don't want to lose him. I'll do whatever I have to do. If he tells me to do something this way, I'll do it, not wanting to be alone, and that fear of being rejected. So whatever he asks me to do, I'll do it."

Listening, I begin to feel sad. Nevertheless, I listen to how Mary is using treatment and the support of the women's program to change the addict part of herself that she calls "stupid, gullible." I shift the conversation from her recovery litany—one I have heard from many of the women who have revealed that they continue to practice risky sex. For me the refrain has begun to take on an ego defensive doing-and-undoing motif, one that I believe must remain unchallenged by me, given my (lack of) understanding of what my quantitative researcher role must be.

I ask Mary what she thinks would help to alter her risky behavior. She answers, "I know, number one, I would have to leave him." Then, for the next 15 minutes, she talks about how she has trouble with this solution that she presented for herself. For her there seems no middle ground of asking her partner to wear a condom or wearing one herself. For her it's an all-or-nothing proposition: she must have risky sex with him, leave him, or watch him leave her. As she talks about her seemingly self-imposed dilemma, I am thinking that this has been an ongoing discussion for her, both in her head and with her boyfriend. She indicates the latter, that she's had this conversation with him by her response to my question about whether she uses condoms with him all the time. She says, "No," it was his

idea they not use condoms. That, "...since I got it [AIDS] from him, his attitude is, 'What the fuck, we've got it anyway, so...'"

I did not ask the women their HIV status and did not ask Mary hers. Therefore, I have no idea that all the struggles around risky sex that she has been telling me have occurred in the context of both her and her partner being HIV-positive. I am, again, shocked. It takes all I can muster to keep from falling on the floor. I do, however, fall out of my researcher role, asking if they know they can become re-infected. She says they do. That means they know the deadly consequences of their sexual relationship. Mary goes on to tell me about the many conversations she has had with her boyfriend, her unhappiness with their risky behaviors, their constant arguing about it and other issues, and her feeling helpless to leave him. She says to be strong enough to break up with him "...is gonna take some time. Oh yeah, it's gonna take me some time. He's in my blood. I say that all the time." She laughs. "N*****, you're in my blood." "He is, literally," I say, wondering if she fully understood the depth and complexity of what she has just said. I repeat, "He is in your blood!" She says to me, "Yeah, he knows that. He don't like what I say. I say, if I wanted to get rid of you, I could not, 'cause I got the disease from you and you're in my blood." I am watching her smile as she says this. The metaphoric, yet very concrete, description she's just articulated renders me speechless. I think, though, that I understand where she's coming from. But, it does not feel like a good place and I do not like it. I don't want to go there; it's not a place I want to be: a place of perpetual trauma, of other- and self-destruction. But, as I was leaving I felt impelled to reflect on the context and history of how I had come to be in that place at that time.

The Social Work Researcher as Case Manager?

As I left Harambi House, I asked myself the same questions I had reflected on over 30 years ago, before I went to graduate school, before I became a "real" professional. Then, I was a case manager, finding myself on my knees alongside my colleague, a

paraprofessional homemaker, sorting through a client's child's bedroom closet stuffed with dirty clothes and a couple of dead pigeons. Although I did not actually handle the dead birds, I nevertheless asked myself, why am I doing this? How long am I going to continue to do this? I never thought I would be asking myself the same questions again, more than 30 years later, in my newfound role of researcher. As I contemplated it, though, I realized that I should not have been surprised; I should have taken a hint two years earlier when I was preparing to conduct this research. Although I had been assiduously taught that skills gained in one helping role can—and should—be transferred to new ones learned, I didn't imagine that might include the role of researcher. Although case management skills, such as extensive and persistent outreach, are now recommended by social work researchers (Wu, El-Bassel, Witte, Gilbert, Chang, & Morse, 2005), I believed that they didn't include my old case management experiences.

For example, in one pilot research study, I interviewed several outpatient recovering women. I arrived early for one of the interviews and I waited for the participant. She showed up with a cab-load of children and groceries. I assisted her, but although I had incorrectly imagined "real" quantitatively oriented researchers never doing so with any regularity, I helped her unload all of the groceries, and then carried two bags and one of her toddlers up three flights of stairs. Her hands, too, were full with bags and "stair step" children, one of whom was groggy from sleep and stumbling. I took on my old case management role almost readily; it was not, after all, one that was new to me. And I did, of course, have my own agenda. If I do not have a clear purpose, according to Maxwell (1996), I'm likely "to spend my time and effort doing things that won't contribute to [my] goals in conducting the research" (p. 14). Quite honestly, I hoped that after carrying her toddler and a share of the groceries up the steep steps, and then helping put both children and groceries away, she would readily give me two hours of her time for my qualitative study.

Although I recognize today my erroneous thinking, at the time I thought, "This is only

pilot research, not the real stuff." Back then, I had not read anything informing me otherwise. Reflecting on this now, it's clear I knew next to nothing either about conducting research or about the real-life adventures of researchers. I did not know what they had to do to get their research project accomplished. I had taken anthropology and sociology courses. I knew there were researchers who interviewed deviant people and sometimes were exposed to dangerous environments. That had always been my social work milieu, so I had not re-contextualized that knowledge. For me, that was not the challenge. I was hoping my research relationships would be contextually different, that I'd really decathect and increase the emotional distance between them and me.

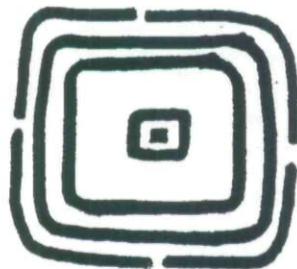
When I began my research, I felt it was okay if I did not get as emotionally close to my research participants as I had to my clients. I was naive, looking forward to just showing up, getting information, and moving on. At that stage of my research knowledge, I hadn't read anything to the contrary. I wanted to go neither further nor deeper than the interviewee might want me to. I wanted to be able to relax, have more emotional distance, and I was willing to settle for whatever the participants were willing and able to share with me in a structured interview. I thought that was what quantitative research was all about, and why I opted to focus almost totally on that methodology. Of course there was also the need to fulfill course requirements, clearly *my* issues. In a sense, I was colluding with quantitative research, a methodology that apparently encourages distancing of the observer from the observed in its promotion of the notion of objectivity (Giami, 2001; Maxwell, 1996). Researchers like Giami and Maxwell, I now know, don't take this stance. But for me, it became my goal.

The Social Worker as Researcher: Cautionary Advice

Discarding some of my professional cautions had its advantages: I had completed two pilot projects and eagerly looked forward to being a researcher. Even after half a decade I was still interested in the intersection of AIDS prevention and substance abuse treatment.

Truthfully, helping recovering women by lugging their children and groceries was less emotionally draining than being a full-time case manager. I believed, partly because I wanted to, and partly because I did not (want to) know better, that research would take a lot less effort than what I had experienced in my old case manager role. Why I thought that, I don't know, but it's what I thought at that time. When sharing with a colleague some of what had happened while completing my pilot research projects, I said that my experience wasn't too bad, although I was glad that it was over, and I was ready to move on to the "real thing." He praised me for overcoming these hardships, but warned me about AIDS research, as he had studied AIDS victims' caretakers. He described his interview experiences and the emotions that he'd felt, trying to get me to hear and understand. My research could have even more serious consequences, he cautioned. I was studying a two-barreled problem: the deadly and devastating disease of AIDS, and the devastating—and sometimes deadly—disease of addiction.

Clearly, I heard him. I am recounting what he said, but I had not really listened. It seems that on the most important level I disregarded his cautionary story. He had studied persons with full-blown AIDS; in my narrow thinking, that wasn't my study sample. What I wanted to know was why they *risked* getting AIDS. I did not think I would be witnessing HIV-positive women telling me, either metaphorically or allegorically, that they voluntarily risked being re-infected or that they initiated sex with partners they knew to be HIV-positive. Sometimes even hindsight isn't 20/20.



The Social Worker as Researcher: Burnt Up or Burnt Out?

Despite denial, avoidance, and other defense mechanisms that become clearer upon reflection, it was not until my conversation with Mary that I felt the interviews begin to take their toll. About 25 of my 45 interviews occurred during the city's summer "dog days." Too many 100-miles round-trip commutes, too many three to four interviews per day, and too many steep steps—all in hot weather—appeared to be my psychological and physical softening agent. By the end of Mary's interview, walking down those steep steps I asked myself, was she serious? What did all of that mean? How do I feel now? For the first time I seriously questioned whether I could complete the 50 interviews I had planned. Mary was my 33rd interviewee; I had 17 more to go. It was just the middle of August. By then I was teaching full-time and had only three weeks to prepare for my fall courses. I had a lot of reflecting to do.

Unknowingly assuming another aspect of my old case manager's role—focused persistence—I redoubled my recruiting efforts since almost four weeks had elapsed before interview 34, the longest hiatus between interviews. My pace increased, but I moved slowly in other ways. Although never late for interviews, I wasn't arriving as early as I had. By interview 42, I was arriving just on time, women waiting while I set up. I felt worn out. I shared with a peer that I thought I wouldn't reach my 50-women interview goal; I didn't have it in me. I reconsidered why I was finding the interviews demoralizing. I'd spent years as a long-term psychotherapist of severely addicted women like Mary and the others, and my sample represented that clinical population. I wondered, what was the difference? Why couldn't I establish and maintain an emotional research distance like the clinical one I had worked so hard to achieve? These were my ruminations when I interviewed Luisa, number 43, a career-altering experience.

Luisa, who is Puerto Rican, lives on the third floor of a three-quarter house.² When I arrive, passing the resident manager in the front hall, I see Luisa on the phone. Covering the phone, she tells me to go on up. I walk into

a bright, airy kitchen with the back door open to the warmth of a beautiful Indian summer day. It's good she's on the phone: I have the time I've now come to need to set up. Luisa is attractive, looking somewhat younger than her 30 years, and has been clean and sober for some time. She is quite open and friendly; we chat briefly before we begin. My first inkling that this interview is going to be different from any of my others comes with Luisa's response to an Addiction Severity Index (McLellan et al., 1992) question about how much she spent on drugs in the 30 days before entering treatment. I watch her thinking this question over. Her answer: \$40,000, the largest sum given by anyone I'd interviewed. I am not shocked, though. Stories of multi-million-dollar entertainers and athletes going broke due to their drug addictions are legion. I sit quietly awaiting her version of this old, sad story.

She tells me the story of her husband and her coming into \$40,000 and spending it all on drugs the month before she entered treatment. They bought drugs not only for themselves, but also for their many friends. Then, there's silence. With a pensive look she says, "Just think, all that money, and all I ever wanted was a family and a house with a picket fence." This, I think, is when my hard-earned, but thin, armor of objectivity begins to shatter. Before I know it, I retort, "Now the dealer has the house with the picket fence." She says nothing. She just nods her head seemingly lost in thought, looking into space as if watching the dealer drive away over a ribbon of black macadam, her house with its picket fence on his flatbed truck. I get myself back in control, my erroneously acquired researcher's façade firmly in place, and the next 45 minutes go smoothly while I am enveloped in a false sense of security.

Earlier, Luisa volunteered she was HIV-positive and had not practiced risky sex since being diagnosed three years earlier. Therefore, I am totally unprepared for her responses to the questions I ask to elicit stories about the context and situations surrounding the women's sex practices. I ask her one of those questions, and, in what I'm learning is her thoughtful and deliberative way, Luisa says that being asked about having unprotected sex

makes her think about the phone conversation she was having when I arrived. It was with her boyfriend. She's been going with him for about six months. She says she told him she was HIV-positive, but that there were ways that they could have safe sex, if he were willing. He called to say he didn't want to have sex with her. She says, "He says he's still not ready."

Silence is between us again. She continues to look pensive. I, however, not being there in the moment, immediately begin to fantasize about Luisa becoming my poster girl for AIDS prevention. She's a sterling example of safer sex for minority women in recovery to emulate; she is a model of harm reduction (DesJarlais, Guydish, Friedman, & Hogan, 2000). The nature of fantasizing being what it is, I quickly move on to wondering about the likelihood of my being able to contact her for a "success story" interview. When Luisa suddenly begins to cry, I snap back to the here and now. First she cries quietly, talking through her tears in a voice much softer than she used earlier. I listen raptly now, paying close attention when she says, "This is the third time he says to me he's not ready to risk having sex with me." Then she cries harder, describing how conscientious she's been in telling her HIV status to the men she's been dating because she doesn't want to pass the disease on to them as her husband had passed it on to her "...totally without my knowledge," she'd said. Then, she completely breaks down, crying with loud racking sobs. Being attentive and mindful of the circumstances, as a good clinician should, I simply sit silently. I look at Luisa, her head in her arms on the kitchen table, crying. Already feeling I had overstepped my bounds with my previous remark about the dealer getting her house and picket fence, I'm wondering if, perhaps, in some way, my retort contributed to her crying in the first place. Given my uninformed, naively stereotypical notion of a researcher, I feel totally useless.

So, I just sit there, stroking her hand as it rests on a table now cluttered with research paraphernalia, in a sunny kitchen on a warm autumn day, and watch her cry. I sit there saying nothing. She pulls herself together enough to say, "I'm all right, now. It's okay

for you to go." I get up to go. I still say nothing. As I pack, I glance at Luisa repeatedly to see what her body language tells me, because she, too, is silent. As I finish packing, I say to myself, in a new, different, and almost unrecognizable "researcher's" voice: thank goodness I followed Institutional Review Board protocol; program staff know about my research and that I am here today interviewing. If Luisa manifests any signs of continued distress, there will be help available. But merely following my naive impression of a research protocol is not enough psychological or emotional solace for me. As is the case with countertransference, this isn't as much about Luisa as it is about me and my falsely dichotomous notion about the differences between researcher and clinician; now I know that even as a researcher, I should have comforted her.

The three shallow steps that I walk down as I leave are, in an important sense, no different from the many steep ones that I climbed to see Mary many interviews ago. My dejection telescopes them. One interview slides into another; the last one seems like the first one, while the first seems just to have occurred. I wanted to tell Luisa she was doing the brave and the right thing, that the fact her boyfriend was still going with her, though he was uncertain about sex, said a lot about him, about her, and about the potential strength of their relationship. I did not say this to her, though, too wrapped up in my own dejection. I said almost nothing beyond good-bye. I just walked down that seemingly endless flight of stairs hearing her last phrases, echoing in my ears, "All I wanted was a family and a home. Was that asking too much? Will I ever meet anyone who will love me? Who would love a woman with AIDS?"

After Luisa, and with input from a colleague to whom I really listened this time, I stopped the interviews. I completed only those already scheduled. I interviewed a total of 45 women, not having it in me to do even five more. I had survived as a clinician working almost my entire career with women like Mary and Luisa because I perceived myself to be—and was—an active change agent in their lives. Helping people to change, and encouraging them to be active participants in the process,

made enduring their traumatic life experiences tolerable. I liken it to the psychological defense mechanism of doing and undoing, but with the research I felt no undoing, just the experience of their doing. The undoing seems to be missing in the researcher's role (at least that is how I viewed it then) being the neophyte I was. I cannot imagine journalists who feed upon or intentionally generate Luisa's type of emotional drama. For me it was enervating, not invigorating. I have been open and forthcoming about my many contributions to the research difficulties in which I found myself during this process. Painful discoveries, I've come to learn, are part of the process of becoming a good researcher (Maxwell, 1996). I do not think enough is done, written about, and discussed to prepare new researchers for what they may encounter. Now that I've finally gotten it, I have a lot of questions that are, so far, unanswered. Therefore, I must reflect even more deeply, untangle my experiences, and figure out how to proceed.

The Reflective Social Work

Researcher: If Not

Countertransference, Then What?

Obviously, this tumultuous research process strongly and decidedly had its impact on me. Without exaggeration I can say that, besides the baggage I brought to this process, the experience was painful. I have used the time since completing my research to read and continue to contemplate my experience of these dyadic relationships. What, I wonder, would I have needed to do the 50 interviews? If I had seen five more women, schlepped to and from interviews with a heavy equipment bag, and just tried to complete the project, would the quality of my research have suffered? I can see an unspoken benefit of quantitative work: researcher angst is never its ostensive focus. This is less true with qualitative research, I believe, and others concur (Boylorn, 2006; Magnet, 2006; Wyatt, 2006).

As a long-time clinician, I often approach relationships from a psychodynamic perspective, using other psychological perspectives as needed. So, for me, in studying and reflecting on research relationships,

countertransference is a familiar key theoretical framework for understanding these dynamics. Many psychodynamically oriented clinicians use countertransference as their stock in trade. It is something not avoided, but processed, understood, and—hopefully—used to accelerate therapy. Countertransference has both traditional clinical and contemporary research meanings that comprise my understanding of this complex notion. Traditional clinical countertransference involves the clinician's unconscious reactions to clients. The reactions relate to the clinician's internal conflicts projected onto the client. Countertransference must be constantly monitored and understood (Barker, 1997). Researchers can experience countertransference also. For them it is the "sum of unconscious and emotional reactions, including anxiety, affecting [their] relation with the observed subject and situation" (Giami, 2001, p. 10). I struggle, however, with using countertransference to characterize my research interview experiences.

Nevertheless, countertransference is my clinical stock in trade, too. My struggle is that it is my only lens and that it is a largely self-referential, wholly intrapsychic, one. Even as countertransference magnifies, it shrinks both perspective and dimension. Since I am writing from a first-person perspective, being self-referential is fair, but insufficient. The interviews, though presented from my perspective, were not actually *all* about me. The women interviewed said and did things *and* I experienced them. Countertransference addresses the latter, I believe. But, the concept is insufficient for understanding the "other," i.e., what the *interviewee* contributes that affects the interviewer.

Exploring interviewees' contributions necessitates broadening my conceptual framework to consider concepts that, along with countertransference, may provide more dimension and substance to my truncated research effort. This, after all, is a qualitative reflection on a primarily quantitative research study by a persistent clinician committed to understanding her new role and apprising others of this transition process. I believe more clinicians should do research. They must do

so, as more and more of them, in this era of accountability, are being pressured to initiate or increase their research and/or evaluation efforts (Blythe, Tripodi, & Briar, 1994; Padgett, 2005). My exploration, therefore, continues.

As I came to realize, many of my interviewees revealed pervasive trauma. Sometimes it was evident in a woman's visage, as in Mary's case. Or sometimes in their stories, as it was with Sara, who described years of sexual abuse in foster homes in which she was placed as a result of her alcoholic mother's severe neglect and abuse. Whatever its manifestation, trauma always seemed to hover at the top of the steps, an enervating aura ready to overwhelm the inattentive in an amorphous haze. It was almost impossible to conduct interviews without becoming engulfed by an aura of trauma. How could it have been otherwise? Becoming ensnared in the women's trauma experiences was not about avoidance choices, but about naming, giving meaning to, what I felt was happening to me (Stamm, 1997).

Traumatology lacks countertransference's psychodynamic depth, but it focuses on knowing and doing more for *interviewers*. It is about being aware of how interviewers are impacted by interviewees, helping the former to work through and with the impact. Trauma, "an injury to the body or psyche by some type of shock, violence, or unanticipated situation" (Barker, 1997), was the aura of many of my interviews. Countertransference is only one aspect of trauma and the interview process. Three additional concepts now frame this discussion: compassion fatigue, secondary traumatic stress, and vicarious traumatization (Stamm, 1997). Virtually synonymous in their clinical contexts, they refer to a syndrome resulting from "exposure to a traumatizing event experienced by a client [that] becomes a traumatizing event for the therapist" (Figley, 1999, p. 11). According to Pearlman and Saakvitne (1993), vicarious traumatization generates compassion fatigue and secondary traumatic stress, having a *cumulative effect across clients*, pervasively impacting the *self of the therapist* (p. 250) [italics added for emphasis]. For traumatologists, vicarious trauma is the overarching concept under which

countertransference, compassion fatigue, and secondary traumatic stress are subsumed. What they add is this: interviewers, including research interviewers, *will become vicariously traumatized when repeatedly interviewing traumatized clients* (Giami, 2001). I embarked on my first research effort with no idea of the extent to which the traumatized lives of my interviewees would traumatize me and, at the same time, was ill-prepared to use my clinical skills because of my uncertainty about my new role.

Learning about, and better comprehending, vicarious traumatization has led me to realize the inevitability of the negative impact of my interviews (Figley, 1999; Pearlman & Saakvitne, 1995; Steed & Bicknell, 2001). It was the natural result of being an empathetic social worker interviewing suffering people. As a clinical therapist steeped in empathy, interviewing recovering women who invariably had traumatic histories (Amaro, 1995; Amaro & Hardy-Fanta, 1995; Brown, 1995), I was a vicarious trauma victim waiting to happen! Given empathy alloyed and vicarious traumatization inevitable, I would seriously question the assertion "...that the methodology of the clinical interview, modified for research purposes, is an effective and safe way of obtaining data on human experience" (Bunin, Einzig, Judd, & Staver, 1983, p. 23). In this case, it seems the authors primarily focused on the safety of the interviewee. They did not go beyond countertransference to acknowledge what traumatologists willingly do: that what interviewees bring into a session can be unsafe for the interviewer.

From the researcher's perspective, how "safe" is safe? How is the social worker or other professionally empathic researcher protected? I would not have thought to be a *less* empathic researcher. I did expect to *do* some things differently (in fact, I eagerly anticipated it), but I did not expect to *feel* differently. I saw empathy, that principal social work quality, as an asset that contributed to decreased resistance and tension in interviews on sensitive topics (Lee, 1993), enabling *interviewees* to feel safe to discuss them with a greater ease and openness. It was a psycho-affective methodological process (Figley, 1999;

Pearlman & Saakvitne, 1995) that facilitated my entry into 45 recovering women's desperate and unhappy lives. Now, Pearlman and Saakvitne are suggesting that the same empathy I honed and developed over the years—the emotional quality central to social work—was an "exposure liability," a trauma-prone characteristic. The concept of vicarious traumatization has made a valuable contribution to my reflection on my novice research experience. I know that if I continue research with this population, I can expect to be vicariously traumatized and that it is likely to worsen with the more women that I interview. I must protect myself. Despite its important contribution, I am still having reservations about vicarious traumatization as the conceptual framework to explain my response to this research experience. That is because many of its manifestations do not fit my experiences; they had other possible causes.

For example, workers experiencing vicarious or stress-related trauma have been described as having symptoms such as feelings of inadequacy or incompetence, burnout, intrusive traumatic thoughts, hyperarousal, and avoidance (McCann & Pearlman, 1990). I have had two of these symptoms: feelings of inadequacy and intrusive traumatic thoughts. The former I did not attribute to burnout, however. I thought it was related to my performing what I deemed a passive researcher role. Doing what seemed to be nothing to me clearly related to my feeling inadequate. I remember, on occasion, sharing with colleagues my feelings about being unable to say or do anything clinical in response to some of the things I heard in the interviews. They tried to assuage me by suggesting, as does Shamai (2003), that the research interview itself can be therapeutic. Subsequently, I've encountered those "aha," moments in research interviews. I have experienced what I believe to be change as a passive by-product of research. I do agree it's better than the nothing I felt I was doing. Nevertheless, I believed that being an active change agent would, to a large extent, have mitigated my feelings of inadequacy during that six-month arduous process.

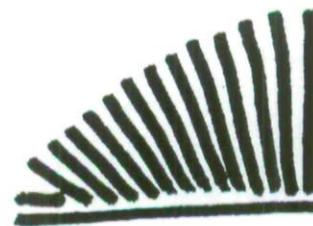
Even if research interviewing can be therapeutic, reservations about vicarious trauma's explanatory efficacy, vis-à-vis my research experience, continue. Not because I don't believe I experienced vicarious traumatization; I am certain I did. I felt for Luisa. Her acquiring AIDS from her partner, drugging away \$40,000 in the space of a month, and then finding herself unable to achieve an open, honest, satisfying safer-sex relationship, that's the stuff of traumatology. Luisa's story, however, was one too many of its kind for me. I wanted to avoid them and did, never reaching my interview goal. Vicarious traumatization isn't ineffective—it is insufficient in explaining how I experienced interviews such as Luisa's. That's because a large part of what I was feeling and experiencing in those interviews had to do with the ways the women were presenting themselves *while* I was interviewing them. I must reiterate that I first became interested in the issue of recovering women's risky sex practices when I noticed that some were becoming pregnant while in treatment, thus implying that they were not effectively practicing safer sex and thus were risking contracting AIDS. That was what concerned me at that time, not past traumas that may have contributed to their behavior, or simply that they were pregnant, which was their right. Typically, hearing this news I went toward the potential problem. I didn't avoid it. I'd meet each woman and ask her to share her thoughts and feelings about the pregnancy. I'd feel energized as a result of these conversations, wanting to know what was on their minds and in their hearts. I wanted to help, to allay, to the extent that I could, any potential for it to undo their sobriety and stability (Brown, 1995), both of which were needed for good pregnancy outcomes.

Psychodynamic clinicians do not just react to what clients reveal about their pasts. They respond to the here and now, and are proactive about what's going on during the interview. That is why countertransference seemed better than vicarious traumatization as a conceptual framework for understanding my research experience reactions. Though I struggled with it, countertransference does

include clinicians' current emotional reactions toward comments and behaviors that clients present in sessions. Conceptually, vicarious traumatization's explanatory inefficacy is due, it seems, to its narrowness, asserting as it does that the basis of interviewer stress is the impact on the interviewer of the interviewee's relating of *past* trauma (McCann & Pearlman, 1990). Interviewers' traumatic feelings are viewed as generated by exposure to interviewees' memories of *past* experiences that have traumatized them (McCann & Pearlman, 1990). My focus is the trauma generated by my exposure to interviewees' *current*, apparently self-destructive, behaviors and experiences as they unfolded *during* the interview process.

The Social Worker as Researcher: A Witness "In" Trauma

One should remember that this is all hindsight reflection. At the time I was conducting my field research, I had not thought about how many times I would have to listen to, be exposed to, and be confronted with women's self-defeating and self-destructive behaviors. Not in the form of stories about traumatic pasts, but comments and predictions uttered in here-and-now interviews. Maybe the results would have been the same, but I was conscious of feeling inadequate because, while hearing the self-defeating and self-destructive conversations, I believed that I could neither do nor say anything outside of what I perceived as a narrow and prescribed research role. I was not a clinician. I wasn't even a participant-observer (Baker, 1994). I was merely an observer, eliciting and taking down information to be processed and analyzed later. It's almost akin to being a bystander watching a toddler wander into the street: you are frightened by the potential danger, but the toddler is oblivious. The child has no fear or anxiety; it's not the child's problem. All the negative, premonitory feelings belong to the bystander. As the witness of a potential accident, the bystander is *directly*, not vicariously, traumatized. Traumatization inheres in the witnessing of an event that involves a threat to another's physical integrity (APA, 2000). In a very real sense, as a



cognizant witness, I am the one "in the trauma," not the unaware wandering toddler.

Teresa is an example of that high-risk toddler. At the time of the interview, she had been in recovery for about 18 months, and was still in outpatient treatment. She also was continuing to have unprotected sex with her husband who had a serious drinking problem and whom she suspected was promiscuous. Teresa said she had risky sex because that was the way he wanted it. If she didn't do it his way he might leave her. She needed him to stay to help financially and to baby-sit their four young children while she went to play bingo. Several months after the interview, he was arrested. Their youngest child was found wandering the streets. Her husband had gone out and left the children alone. Another, Barbara, in recovery for over two years, revealed she was prostituting (she didn't call it that) because her SSI check didn't cover the cost of cigarettes and snacks. Then, there was Jane, six months into recovery. She told a story about her drugging days during which time her boyfriend had thrown her out of his apartment, where she'd lived with him for several years, because she refused to have sex with him. However, during her interview, she revealed they'd become engaged and would marry shortly after both had completed treatment. They were relating not only traumatic past events, but also describing here-and-now self-destructive situations. I was traumatized *in* those interviews because I was witnessing women discussing behavior that was threatening their stability and even their lives and, for Mary, the lives of others. What was most distressing about interviews with women like Barbara, Teresa, and Jane was that they seemed, if not pleased, then satisfied with themselves. They focused on, and talked convincingly about, how much better their lives were.

Quantitatively speaking, being in treatment was a confounding variable in my AIDS risk study. From Mary's perspective, for example, she *was* doing better. From a harm reduction perspective, by being monogamous she had lowered her AIDS risk. For some of these women the fact that either they, or their partners, had AIDS or were still on drugs or

were in a residential program and, therefore, had no idea what their partners did when they weren't around was not betrayed by their demeanors. Their seeming obliviousness was what was traumatizing. *I* was the one shocked by what they were doing or saying. *They*, however, did not seem to be. Often during interviews I asked pointed questions, such as, "And you did *what?*" or "He's *still* an active heroin user?" or "You didn't *want* to use a condom?" It was like working with a caseload of suicidal clients, not vicariously traumatized by their stories of having attempted suicide, but traumatized by sitting in their presence as they talked convincingly about preparing to commit the act. Except, as a researcher, I wouldn't be their clinician and able to have give-and-take discussions or draw up anti-suicide contracts. Instead, I would merely listen, observe, and maybe find out later if they were successful. (This example is for analogical purposes only.)

As an observing researcher, I am traumatized, but not vicariously as a listener to past experiences. I am a witness to their presently hurting themselves or, as in Luisa's case, being hurt by someone else. It was more than being an empathic interviewer. Pearlman and Saakvitne (1995) do not adequately explain my experience by suggesting that I "understood" Luisa's experience or that I "felt" her pain. It was more than that: I had pain that was my own, pain generated by what was going on during that interview, by having to be there with her. The aura of traumatic pain was in the room that we *both* shared. She was not merely telling me *about* having cried because she was in despair about never being loved. She cried and was despairing in my presence, and I was in the trauma as I witnessed grief threaten her emotionally and psychologically. I was horrified and pained in the space I shared with Teresa (the interviewee who prostituted herself) when I learned that she was virtually risking her life for cigarettes and soda. I felt fear because Teresa, unlike Luisa, did not appear to care about her risk. I think my feelings solidified into traumatic ones because in Teresa's situation, for example, and as in Mary's and others, I felt bad, but they didn't seem to. I was observing, through my

flawed researcher's window, a heavily trafficked street teeming with unattended toddlers, experiencing overwhelming feelings of premonitory dread. The way these women blithely talked about their self-destructiveness made my trauma direct and primary, not vicarious and secondary. My struggle with vicarious trauma theory, therefore, isn't about its inappropriateness as a theoretical framework. Rather, it's about its inadequacy when deconstructing my research experiences. It doesn't go far enough in explaining the negative impact interviewees like Mary, Barbara, Luisa, and Teresa had on me, a neophyte social work researcher. The bottom line is this: vicarious traumatization is bad, but witnessing or being "in the trauma" is worse, much worse.

The Social Work Researcher Objective: "Good Distance"?

Qualitative research writing is replete with discussions about the impossibility of achieving real objectivity. The intra- and inter-subjectivity of this methodology may be all there really is (Denzin & Lincoln, 1994; Giami, 2001; Mishler, 1986; Weiss, 1994). The objectivity sought by quantitative researchers is a mirage; according to Giami, it is impossible. What one has to do, he instructs, is to find the "good distance," according to one's research objectives" (p. 23) It's something I had never considered. That I hadn't might explain the all-or-nothing approach with which I tackled my research. It seems that accomplishing this good distance was easier for me as a clinician than as a researcher. If I were to do this research project again, I think a "good distance" for me would be *closer* to the research participants, even though it might have necessitated revising my research objectives. Even though it is likely I would have suffered some vicarious trauma while interviewing a number of these women, I believe a lot of direct traumatization would have been avoided. The distance between the women and me needed to be titrated; I was too close to be out of range of the many negative emotions they generated in me. Yet, I was too far away to respond to them more naturally, actively, and helpfully. Though they were clean, clinically, many were in very deep

denial about the dangers they were courting. I believe that my newness as a researcher and my "oldness" as a clinician account for much of my inability to find Giami's (2001) good distance.

Overall, though, the research project was a good piece of work, I believe. And although I have not had any subsequent contact with any of the women I interviewed, I have been in contact with staff from their programs and know that they were in no way harmed in the process. It appears, though, that I would have done a better job, or at least not have felt so bad in doing it, had I given more thought to the study's objectives and the potential sequelae of its processes. I believe it would have been better had I approached it *more* clinically, not less. Had I done so, it is likely I would have considered potential countertransference and trauma consequences earlier on and secured support and guidance then.

Clinical countertransference, the quality of interview relationships, and reflecting on their processes have methodological and research implications. To some extent choosing a quantitative methodology is also at issue. Without "therapizing" research (Berger & Malkinson, 2000), qualitative researchers are much more likely than quantitative ones to consider interviewer-interviewee relationships and the distance between them in the research process thoughtfully (Bunin et al., 1983; Giami, 2001; Mishler, 1986; Shamai, 2003; Weiss, 1994; Wyatt, 2006). Getting closer to research subjects (Giami), rather than getting farther away; looking at interviewees more clinically (Shamai), not more objectively; and adopting a more clinical role and less of a "scientific" one, might have kept me safer and, perhaps, made me a better and more helpful interviewer (Shamai). The implications of these qualitative research components are fraught with ethical and other dilemmas (Shamai). That, however, is for another paper.

My motivation for writing this paper and sharing my experiences of Mary, Luisa, and others was born out of a need to practice my clinical training. I felt compelled, as a good social work clinician, to examine and analyze my research experience in light of the fact that it did not turn out as I had planned, even

though I risked exposing my extreme research naiveté and my sometimes less-than-generous feelings and thoughts, both about clients and my mistaken quantitative research beliefs. Considering countertransference as my primary theoretical framework, I examined the confluent impact of countertransference, roles, traumatization, subjectivity, objectivity, distance, and research objectivity upon me as I reflected on the entire research process. By contemplating and analyzing my painful and not-so-stellar, but enlightening, experience I have come to grips with what happened and why. It was difficult, but the compulsive desire has been assuaged.

The process has also been rewarding. I am left with a genuine appreciation for the research process and have concluded that a qualitative approach to my research study would have yielded better results—both for the study and for me. Based upon my personal experience, I actually have come to believe the contention of Bunin et al. (1983) that there is an affinity between research and clinical interviewing, even though they do not discuss qualitative research specifically. I guess that was left to me! What I would like to add to their model is the need for more training and support (not just debriefing sessions) for qualitative researchers, particularly for those (new to it or not) studying “matters concerning experiences, opinions, and feelings that people find painful or embarrassing to discuss” (Bunin et al., 1983, p. 31). This training, as I envision it, would define Bunin et al.’s “people” as including both the interviewee and the interviewer. Some budding researchers need help in creating and maintaining a “good enough” research distance. Psychotherapy for researchers involved with self-destructive participants, such as some that I interviewed, should also be strongly encouraged, as it often is for clinicians working with traumatized populations. Having gone into therapy upon completing this project partly explains my courage and ability to return to it for a better understanding of what I did and didn’t do and has given me an objectivity I did not have then.

Though I may have sounded offhanded in the recounting of my interview with Luisa, please note that I was aware of the presence

of counselors onsite when I visited her. Prior to beginning this project, all program directors, staff, and prospective participants were advised of the risks inherent in this study. During recruitment, and included in the consent form, prospective participants were not promised confidentiality in this context because of the study’s inherent risks. As stated earlier, no staff advised me of any negative consequences generated by my interviews. I’m convinced I was the one who left interviews with bad feelings, not the participants, perhaps with the exception of Luisa. Did I make mistakes? Yes, many. But none that were detrimental to others. Many of the programs’ directors knew me and had confidence in my clinical skills, and I believe their confidence wasn’t misplaced.

My reflections are at an end here. But, a somewhat intrusive afterimage lingers: I believe that Luisa really is, or could be, a poster girl for good, responsible safer sex. However, I don’t want to interview her again. I don’t want to plumb the depths of what leading that “good” life would be or feel like. I would hate to think, though, that Mary is her alternative. Somehow, despite my reflection, intellectualizing, and insight, it is a bit too much for me. I have yet to find my good enough distance from them. I’m still way too close—I’ve got them in *my* blood, and what remains before me is the rest of my social work life (Herman, 1992).

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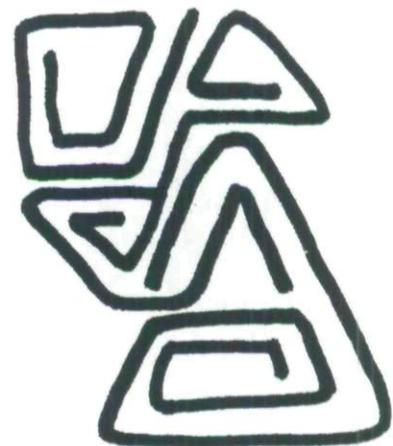
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¹ The term AIDS will be used for HIV and HIV/AIDS throughout.

² Transitional residences frequently used by those who have problems with alcohol and/or drug dependence, who require some minimal professional support (Barker, 1997).



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