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Qualitative Social Work 2003; 2; 383

DOI: 10.1177/1473325003024002

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ARTICLE

The Ubiquity of Ambiguity in Research Interviewing

An Exemplar

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ABSTRACT

This article examines the shifting word meanings in one encounter with a serodiscordant older African-American heterosexual couple who were struggling with the effects of HIV infection and heroin injection. The author raises concerns about the complexities of language, cultural contexts, relationships between research participants, interpretation, and how qualitative interviews may produce ambiguous results. The purpose of the exercise is to trouble the borders between meanings of words and between researcher and researched. The project is a methodological exercise in 'unpacking' the tightly packed components of an interview between participants who differed in social locations and experiences. Closely re-examining the interview uncovered rich and varied uses of language, especially referring to the continuum of illness and wellness. The analysis suggests that social work qualitative researchers should attend closely to language and ambiguities, be vigilant to the possibility of misinterpretation, and acknowledge their social positioning in the research relationship.

KEY WORDS:

AIDS
caregiving
HIV
interviewing
narrative

Qualitative methods, including open-ended unstructured interviewing, are increasingly used in social work research. Realizing that many aspects of human experience cannot be explored fully through a query and response mode, researchers invite conversational encounters to create a space for intricacies and vicissitudes of respondents' lived experiences. Going further, narrative researchers identify and analyze naturally occurring stories embedded in interviews to further elucidate meaning-making. Many researchers believe that these methods can help to achieve deeper insights and richer understandings. Yet dealing with language is far from clear-cut. As narrative researchers have articulated, words are often ambiguous; meanings are various and not necessarily obvious (Mishler, 1986; Riessman, 2000). Investigators may miss or misinterpret text excerpts due to style of narration, heavily influenced by such factors as class, age, religious background, regional origin, ethnicity, and sexual orientation. Interviewers may get confused about an account or not 'hear' what is most important to the teller because of linguistic, experiential, theoretical, and cultural filters and disparate frames of references (Riessman, 1987). However, scholars rarely carefully ponder words – their definitions and socially constructed contexts of meaning – or our role in co-constructing research interviews through verbal and non-verbal interaction (Mishler, 1986). Whether we are fully cognizant of it, we are constantly interpreting those with whom we speak. We continue research conversations, believing that each participant is understanding the other, yet sometimes we arrive at conclusions without clarifying. Likewise, whether we acknowledge our social positions vis-a-vis our research co-participants, we struggle to communicate across those chasms as well. Demographic and cultural differences between researchers and respondents can be enormous, yet typically social workers are taught to ignore these social realities in favor of cloaks of neutrality and objectivity.

This is a methodological treatise designed to add to ongoing discourses regarding ambiguity of language, relationship between research participants, and interviewer positioning. I wish to contribute to troubling the borders between meanings of words and between researchers and researched. The analysis builds on the work of narrative researchers who draw on literary criticism, philosophy, poetics, philosophy, ethnography, and linguistics. I use excerpts from one research encounter with two persons to better understand my role, our differences, and use of language to communicate. I closely examine the specific way the participants use the same word to stand for very different aspects of disease and health to raise general questions about whether language can be assumed to be unambiguous. I disclose some information regarding my personal and professional characteristics to invite thinking about how an investigator's positioning may contribute to and detract from the ability to represent experiences and amplify voices of others.

CONTEXT OF THE ENCOUNTER

I conducted this interview in 1996 with an African-American heterosexual couple in their apartment on the west side of Chicago, Illinois. The woman (pseudonym Jen) defined herself as caregiver to her HIV-infected lover (pseudonym Art). Art had lived intermittently on the streets and in shelters, but was now in the home with Jen. They defined their 15-year domestic partnership as a common-law marriage (see Poindexter, 2002a for a detailed report of their relationship). They were part of a familial network, including parents, siblings, children, and grandchildren on both sides. Jen was the 16th participant in a qualitative study of 20 older HIV-affected caregivers (part of my dissertation at the University of Illinois at Chicago – for reports of the study see Poindexter and Linsk, 1998, 1999; Poindexter et al., 1999). At the time Jen was 47 years old and Art was 51. Art believed that his HIV infection came from sharing a syringe with a friend while they were injecting heroin. Jen described numerous aspects of her life as a HIV-affected partner: needing support, living with HIV stigma, and coping through faith (see Poindexter and Linsk, 1998, 1999; Poindexter et al., 1999) and several relationship stresses caused by his intermittent substance use and subsequent HIV infection (see Poindexter, 2002a). Here I focus not on their themes of strength and struggle, but on use of language to communicate concepts of sickness and cure in order to illuminate linguistic and interpretive challenges faced by qualitative researchers.

REVISITING THE ENCOUNTER

I returned to the transcribed interview and field notes six years after my dissertation was completed, feeling intrigued with this encounter for several reasons. First, Art – the care recipient – had moved in and out of the room and was at times a full participant in the interview. This created various interlocking dialogues and some ‘trialogues’ (Riessman, 2000), and I was curious about those dynamics. Second, I had begun using narrative methods to pay sustained and close attention to long stretches of talk, which had sensitized me to ambiguities of language, difficulties communicating across cultural divides, and researcher contributions to constructing text. I remembered that Jen and Art had been revealing and that the interview seemed to go smoothly, despite our cultural and demographic differences and the brevity of our acquaintance, and I wished to explore what our conversation could teach me about communication, culture, and co-construction of meanings. Third, I had joined a faculty development project on substance use, which rekindled my interest in the time spent with Jen and Art. While writing about the intersection of HIV and substance use and the words used to describe those challenges, I became aware of our extensive talk based on the words ‘sick’ and ‘cure,’ which I had not noticed in my

previous work with the material. The discussion here emerged primarily from my growing fascination with the various expressions and ideas of illness versus wellness in this text and my curiosity about what could be learned from thinking about them.

METHODS, TRANSCRIPTION AND RE-PRESENTATION

My interviewing methods will be familiar to any qualitative researcher. I approached the study sensitized to certain concepts because of literature reviews and practice experience, but conducted the interview in an unstructured way. As is typical in conversation, my participation included paralinguistic and non-verbal responses; I interrupted occasionally with probes, questions, reflections, and clarification requests, trying to at the same time honor the narrative urgency and eagerness exhibited by the respondents. The themes I noticed and reported emerged from what the participants choose to tell me.

The transcription methods used here bear explanation. I re-transcribed the entire interview using Gee's (1986, 1991) poetic structural approach, attending particularly to phrasing, accentuation, and pauses. Often narrative scholars who use Gee's approach do so for small amounts of text in which they are most interested, specifically stories that are bounded with clear beginnings and endings. I decided to re-transcribe the whole tape in this way because I was interested in the couple's views of health and illness interwoven throughout our encounter. Because Gee's method of re-presenting text does not include researcher utterances, I adapted the approach following Mishler (1986; for an explanation of why and how I arrived at the model see Poindexter, 2002b). This re-transcription procedure resulted in 1016 lines in poetic form with interviewer speech included.¹ While my method of re-presenting excerpts can be confusing to those not familiar with forms of sociolinguistic analysis (Capps and Ochs, 1995; Gee, 1986, 1991; Labov and Waletzky, 1997), when the excerpts are read with the aid of the transcription key,² readers can, I believe, more fully experience the talk of the research participants. When presenting text, I note the line numbers in the left margin to give readers an estimation of where a particular utterance appears in temporal sequence.

THE ENCOUNTER

Jen had defined herself on the telephone as an HIV caregiver, but I did not know the relationship or identity of the person with HIV until Art asked to remain in the room and defined himself as the subject of our talk. After Jen signed the consent form and I turned on the tape recorder, I realized that Art had settled in and was making no move to leave, and Jen did not seem to be requesting or signaling that he do so. I asked him if he would like to stay, and

he asserted that my research was ‘about’ him. As soon as he said that, I realized that he was disclosing his HIV status to me:

- 1 [I: {to Jen} That's the end of the business we have to take care of.
- 2 {to Art} Would you like to stay?]
- 3 Art: If I could. It's about ME, ain't it? {chuckles}
- 4 [I: It's ABOUT Ms. M., but it has to DO with you.]
- 5 Art: Right. If you don't mind.
- 6 [I: No, I don't mind at ALL.]³

Thus began our dialogue. Art's presence or absence influenced the way I came to view the structure of our encounter. I think of it in four distinct sections, like a play or symphony. Each ‘scene’ or ‘movement’ is bounded by Art's entrances and exits. In the first section (lines 1 to 239), Art was present and listening, mostly silent. Art smoked cigarettes and listened quietly in a far corner for approximately 20 minutes while Jen talked to me about her reactions to his having HIV. When she began to cry, he left the room and came back in with a tissue, which he handed her without touching or speaking to her. She took it without speaking to or looking at him. He left again and was absent for a long while. (I do not know where he went, or whether he was outside listening.) Section 2 (lines 240–445) is a 20-minute segment with Jen alone, during which she delved into her responses to his drug use and HIV disease and their relationship. Section 3 (lines 446–626) begins when Art re-entered, sat down, and immediately recounted the story of his infection. During this time he was the primary focus and was in control. I thought then that he was trying to get his side of the story ‘on the record.’ Jen listened, occasionally commenting. After 15 minutes, Art left without announcing or explaining his departure. In the last section (lines 627–1014) Jen and I were alone for another 30 minutes. Jen ended with: ‘I have really appreciated this time with you. It's my therapy for this week’ (line 1014, more on this later). Then Art walked back in and closed his participation with: ‘It was nice meeting you’ (line 1016).

Below I dissect key segments of the interview, focusing on language signifying various stages of physical and mental sickness and health. At each point of the discussion I include the interview excerpts referred to. I then reflect on the influence of my positioning and conclude with implications for qualitative social work research.

VARIOUS AND AMBIGUOUS MEANINGS: SICKNESS AND CURE

Psychologists, sociologists, and others view categories as ways that humans make sense of the world (Silverman, 1998). Illness and wellness are commonly accepted as bifurcated categories that communicate clearly and immediately. Physical and mental health similarly occur along a spectrum, although we know they are not dichotomous. But like the path of a roller coaster, the sickness–health continuum can be fraught with dread and fear. Here I am examining particular words, phrases, and concepts indicative of illness and wellness.

The referential meaning of words regarding HIV, drug use, and medicine, often taken for granted by listeners, can be confusing when conveying different situations. When Jen and Art speak of the biomedical and the substance use worlds, they often use the same words to mean completely different concepts, situations, and events. Yet, as often happens in conversations, they seem clear about their shifts in definitions and we seemed to be grasping each other's meanings, so I as listener did not feel the need to question or clarify. As I illustrate with the excerpts, they seemed to understand my usages of the same terms, even when my definitions did not match theirs; I assert this because they did not ask for clarification and their responses seemed appropriate. Furthermore, I felt that I was following their narrative threads and did not feel confused. However, when years later I began to unpack the various meanings of certain words and realized how often the three of us shifted meanings without seeming to be becoming bewildered, I was amazed that our interlocking conversations had seemed to progress so well.

Sickness

I use the word 'sick' as an example of the complexity of communication. 'Sick' signified different situations depending on implied – but not articulated – contexts. The couple used 'sick' in six distinct ways to describe physical distress (never mental – I discuss mental health later): medication side effects, HIV disease, HIV-related symptoms, heroin withdrawal, heroin absence, and non-HIV illnesses.

In the first part of the interview, during which Jen was the primary speaker in Art's presence, she used 'sick' in four different ways. She introduced the topic very soon after we begin to talk:

18 Um, I can say, some days {pause} he doesn't feel very good. [I: yeah] {pause}

19 Like the medicine makes him sick=mostly in the morning

20 and then he has to SUFFER. {pause}

In this instance, clearly Art's being 'sick' and 'suffering' were due to the antiretroviral medication that has been prescribed to fight HIV. This type of sickness is often intestinal upset. Since the treatment for the life threatening disease makes him feel bad, 'sick' here signifies self care and medical treatment, part of the goal to feel better and be healthier in the long run. It is interesting that 'sick' here signifies two different temporal relationships: Art was sick with side effects now so he could possibly avoid being more seriously sick later.

The second time Jen used 'sick,' she was recounting an episode in the past when she was terrified as she waited in the clinic parking lot when Art was inside hearing about his HIV test result. She said that she prayed, 'God PLEASE don't let him be SICK' (line 82). It is obvious that 'sick' here is HIV, the diagnosis she was dreading, because she knew that he was inside learning the results of his HIV blood test. 'Sick' takes on a new temporal meaning here as well, because HIV is a continuous permanent condition, existing in both present and future and with no known cure.

The third mention of 'sick' appeared soon after, during Jen's explanation that Art believes that he became infected during a past episode when he shared a syringe with a buddy. 'Sick' here means being in the midst of heroin withdrawal, which I deduced because we were within the context of syringe sharing, which Jen signifies through the use of the word 'needle.' Being 'sick' due to withdrawal has an urgency to it, which she signals with 'he didn't have TIME to be getting his OWN needle.' This is another way that 'sick' related to time in her account: Art had to hurry up now to get something that would ease his withdrawal symptoms.

95 And when he did THAT, he said he was REAL sick=

96 He didn't have TIME to be getting his OWN needle or whatever.

Jen's fourth use of 'sick' seemed to refer to a common HIV-related condition: wasting syndrome, or anorexia. Earlier (lines 62–7) she had described what AIDS looks like to her by saying that at the clinic or food pantry she sees other persons with HIV who are losing weight and she cannot stand to think that Art will ever look like that. Again, time is an underlying concept: because Art looks well now, she cannot believe that he has an ongoing condition that might make him ill or kill him in the future. In the following excerpt Jen defined sickness from AIDS as a particular type of appearance:

128 I can't- I look at him and {short exhale}

129 I just can't BELIEVE he even SICK!=

130 you know, he don't LOOK sick.

The above examples illustrate that very early in the interview Jen used variations on the same word to refer to several unrelated meanings regarding her care-giving situation. She shifts meaning without articulating definitions, and I do not ask for them. She has begun weaving a story wherein Art's being 'sick' with heroin withdrawal in the past caused him to become 'sick' with HIV in the present, leading him to be on life saving medications that make him 'sick' with nausea and diarrhea each day even though he does not yet look 'sick' with weight loss. The listener or reader grasps Jen's meanings through the surrounding conversational context. The next time 'sick' was uttered, I was the one who said it. I use it as a stand-in for 'HIV-infected' when I ask her about whether she has disclosed Art's HIV status to her family: 'Do your kids and grandkids know that Art is sick?' (line 291). Without asking what I mean, she seemed to respond to this new context, stating that her adult children all know that he has HIV. If she thought I was referring to HIV symptoms, rather than HIV itself, she might have answered, 'He hasn't been sick,' and if she thought I meant withdrawal from heroin, she most likely would have said that he does not 'shoot up' anymore, which she told me elsewhere in our conversation. Already five different definitions of 'sick' have been put out into our conversation without either one of us getting lost in the unannounced changes of meaning or temporal context.

In Section 3 of the interview, when Art has re-entered the room to tell his side of the story while Jen remains fairly quiet, Art also used illness language in different ways to explain his perspective. Explaining how he became HIV infected, he referred to the same urgency that Jen did, stating that he could not take the time to find his own injection equipment because he was in the midst of intense withdrawal. As the following dialogue illustrates, he defines 'sick' in the context of drug use – possibly intending to test my ability to understand his vernacular – and I, in a communication partnership with him, show through my affirming utterances (like 'yeah') that I understand. I echo 'sick' in that same pressing drug withdrawal context:

464 People that's not strung out, always depending on this drug, using heroin=

465 they don't understand.

466 This particular day and I hate to be sick, you know, why,

467 when we say 'sick' it means we need a fix [I: yeah, yeah, yeah]

468 THIS day, THAT was going on. [I: You were sick, yeah.]

Just a few lines later, Art changes the meaning of the word 'sick' completely, using it to mean HIV-infection, still without articulating the shift:

478 But I always used to use my OWN stuff. [I: yeah]

479 I used his, got SICK.

480 That's how I got it.

'Got sick' in line 479 seems to mean the same as 'got it' in the next line, with 'it' referring to HIV, which entered his body through the syringe ('stuff'). Soon after, however, he changes the meaning of 'sick' yet again to mean being temporarily impaired with an infection or illness, not necessarily related to HIV. The listener surmises this shift: it does not mean either drug withdrawal or HIV, because he said he had 'never' been sick in this way, and his reference to the hospital gives the listener a further possible clue that he was speaking of never having had an acute illness:

491 You know, I'm a pretty strong person=

492 I never get sick in bed [I: um]

493 I was in the hospital ONCE

494 for a broken arm in '55

495 But I've never been in the hospital {implied, for anything else}.

There follows a remarkable passage where Art referred to many types of 'sick' in a whirlwind of meanings, all within a few lines: the sickness caused each day by the antiretrovirals as well as the potential for these same medications to save him in the long run, the sickness caused in the past by the absence of heroin, HIV as an ongoing sickness, an episode of HIV-related pneumonia as a sickness, and illegal narcotic as medicine for both heroin withdrawal and pneumonia (refer to lines 512–32). He begins by stating that his HIV medicine makes him 'sick.' Intuiting that he means nausea, and knowing what often causes that, I ask if he was now on AZT. He replied affirmatively and told me the name of his other prescription as well. Then he said that these treatments, which make him feel bad physically, can also save his life ('So you know I feel like, if I take my medicine, try to take it everyday, take the pills, you know, and if I live right, maybe I'll make it'). 'Make it' implies hope for the future: he could survive HIV, regain good health, live until the cure is made

available. Trying to gauge the stage of his HIV infection right now, I reflected something that I remembered his hinting at earlier: that he was infected approximately two years ago. He affirmed that he thinks he has only been infected for a short while, then explains that he was able to find out his HIV status only because Jen was concerned about his persistent cough, a symptom of poor health. He had been able to ignore being 'sick' with pneumonia because he was using heroin each morning, which stopped the coughing and made him feel better. First 'sick' means pneumonia, then he evidently immediately switches the meaning of 'sick' to heroin withdrawal, although here it could mean coughing with or without withdrawal. He seemed to be saying that being sick with pneumonia was a benefit in disguise, because it caused Jen to insist that he seek medical care, which led to HIV testing, which led to pharmaceutical intervention for HIV. Here is the entire exchange:

512 Like, sometimes the medicine makes you real sick. [I: Is that your AZT?]

513 Yeah. I use AZT,

514 ah a new a new drug, Lamadine, {likely Lamivudine} something like that.

515 I WAS using DDI [I: umhum]

516 So you know I feel like, if I take my medicine=

517 try to take it everyday, take the pills, you know=

518 and if I live right, maybe I'll make it.

519 [I: Well you think you've only had HIV for a couple of years?]

520 That's all. That's all.

521 You know, by me being sick, you know-

522 I got real sick.

523 I was walking around here sick for a couple of months. [I: yeah]

524 I didn't know I had HIV, but I knew I had pneumonia. [I: yeah yeah]

525 {pause} I was coughing, I coughed up a lot of yellow stuff OK?

526 but I USED, the coughing stopped.

527 So, by nature {implied, human nature}, I just pushed it to the side. [I: right]

528 I just pushed it to the side.

529 If 12 o'clock came, and I didn't have the shot, I was sick.

530 After 12 o'clock, I used, I was fine.

531 So I just pushed that pneumonia to the side.

532 So I wouldn't have went {to the doctor}, my system was fine.

Immediately (refer to lines 540–45) he again used 'sick' to represent narcotic withdrawal, but I unthinkingly switch its meaning to 'HIV' when I ask if he knew that his buddy Smitty (pseudonym) was sick, and he seemed to follow my abrupt change easily. He could not have been sure that I would understand his meaning, because when I used 'sick' earlier to mean HIV, he was not in the room. He and his drug buddy knew they were in danger of contracting HIV, but could not pay sufficient attention to precautions because of the urgency of easing the symptoms of withdrawal. In this passage one type of sick (the necessity of quickly easing withdrawal) caused another kind of sick (HIV, a permanent condition); one type of wellness (feeling temporarily better after shooting up) leads to an ongoing health threat (living with HIV):

540 We kept saying, man, we're going to catch it, we gonna catch it. [I: yeah?]

541 But you know, when you use, when the sick is on, that's the last thing on your mind.

542 The first thing is getting well, OK? [I: And you didn't know that Smitty was sick.] No.

543 He coulda had it as long as I have, probably even more [I: I'm sure]

544 Cause he was the one that SHARED {syringes}.

545 I NEVER shared {syringes}[I: yeah].

An exchange between Art and me follows that could have been easily misconstrued by Art because I realize in retrospect that I was not careful with phrasing. Yet he seemed to focus more on my meaning than on my actual words. I remark, 'You are very fortunate, if this makes any sense, that you caught it early, that you knew early' (line 551). 'Caught it' could certainly have been taken

for 'contracted HIV.' Indeed, 'it' had meant HIV earlier when Art talked about how he 'got it.' Here, though, he responded positively, agreeing that early diagnosis was good: 'I looked at that' (line 552), which I received as agreement with my statement. Yet concerned that I had not been clear enough about the benefit of knowing one's HIV status, I continued: 'Because a lot of people don't know it for a long time and they get sick. But you're on medication and you've just been infected two years' (lines 553–4). By 'sick' I mean neither heroin withdrawal nor HIV disease per se. Here I used 'sick' to stand for HIV-related symptoms. Art seemed to comprehend my usage, and goes on to express optimism about living a long time and remarks how well and symptom-free he was in comparison to other HIV-infected persons. Art and I were participating in the traditional medical model and co-constructing a view that early detection and intervention are fortunate and worthwhile because they delay opportunistic infections and prolong life.

In Section 4 of the interview, where Jen was alone with me for the second time, 'sick' again represents several concepts. She referred again to appearance, but this time not regarding HIV, but substance use. She said that Art looks so well that you know he is drug-free. She equates wellness with being off narcotics, and used 'sick and ugly' and 'half dead' to describe his state when he was shooting up and living on the street. 'Sick and ugly' could refer to being in withdrawal, but it is not clear that it does here. Just as earlier Jen equated a wasted appearance with being sick with HIV, she here equates being addicted with a bad appearance. 'Sick and ugly' also appears to signify the general state of addiction:

676 You can just LOOK at him and TELL that he don't do drugs.

677 [I: He LOOKS very well.] He looks WONDERFUL. [I: yeah]

678 Last year this time, he was half dead.

679 Cause he wanted- he was on the street.

680 I saw him?

681 You know, and I used to rescue him=

682 when I put him out?

683 when we'd have our fights?

684 he'd go out there?

685 he'd shoot drugs?

686 he'd be all sick and ugly.

A bit later 'sick' seems to mean incapacitated with HIV-related illnesses. Jen was explaining why they decided not to move into separate houses, which they were considering so that the grandchildren Jen keeps during the day would not disturb Art when he is not feeling well. She said of moving:

741 I just CAN'T!

742 I don't WANT him away from me.

743 I don't want him to have to call me and say, 'I'm sick, come get me.'

744 If he WITH me every day, then I KNOW what's happening.

Later she returns to the earlier definition of heroin withdrawal when she described how angry she became when she realized he had shared syringes. She had a difficult time imagining what would drive him to do this, because she had never witnessed him sick with withdrawal:

813 I was MAD for a whole year.

814 {As if to Art} 'How COULD you? Ain't like you had just started shootin'?

815 You was shootin drugs for a LOT a years. And YOU ain't never shared no needles.

816 Why you have to share a NEEDLE?'

817 That was, I just couldn't get WITH that.

818 Cause, like he say, I never saw him SICK. HE never let me see him like THAT.

'Sick' changes once more to mean HIV when she reported her fear that contact with Art could make her sick. She does not mean that kissing Art will nauseate her; she means that she thought that kissing could infect her; she could 'get it,' with 'it' once more referring to HIV:

907 If I kiss him, I'm gonna be sick!=

908 His doctor say, 'no, that's not the way to get it.'

In sum, looking at the whole interview, the meanings ascribed to 'sick' vary widely, with no discernable pattern, depending on context. Multiple and complex meanings layer over time. It was evidently semantic context that cued each of us to the meaning of 'sick' in the particular moment. I move on to discuss 'cure,' another word that changed meaning with each usage.

The Cure

'Cure' was repeatedly used by the couple to convey their struggles to live with HIV. 'Cure' can be regarded as the antithesis of 'sick'; it implies banishing a once problematic illness. But the language of 'cure' takes on several distinct meanings as Jen and Art disclose their hopes and world-views. At different times the word referred to a dream that all persons with HIV will be saved, a hope that Art in particular will be spared, a bitter certainty that the remedy for HIV already exists and is being withheld from them, and faith that God will heal Art without and then with the help of science.

Soon after Jen said that the pills make Art sick, she switched from defining the medicine as the *cause* of daily illness to seeing it as the *answer* to HIV disease and the threat of death; again, medicine may make you sick in the short run but it will cure you in the long run:

57 I don't believe he's just gonna DIE.

58 You know, I think that, if he takes his medicine {pause}

59 uh, I feed him WELL, um {pause}

60 that he can overCOME this, you know,

61 and maybe one day they'll find a CURE.

'Cure' here means a generic hope for everyone with HIV, and Art's medicine could help him live long enough to benefit from future discoveries. Art also voices the hope for a yet to be invented intervention which may be available to him. In the following segment Art explains that he was trying to take care of himself so that he can live until the cure for HIV can be found. He acknowledges his own power and agency in sticking around for the eradication of HIV. The implied subplot, again based on the medical model, is that if he suffers now through medication side effects, he can increase his chance of survival in the long run:

508 So I don't take it lightly=

509 I just say, well, I got it, I live day by day [I: umhum]

510 and pray to God that people find a cure, right!

They saw the cure not just in the future, but in the present. Often they spoke of the cure as on the horizon, but Jen and Art were most animated when they explained that a cure for HIV exists already, but withheld from people without money. Jen attributed this injustice to socio-economic class rather than race or ethnicity. We know that because she pointed to Magic Johnson, of African descent as they are, as someone with HIV who has the financial resources to get the cure. She did not say one cannot get the medicine if one is 'Black' but instead 'poor and Black.' She included Art (by saying 'both of us' and then speaking directly to him) in constructing the view that equal access to care and medicine does not exist. (Note that once again she associates illness with appearance, she asks of Magic: 'do HE look sick?'):

134 Jen: The BOTH of us feel like=

135 they HAVE a cure already! {or all READY} for this disease/

136 but if you POOR and BLACK and don't have any MONEY/

137 you can't afford the medication=

138 which costs like {to Art} what did they say, thirteen thousand?

139 Art: Doctor say thirteen thousand a year.

140 Jen: Thirteen thousand a year for this medication.

141 Like, OK, Magic Johnson, that – look, he got MONEY. Do HE look sick?

142 So, since we DON'T have the money, we have to have the FAITH. In God.

Art and Jen in tandem then constructed a notion of the elusive current cure. The following exchange occurred when Jen asks Art about what his doctor had said about 'a cure.' Their interwoven talk consisted of short to-the-point statements. Note their repetitions of 'none of that' to stress the absolute despair with insurance covering the cost of this treatment:

575 Art: The doctor said the medication would cost you about 14 or 16 thousand a year.

576 You take 12 tablets a day, 4 three times a day. No more AIDS!

577 Jen: We surmise that, if you got money,? you won't die!

578 Art: You can't get it.

579 Not unless you got money.

580 They told me.

581 I asked the doctor.

582 Jen: You think INSURANCE gonna pay for that?

583 Art: NONE of that.

584 Jen: NONE of that.

585 Art: She told me. NONE of that.

586 Jen: You got to have MONEY.

When Jen and I were alone, she referred again to an existing but out-of-reach cure, reiterating how poverty transcends race and ethnicity as the reason people must remain ill:

885 I hate the idea that because people don't have MONEY, they can't get cured!=

886 Because they Black, White, Hispanic-

887 if you DON'T have money, you CAN'T get the cure!=

888 That is SO stupid to me.

Jen presented religion as a pathway to the cure for HIV and a way to mediate injustice ('since we DON'T have the money, we have to have the FAITH. In God,' line 143). Now faith is the treatment, since they do not have the resources to get the cure from medical institutions. Yet their hope vacillated between science and a deity. Art seemed to say that 'they' who will have the cure are researchers in the biomedical world: 'I'll survive; hopefully, they'll have a cure' (Lines 558–9). Note the similarity to Jen's first reference to 'they': 'maybe one day they'll find a CURE' (line 61). 'They' seemed to refer to nebulous medical institutions, over which this couple has no control and with which they have no connection. However, Art said he would 'pray to God that people find a cure,' inviting both divine and human intervention (line 510). Toward the end of the interview, Jen also pinned her hopes on God, emphasizing that the cure, when it comes, should be equally available:

1007 This is the worst thing that I see that happened in this lifetime.

1008 I just hope God makes a way for a cure, for EVERYbody, you know.

Mental Health

There was an additional way in which Jen referred to wellness and illness: her own emotional and mental state. She did not use the words 'sick' or 'cure,' but those concepts were clearly present. Jen first described her emotional response to Art's testing positive by using metaphoric images ('snapped' and 'tumbled') to paint a picture of someone who was broken or thrown down by devastating news. She used emotionally laden words ('hurt' and 'cried') to express feeling wounded and grief stricken. She eloquently narrated her compromised mental health and a sickened spirit:

29 Snapped ME.

30 I just, my whole WORLD was tumbled=

31 and I just KNEW I wasn't gonna {pause} be able to regroup=

32 I just HURT SO MUCH=

33 I, I CRIED for a year.

Later she used 'knock,' a powerful and possibly violent word, to describe what Art's diagnosis did to her emotional and mental stability: it figuratively brought her to her knees, not in an attitude of worship, but in defeat:

77 AI:DS will knock you to your KNEES=

78 The thought of the person that YOU love more than anything in the world?

79 And AS you can see, I can't talk about it LONG without crying.

Toward the end she said she would be 'nuts,' a word traditionally used to describe losing one's mental faculties, if Art died. She alludes to a mental ward, saying that they would have to 'lock me up.' The absolute certainty that she would become dysfunctional is demonstrated by the fact that she repeats six times the word 'knows'; she *knows* that they would have to put her away:

66 WHAT would I do if HE {Art} died? {I: yeah}

67 They would have to lock me UP, I KNOW.

68 I KNOW it, I know it, I know it like I know ME.

69 I know I would not be able to {pause} DEAL.

70 I KNOW it. {chuckles}

71 I would be NUTS!

Jen seemed to be well aware of her potential to be emotionally and mentally impaired (sick) in the face of HIV. She said several times that psychotherapy has been vital to her adjustment to Art's illness; it had saved her from depression and unbearable grief. She spoke positively about counseling. Therapy, known traditionally as 'the talking *cure*,' has facilitated her own emotional healing as a caregiver to a man whose illness cannot yet be cured. Consequently, when Jen said 'I have really appreciated this time with you. It's my therapy for this week' (line 1014) she signaled familiarity with the benefits of therapy for mental health. She might also have been thanking me for providing her with support, connection, and catharsis. She might have indicated that she felt on some level that we were communicating effectively. She could have been hinting that our time together contributed in some small way to her mental health.

REFLECTIONS ON RESEARCHER POSITIONING

Narrative researchers stress the importance of the investigator's position in juxtaposition to co-participants and topic. (Interestingly, both interviewees and interview topics are called 'subjects,' and 'subjectivity' is under scrutiny when researcher positioning is explored.) Weingarten (1992), writing about interactions in therapy and parallels to research, argues that achieving meaning-making and connection requires a perpetual examining of words and meanings and acknowledgment of the listener's part in constructing interaction. Fine (1994) criticizes qualitative research for contributing to a discourse of 'others' when they artificially and protectively separate themselves from the researched, muting the outrage and suffering of respondents by cloaking ourselves in rationality, scholarship, and analysis. We sometimes ignore our privilege and do not take a stand, hiding behind the stance of scientific neutrality. Fine pushes researchers to question methods, contexts, and interpretations; our places within oppressive master narratives; and the ethics of speaking for others without acknowledging our own presence and investment in our research products. Rojiani (1994) asserts that professional helpers and researchers view events and interpret them from the roles we inhabit, roles different from those of service recipients and research respondents. Bell

(1999) positions herself as a feminist activist who moved incrementally away from the belief in 'objectivity' in interviews: her philosophy, values, and role are part of the research picture. Luttrell (2000) discusses the inherent distinction between observer and observed, accentuating a research quandary when we strive to represent oppressed or silenced persons authentically and accurately, even as we shape the encounter and fit the report into theoretical, personal, cultural, and structural frameworks. Riessman (2002) re-examines a previously published research report for what she did *not* include in her analysis and reflects on how her own personal, theoretical, and political positioning at the time influenced the reconstruction of a divorced battered woman's story. By acknowledging her own interpreting filters and musing about biases, she models reflexive and responsible research. These scholars challenge their colleagues to acknowledge, name, and investigate the authority we hold as authors, to admit that where we stand determines our standpoints.

Educators and supervisors warn social worker practitioners – whether they are micro, mezzo, macro, or generalist – that self-disclosure can be quite dangerous, especially when it detracts from social work purposes and unduly attracts attention to the practitioner. It is the same in research. Self-disclosure should not be excessive, gratuitous, or self-serving; we must strive to evaluate any revelations for their relevance to the task at hand. However, because qualitative and narrative methods involve conversations where communication can be enhanced or derailed by cultural differences, it is important to position the researcher in the interaction and interpretive process. Scholars, in research reports, edit constantly, just as film directors cut, journalists carve out sound bites, and photographers crop their pictures. Researchers are forming narratives from the respondents' shaping of events and experiences into stories. The way that we shape our retelling of respondents' accounts can be influenced by our thoughts and experiences, as well as by feedback from colleagues, reviewers, and editors. Not being able to remove ourselves from these multiple levels of meaning construction, we should probably state as clearly as we can what we bring to the process.

My first bit of self-disclosure is to admit that I am not inclined toward self-disclosure. I tend to shy away from talking about my health, income, beliefs, and background. (Committing private details in a 'public-ation' is the worst possible scenario.) However, I see the need to appropriately reveal salient personal facts if they can enhance case management, counseling, group facilitation, teaching, or research. It is with some anxiety that I introduce aspects of my self, but who I am could be relevant to this analysis.

It would be difficult to imagine my positioning being more different from that of Jen and Art. They are African-Americans in a racist society, residents in a depressed and neglected Midwest urban area, individuals who define themselves as economically disadvantaged, adults who have not been formally

educated, participants in the tradition and language of the Black church, recipients of social and financial services, and a couple negotiating the rough terrain of HIV disease, substance use, and periodic homelessness. As a White, rural-raised, Southern, middle-class, academic, non-religious, single, HIV-negative, non-addicted, fully housed person who has not yet had to request social services, I have footing and history in *none* of their worlds. Not only did we have few discernible common characteristics, as a White person with education, I hold privilege they cannot yet access in the USA. In addition, I hold the power of a researcher: the opportunity to treat their pain as 'data,' to judge them, to draw conclusions about their lives.

Our different positioning surfaced even before the interview. From the moment of my arrival they knew they were dealing with a White educated university researcher. According to my audio taped and transcribed field notes, events before the interview foreshadowed the differences between the academic world and the neighborhood in which the couple lives. The University of Illinois campus is also on the west side of Chicago, just minutes away, but culturally much further. When I went to pick up the car at the university motor pool, I was standing at the counter, studying the map, looking for the short side street where they lived. A White man who worked at the motor pool offered his help to find the address, and when he located it on the map, he insisted that I not go into this neighborhood alone, but that I follow him as he drove the motor pool truck. I suspect it is unusual for employees at the university motor pool to use a second vehicle to lead researchers to their destinations. I assumed at the time that he felt that the neighborhood in which Jen and Art lived was unsafe for Whites or women or specifically for White women. We argued about this, and then I accepted his insistent offer. I told him, however, that I wished for him to point to the street when we got there, but not turn on to it. I thought at the time that this could be hurtful and off-putting to anyone who might observe my being lead in. After I arrived and parked, Art approached me and asked if I was looking for 'Jen W.' As he escorted me in he said that he had been looking for 'a university car' so he could greet me. The cars are not marked with insignias, so when Art called to me, he may have put two and two together: a White woman with a large carry-all emerged from a big new car that he did not recognize. Chicago is rather segregated, and I speculate that perhaps White people in big cars are viewed as strangers in that neighborhood. It is common for White middle-class professionals to enter some predominantly Black neighborhoods to purchase illegal drugs; sometimes child protective service workers and home health nurses look like I do. I do not know what Art was thinking. But our differences may have affected our first encounter, so they are worth acknowledging and contemplating.

Another indication of our different worlds was my immediate internal response when Jen and Art asserted that a cure was available already but not

for poor Black folks. For a second I was quite taken aback. My initial reaction stemmed from my 'knowledge' that there is no cure for HIV (I monitor and trust the medical journals and grass-roots treatment alerts). But my second thought followed immediately as I realized that their suspicions were rational, given their social positioning. Against the backdrop of powerlessness in the face of governmental policy and the medical establishment, as well as the history of the Tuskegee Syphilis Project (Jones, 1993), deep distrust – like what Jen and Art articulated – makes sense. For decades a cure for syphilis was available but withheld from poor Black men who had enrolled in the study. Art is a poor Black man with another stigmatized sexually transmissible disease, and one needs little imagination to draw the parallel. Adding the historical contexts of slavery, lynching, and Jim Crow laws, distrust of the establishment is completely rational. Jen and Art could therefore easily believe that a cure for HIV was available, but not to people in their socio-economic circumstances. The fact that I did not anticipate and immediately understand their statement about the withheld cure is an indication of my privilege. Art and Jen do not have the luxury of forgetting that health and wealth are linked.

There was one aspect of my positioning that may have helped us connect. Although a doctoral student new to research, I had worked in the HIV field as an advocate, grant writer, case manager, trainer, and supervisor for a decade, have several HIV-infected friends, and had been the personal caregiver for my best friend who had died of AIDS three years before. I knew terminology related to HIV and drug use. I was familiar with accounts of fear and grief, empathic toward care giving concerns, and predisposed to align with persons with HIV and their loved ones. I cannot know whether my history assisted our communication. It could not have directly influenced the couple because neither asked questions about my experiences, interests, nor knowledge. It may have influenced our interactions indirectly. I speculate that our way was eased to the extent that I was able to follow their accounts without needing to interrupt for clarification of terms and showed my alliance through nodding and encouraging utterances. On the other hand, there is a danger in being too schooled in the area of inquiry: the investigator may assume understanding, thus missing information and subtleties. I leave it to readers to scrutinize the text excerpts in relation to these questions.

CONCLUSIONS

My close re-examination of a trialogue involving intimate partners and a doctoral student led to insights and conundrums about the relationship and boundaries between research and researched, and between words and meanings. Transcript excerpts illustrate how research interviewing is challenging and assumptions about understanding slippery. When research participants speak the

same language, they tend to assume there is no translation problem (Riessman, 2000); in reality, ambiguity is ubiquitous. Although the three of us were conversant in HIV and substance use vernacular, there were rapid and potentially confusing switches in frameworks, paradigms, and meanings, requiring cognitive gymnastics.

Jen and Art drew on several cultural resources in developing their accounts: medical discourse that talks of sickness and cures; substance use discourse to explain what it is like when 'the sick is on'; social justice discourse to articulate class inequities in access to care; and the cadences of the Black Church through which spiritual faith is declared. These discourses are often taken for granted by insiders. In this exemplar, the research participants traveled between these domains and cultural referents without explicitly signaling the shifts. I did not have the same access to these spheres of meaning as I would have if I had been part of a HIV-related, African-American, inner city, or substance using culture. To the extent that our respective vernacular speech had different rules, patterns, pace, rhythms, colloquial expressions and metaphors, we were negotiating layers of translation.

Humans understand a word, object, or concept as an exemplar of a category (Lakoff, 1987). This exemplar demonstrates that assumed paradigms may be more important than words. When does 'sick' mean physical disease, physical symptom, or physical withdrawal? When does 'cure' mean something that is in the hands of individuals, scientists, politicians, or a deity? If so many disparate meanings can be derived from such simple words, interviewers cannot count on any one word corresponding to a particular object or concept. Understandings develop not from the word alone, but from the larger category, typically unspecified and unquestioned by the listener. The interlocking dyads (Art and I, Jen and I, and Art and Jen) never stopped to ask each other to specify the meaning of words, yet we seemed to accept each other's divergent definitions and to go forward and deeper into our talk. To the extent that we clarified each other's meanings, participated actively vocally and non-verbally, and responded along the same threads of thought, we were successfully co-constructing meaning in context. However, there is no way for me to be sure that I adequately understood their realities. Thus this interview has in common with all research interactions a hovering cloud of ambiguity.

RESEARCH IMPLICATIONS

I offer implications for social work research regarding both ambiguities in language and the influence of researcher positioning. First, I present several points that arise from the complexity of words. For starters, this analysis calls into question the occasional research practice of using the number of times a word or phrase appears as a proxy for the importance of a topic. The varying

and ambiguous uses of 'sick' and 'cure' demonstrate how misleading such practices can be. 'Sick' and 'cure' appeared frequently, but they did not mean the same thing each time. Dealing with those words merely as recapitulations would have missed the mark. In addition, although our profession is predicated on relationship and communication, social work researchers infrequently closely examine words and connotations or present details of interactions. As the rapid shifts in the definitions of 'sick' illustrate, meanings can get negotiated without acknowledgment from or awareness of any of the conversing partners. When I closely examined the various usages of certain words in this encounter, I was taken aback by my own unconsciousness about shifting meanings. I did not recognize these definition changes while they were occurring, did not clarify or probe for specific meaning during the interview, and was not careful with my own word usage. I would not have discovered these ambiguities if I had not later applied a close narrative examination. I expose my own thought processes (or lack thereof) to suggest that perhaps we could all listen and look more carefully for shifts in meaning in research interviews, striving to understand the non-verbal and contextual ways in which communication happens. Ambiguities are unavoidable, but not necessarily undesirable. However, if we do not acknowledge the possibility that words have multiple meanings within various contexts and if we do not listen between the words, we could be mistakenly sure of our interpretations during the interview, transcription, coding, analysis, and reporting. Research conclusions could perhaps be improved when subtleties that may be shaping understanding are unearthed.

Regarding research positioning, social work scholars should more often acknowledge the ways we co-construct interviews and conclusions and own up to what we bring to the interaction. Interpretation does not begin after the interview is done; it is an omnipresent force while the talk is being constructed. Judgements about meanings cannot be avoided when humans converse and listen. Our goal cannot be neutrality; instead it should be close enough understanding, aided by reflexive questioning. Assuming that we know what a respondent means may put us in a precarious theoretical situation. Language is always subject to interpretation and misinterpretation. When culture, class, ethnicity, age, sexual orientation, gender, origins, experience, personality, and health status are part of the mix, we can never be sure that we are understanding what people are trying to teach us in research conversations. The shades and mystery of communication should not be ignored or shoved aside, however, but should be acknowledged as an important part of the research. Possible misunderstandings and multiple meanings are ripe and rich opportunities for analysis. If we do not disclose our positioning and question our assumptions about words and meanings, we could reproduce power inequality in social research. Furthermore, cultural context may be as important as language. Narrative forms and norms, concepts of time, and word definitions often differ by culture, possibly leading to misunderstandings

(Etter-Lewis, 1991; Riessman, 1987). Jen and Art were relying on several cultures with which they were familiar. We were separated by walls of ethnicity, color, class, education, recovery, and health. Often researchers have different cultural and economic worlds than do respondents. I have argued that we may think that we are drawing on common meanings, and may be wrong. Recognizing researcher positioning is important because subjectivity cannot be avoided, only acknowledged. The researcher's verbal and non-verbal participation in the interview, assumptions about language, and imported social constructions and experiences probably contribute as much to the emergence and construction of meanings as do the so-called 'subjects' of the research. It is not only our subjects who are subjective.

In conclusion, if empowerment, participation, and understanding are aims, as in many social work studies, it is essential that researchers invite people to construct their unique stories with us. When we invite people to use their own voices, forge their own meanings, and articulate their own conclusions, however, we should be prepared to receive and deal with layers of complexity. Especially in the HIV field, words as labels carry enormous cultural weight and can shape the attitudes and actions of society and individuals (Martin, 1994; Treichler, 1999). It is important to explore the complicated and sometimes unfamiliar words with which respondents give expression to opinions and experiences. Simply presenting a quote verbatim is not sufficient; we must use empathy, clarification, and knowledge of others' circumstances to offer possible interpretations of language use.

Acknowledgements

I am grateful to 'Jen' and 'Art' for speaking so freely. I thank Catherine Kohler Riessman for acting as narrative midwife and to Melvin Delgado for inviting me to explore the intersection of substance use and HIV. I owe much to Karen Staller of the University of Michigan whose reviews pushed me much deeper into a consideration of the effects of researcher–respondent differences. I am also grateful to my narrative group for a moving and illuminating discussion of the tapes and transcripts of this couple's interview (facilitator Elliot Mishler and members Trudy Duffy, Sandy Jones, Jane Liebschutz, and Branca Ribeiro). I am indebted to Nancy Capobianco Boyer of Boston University School of Social Work for help with transcription. Data collection in 1996 was funded by the Center for Health Interventions with Minority Elderly (CHIME) at the School of Public Health at the University of Illinois at Chicago through the National Institute on Aging (NIA Grant #HHS-AG 12042–03). Re-transcription in 2000 was funded by the Boston University NIDA Minority Research Center (National Institutes of Drug Abuse Grant #1 R24 DA12203–01A). Data analysis in 2001 was funded by the John R. Hartford Foundation Geriatric Social Work Scholars Program.

Notes

- 1 The full transcript of the interview in raw form or in Gee/Mishler format is available from the author.
- 2 Transcription key:

CAPS	Speaker's vocal emphasis
?	Rising intonation or pitch glide
.	Falling intonation or pitch glide
!	Rising emphasis
-	Utterance broken off
=	Successive utterances with no gap
:	Elongated vowel
[]	Interviewer utterances
{ }	Author explanations
{pause}	Pause longer than a breath
hard return	Indicates a shift in subject
- 3 My field notes and memory bear witness to my being rattled by Art's desire to stay at first, as well by his comings and goings. As a doctoral student, I did not feel sure of the protocol here. I could have asserted my authority and used words like 'procedures' and 'confidentiality' or simply expressed a desire to speak with Jen alone. Yet I felt compelled to let him listen and speak as he wished, as long as Jen – the primary subject – did not object. I do not understand even now where that impulse came from. I did not use any of Art's talk in the dissertation or subsequent articles because he did not fit the caregiver criteria. Not until I revisited the interview and decided to treat them as a unit was I able to examine Art's accounts. In retrospect, I am grateful for his perspective and the talk between the couple and among the three of us.

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