Article

The Process of Writing a Constructivist Dissertation: A Constructivist Inquiry Into the Meaning of Pregnancy for African American Women Infected With HIV

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Abstract

The study depicts the procedure of writing a constructivist dissertation by reporting side by side the story of HIV-infected African American women's reproductive health decision-making. The context of these women served as the framework from which the dissertation was written. The article describes how these women and their stakeholders experience HIV/AIDS and how they make their reproductive health decisions. These women's perceptions and psychosocial factors are examined to understand what they view as important to them as women and as mothers. The article addresses how to teach doctoral students to complete doctoral research using the constructivist paradigm for research. Implications for social work education and practice are discussed.

The process of writing a dissertation is one of the major requirements for graduation in doctoral programs. Writing and defending a dissertation represent a creative effort by students to build knowledge or to demonstrate expertise in specific areas of their training. In addition, it is an opportunity for identifying a phenomenon and providing possible solutions or for expanding the current appreciation of a given phenomenon pointing out some of its larger complexities (Gardner & Gopaul, 2012). Through the years, doctoral programs have established their unique policy toward this requirement in accordance with their mission statements (Knight & Steinbach, 2008).

This article tells the story of my experience writing a constructivist dissertation on the intersection of social work and HIV/AIDS. It depicts the process of all activities undertaken to write the thesis and tells the story of some African American women infected with HIV and their decision to become or not become pregnant. This study is an introspective examination of my experience with the use of qualitative research methods, that is, semistructured interview and participant observation (McCotter, 2001). To protect the confidentiality, privacy, and anonymity of my participants and places, the article uses pseudonyms to identify all places and persons in the narrative.

In retrospect, the idea of writing a dissertation haunted me from my admission into the doctoral program at Jane Addams University (JAU) in the mid-Atlantic area of the United States. The dissertation policy at JAU is that, although students are discouraged from working on their dissertation during their academic training, they are inspired to work toward it by focusing on specific areas of their training (Grover, 2007). As a result, I kept abreast of the latest advances in social work and HIV/AIDS through reading and attending conferences at local, state, and regional levels. Prevention of HIV transmission was my area of concentration. Coming from Sub-Saharan Africa, where AIDS is a sexually transmissible infection, I wondered what pushed women infected with HIV to become pregnant and to carry their pregnancies to term. I wanted to understand what prompted these women to become pregnant in the face of all the risks and challenges that typically occur with HIV.

Despite my trepidation, moving toward this final stage of my education was invigorating in many ways. After my comprehensive exams, I decided that the title of my thesis was going to be *A Constructivist Inquiry Into the Meaning of Pregnancy for African American Women Infected With HIV* and conferred about the structure of my committee with my adviser. I needed professors who could help me develop into

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a writer, teacher, and researcher and committee members who had experience guiding students through long projects and who were well-versed in qualitative studies. Hence, I chose a constructivist researcher as my chair, two social work faculty members well-versed in Health Care Policy and HIV, and a qualitative researcher from our School of Nursing (Foss & Waters, 2012; S. Ray, 2007).

At its onset in 1981, AIDS was considered an incurable illness, one with many acute episodes, but one that eventually ended in death. Technically, an HIV diagnosis at that time meant a death sentence. Promptly, the AIDS disease morphed into an epidemic that relentlessly spread all over the world, infecting men and women, young and old, and rich and poor indiscriminately (Gottlieb et al., 1981). Generally, the poor were and are still the most disproportionately affected worldwide. However, with time and availability of medications, AIDS is now becoming a chronic illness with which men, women, and children are living longer than before (Colvin, 2011; Scandlyn, 2000). Today, many people with HIV are leading highly productive and satisfying lives for several years. By and large, the current medications are so effective that AIDS patients are not dying of complications of the disease but suffer organ failure due to the toxicity of medications (De Cock & El-Sadr, 2013; Franco & Saag, 2013).

This improved survival rate makes it possible for AIDS patients to infect others, particularly unborn infants via perinatal transmission (Church, 2000). This means that the unborn infant is infected either in utero, at the time of delivery, or through breastfeeding (Davis et al., 1995) and the adults through exchange of body fluids with an infected partner through unprotected oral, anal, and vaginal sex or through blood transfusion.

Over the past three decades, research has attempted to address issues of HIV/AIDS in conjunction with other diseases, but little or no attention has been focused on the question of why women living with HIV choose to conceive and carry a pregnancy to term in the face of all the odds that occur with HIV infection. Considering the prevalence and magnitude of AIDS among African Americans, the issue of pregnancy takes on greater importance and compels professionals, including social work practitioners, to ask fundamental questions like the following:

- What are the odds of a pregnant woman infected with HIV to transmit the virus to her child?
- What is the impact of AIDS on a pregnancy?
- What is the impact of a pregnancy on the progression of AIDS?
- What is the meaning of a pregnancy for these women?
- What meaning do African American women assign to marriage and/or committed relationships, to pregnancy, and to the need to be survived by somebody after death?

Answers to these questions vary from woman to woman and from stakeholder to stakeholder depending on their specific HIV/AIDS context and culture. A universal way of understanding reproduction among these women would be to grasp the meaning women assign to womanhood and motherhood, to realize whether womanhood necessarily leads to motherhood, and to analyze the salient milestones of female growth. Using my dissertation into these topics as a context, this article addresses how to teach doctoral students to complete doctoral research using the constructivist paradigm for research. It describes in a step-by-step fashion the various stages I went through to complete this study.

Method

Sampling

Because qualitative research is concerned with meaning making (Crouch & McKenzie, 2006), purposive sampling along with the snowball sampling was my method of choice. Purposive sampling is a method in which potential participants are selected by the researcher, based on a variety of criteria that may include specialist knowledge of the research issue and/or capacity and willingness to participate in the research. Sample sizes, therefore, depend on the resources and time available as well as the study's objectives (Oliver, 2013; A. Ray, 2012). Conversely, snowball sampling is a method in which one participant (successfully recruited) suggests others known to them who might similarly be eligible. The latter method was particularly beneficial to me as I was interested in African American women infected with HIV who might have been or were pregnant around the time of the interview. These women were a group not easily accessible to research through other sampling strategies (Babbie, 2008). After clearance by the university institutional review board (IRB), I recruited a total of 35 men and women and started the data collection.

The recruitment criterion was to identify and recruit HIV positive African American women of childbearing age who were willing and able to discuss (in English) their HIV infection and pregnancy while infected with HIV. These prospective participants had to be in good health at the time of the interviews. As a constructivist researcher, I assumed these women to discuss their experiences living with HIV/AIDS and their experiences of terminating or carrying a pregnancy to term with someone in their community. Hence, the second criterion required participants to designate people around them with whom I would discuss their specific situations. The designated people were dubbed stakeholders and ought to have known the participants in such a way that they could freely discuss the participants' HIV infection and struggles with reproductive health decision-making. No restrictions were placed on the choice of stakeholders with regard to religion, age, race, class, sexual orientation, or gender (Rodwell, 1998). Excluded from the study were women with a history of mental illness and women whose HIV status was still confidential.

My recruitment plan was based on Connelly and Clandinin's (1990) theory that humans are storytelling organisms who, individually and collectively, lead storied lives and generally form a community of others with whom they can learn and share through dialogue. Through this process of socialization, an individual becomes a part of a community and ultimately participates in the socialization of others. I thus assumed that people arrive at certain decisions by directly or indirectly interacting with people around them. Little is known about who, if anyone, is involved when women make reproductive health decisions (Sowell & Misener, 1997). My stakeholders came from all lifestyles, mostly from parents and siblings, friends, church representatives, health care providers, social welfare officers, and many others. For confidentiality sake, I used a multilevel approach in the recruitment process. First, the gatekeepers talked to the prospective participants about the study and its potential benefits to pregnant women. Second, when these women were referred to me, I also discussed the study and potential benefits and persuaded them to play a part. Third, recruits and I chose a date, time, and location for the interviews. Informed written consents were obtained before each interview.

In total, 12 African American women or primary participants and 23 stakeholders agreed to enroll in the study. Represented among stakeholders were participants' parents and siblings, friends, an African American Baptist minister, health care providers, and social welfare personnel. Most participants' parents were either deceased or separated and/ or not in contact with their daughters. The average age of primary participants was 31 years, ranging from ages 21 to 43. These women had been living with HIV for an average of 4 years, ranging from 2 months to 13 years. In terms of care, they were on either Medicare or Medicaid and at different stages of antiretroviral therapy depending on their individual morbidity. Those ineligible for Medicare or Medicaid were part of either the Ryan White HIV/AIDS Program or AIDS Drug Assistance Program (ADAP; The Henry J. Kaiser Family Foundation, 2008). All participants received US$20 as an incentive for their participation in the study.

Study Design

The study design was emergent rather than predetermined as the meaning of pregnancy was going to be generated and defined by these women in their individual actual living context. As an emergent design, the plan allowed an orderly progress of the inquiry based on what came forth from the context and the process, without predetermining the structure and process (Rodwell, 1998). In this way, we obtained exactly what the participants knew about their situations and what they wanted us to know with less interference from the researcher. With each finalized interview, the meaning of pregnancy for this group of women was being refined, clarified, and made easier for the reader to understand.

Data Collection

Data were collected through in-depth, semistructured interviews and observation. My interview schedule explored these women's knowledge, perceptions, and realities regarding such variables as knowledge and beliefs about HIV/AIDS and pregnancy, the illness and treatment experience, motivations, and support systems. Interview questions were asked in an open-ended fashion to "minimize the imposition of predetermined responses when gathering data" (Patton, 1990, p. 295). These questions allowed participants to express their opinions, concerns, and feelings unreservedly, thereby allowing the conversation to flow where it needed to understand their meaning of pregnancy. Not all questions were couched ahead of time. The majority of my questions were created during the interview to target the interviewee specifically (Smith, 1995). The gist of the interviews depended on the participants' level of comfort, their personality and competence, and the ease of the rapport between the researcher and participants.

All interviews were informal, audiotaped for subsequent transcription and analysis, and lasted between 3 and 90 min. The shortest time was when two mothers declined to talk to me and graciously summarized their daughters' situations. It was common to move from happiness to sadness and to happiness again as the interview evolved. Overall, the interviews allowed participants to generously express their thoughts about motherhood, childbearing, and reproductive health. With each completed interview, I became smarter and smarter than I was at the beginning of the study. Follow-up interviews, which were mostly telephone calls, were opportunities to clarify participants' inputs and to focus on any change in perception about their reproductive health decision-making since the first interview. In these second interviews, most participants emphasized that they valued having "someone taking time to really listen and not judge their experiences." In fact, central to qualitative research is the notion of listening to respondents and understanding their lives "in and on their own terms" (Denzin & Lincoln, 1994). I served as the mouthpiece for these women who have been silenced so much and for so many years.

To complete the process, I chose the grounded theory, an inductive method to generate theory about social and psychological occurrences. Grounded theory provides the researcher with greater freedom to explore a phenomenon and allows issues to emerge freely from participants (Charmaz, 2000; Glaser, 2001; Morse, 2001). The perspective of symbolic interactionism informs grounded theory. Symbolic interactionism defines individuals as creative social actors whose behavior always occurs in social contexts that include other people and social structures such as family, friends, culture, and society (Blumer, 1969). In this study, the women were the social actors whose reproductive health decisions were either enhanced or hindered by their stakeholders. Simply put, their decisions about their reproductive health were a reflection of

their daily interaction with stakeholders. This allowed me to "discover what is going on, rather than assuming what should be going on" (Glaser, 1978, p. 159).

Data Analysis

In constructivism, the co-occurrence of data collection and data analysis is the norm. In other words, data analysis began after the first interview and continued until the production of the case study report (Rodwell, 1998). All interviews were professionally transcribed and checked for accuracy. Once the first interview was transcribed, I engaged in data analysis, which first involved the deconstruction of the text into units and then the construction of the case study report. Unitizing is defined as a process in which raw data are systematically transformed and aggregated into units, which permit precise description of relevant content characteristics. Units, which are single pieces of information, may be a single word or a single sentence or an extended paragraph (Atkinson, Coffey, Delamont, Lofland, & Lofland, 2002; Rodwell, 1998). Each unit was recorded on an index card for easy access, retrieval, and manipulation. Units were coded so that they could be traced back to the raw material, hence, the code referred to the participant, the interview number, page number, line number, and to the field notes (Lincoln & Guba, 1985). Some 1,154 index cards were created by the time all interviews were transcribed and analyzed.

Once unitized, the data were analyzed via the method of constant comparison, that is, one unit after another was compared with the last, and they were ultimately grouped together conceptually. This led to the coding of units. Codes were developed from theory, prior literature, the research question at hand, my insights, and most importantly from the interview data (Cohen, Manion, & Morrison, 2000). From the coded data, I moved to the construction of categories. A category referred to a process, a pattern of behavior, or theme that was distinguished from the data (Strauss & Corbin, 1998). For instance, "pregnancies happened to me" was a category that emerged in relation to the previously described codes. This category described the way in which these women became pregnant. I focused on categories that fit well with new data and that were connected in a way that pointed toward a credible understanding of the way in which these participants made their reproductive health decisions. I halted this process as soon as I reached a saturation of categories, meaning that no new or relevant data seemed to emerge regarding a category and that relationships among categories were well established and validated. Finally, as patterns began to develop among the categories and to show how categories interrelated, I also started to write parts of the final report.

During the process of this study, I kept two journals—a methodological and a reflexive journal—in which I recorded my methodological decisions (file memos, attestations from debriefers, research syntheses, etc.) and my moments of success and frustration. Langer (2002) describes journaling as a heuristic tool and research technique that helps to refine the understanding of the role of the researcher and the responses of participants in a study. Speaking of the empowering side effect of journal writing, Loo and Thorpe (2002) see the writing process as an opportunity for learners to take control over their individual learning experiences and thus to give personalized meaning to their learning. Hence, memos were written to document and store my methodological processes and decisions in my methodological journal. Besides storing information, memos also contained information about how certain decisions were reached and why and how they were applied. To link up the various events that occurred throughout the study, I regularly wrote myself notes, which I used to develop new questions and to facilitate data analysis. These notes were chronologically produced and contained not only "descriptive" information but also a detailed depiction of participants' nonverbal behavior and facts that I, as the inquirer, had observed during the interview. This information was gathered in my reflexive journal, which also contained thoughts and feelings, values and beliefs relevant to emerging issues and problems related to living with AIDS while pregnant (Lincoln & Guba, 1985). In short, a reflexive journal was and is a way of thinking in a critical and analytical way about work in progress.

Criteria for Rigor

In qualitative research, the researcher must clearly describe the procedures followed to ensure that data were recorded accurately and that data obtained are representative of the "whole" picture. Lincoln and Guba (1985) posit that in constructivist research, trustworthiness is manifested through four criteria:

- Credibility
- Transferability
- Dependability
- Confirmability

Credibility is the confidence that the findings of a study reflect accurately the views of the respondents. Credibility is created and achieved through prolonged engagement, participant observation, triangulation, peer debriefing, and member checks (Lincoln & Guba, 1985; Rodwell, 1998). From the onset of the study, I promoted trustworthiness and authenticity through interaction with participants, observation of community conditions, and reviews of local HIV/AIDS documentation. I visited the waiting room of the Infectious Diseases Clinic to meet and acquaint myself with potential participants. Each day that I was at the clinic, I introduced myself to new patients, talked to them about my project, discussed their options, and observed them interacting among themselves and with me. Through my observation, I noticed little things here and there that nobody

mentioned in the interviews because these little things were so familiar that nobody thought they were worthy of reference; I also rejected information I deemed irrelevant for the study, for example, embellishment of answers, and answers tailored to me that were provided to satisfy me but not the study. Prolonged engagement with participants and their stakeholders was instrumental in grasping participants' insights. This contact allowed me to see how participants interacted with other people and to attend to the distortions and inaccuracies that participants and/or I might have injected into the inquiry.

Very quickly I found myself surrounded with multiple sources of information. Some were HIV/AIDS literature, namely, local brochures, pamphlets, and posters, whereas others were information I shared with either participants or health care personnel at the clinics. The daily dealings between participants and their stakeholders were also a sine qua non source of information. Triangulation helped me sort these pieces of information and find the source of information worth recording for final analysis and inclusion in the case study report (Creswell, 2002; Patton, 2002). Through triangulation, I really understood the context of their pregnancies and the long, and at times painful and draining, deliberations these women had to go through with their various stakeholders.

To ensure that the inquirer does not skew the study, constructivists introduced the idea of peer debriefers in the process. Lincoln and Guba (1985) defined peer debriefing as "a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the research that might otherwise remain only implicit within the inquirer's mind" (p. 308). Cognizant of the topic and the method, peer debriefers act as monitors constantly checking the veracity of the information acquired and the strict adherence to research guidelines. My peer debriefing evolved in two phases, the first phase was when I worked with Antonio as my only peer debriefer and the second phase when Antonio and I invited three other students to join us so that the debriefing was no longer a one-on-one but a group experience (Lincoln & Guba, 1985; Schwandt, 1997). Although I enjoyed both experiences, the group experience not only improved my performance as a researcher but also provided me with a chance to look at my study from different viewpoints.

My study sample included participants' stakeholders who provided *thick descriptions* from their perspectives as wives, husbands, parents, siblings, health care providers, ministers, and so forth. A *thick description* usually consists of a good description of the site of the research, a detailed description of the phenomenon being studied and the lessons learned from the study (Geertz, 1973; Ponterotto, 2006). As a researcher from Zambia, I knew what I would take from this experience because I participated in it and because participants, both in Zambia and here, share a lot of similarities, namely, "respect for life, sanctity of life," and the resistance to abort an unborn infant.

To ensure the dependability of my study, I maintained field logs and field journals to account for the ever-changing context in which I was carrying out my research. Field logs consisted of dates, times, and strategies that were utilized to enroll participants, whereas field notes detailed specific information about the negotiation of interviews and participants' comments. As my study was an emergent design, I always recorded all changes in design and methodology by keeping a methodological journal, engaging in peer review sessions, and maintaining an audit trail (Rodwell, 1998). Angela, my auditor, attested to the dependability of my findings by showing that changes in my study were accounted for and fully justified (Creswell, 2007; Patton, 2002).

Besides the checks and balance guaranteed by peer debriefing, I had to ensure the confirmability of my findings. Confirmability refers to the extent to which a researcher can demonstrate the neutrality of his or her research interpretations. It is in this vein that I provided an audit trail consisting of raw data—process and personal notes, analysis notes, reconstruction and synthesis products, my reflexive journal, and the draft case study—to allow the reader to track each piece of my constructions, assertions, and facts to their original sources. The audit trail was intended to allow the auditor to understand and evaluate how the data were coded and categorized and how these categories were clustered in response to the research questions.

One of the major strengths of constructivism is the rapport that the inquirer and the interviewee maintain during the process of the research. This rapport requires them to be authentic with one another and with the principles of constructivism. And the beauty of constructivism lies in the fact that each participant has the right to develop his or her personal construction and that each respondent is invited to participate competently in the analysis and interpretation stages of the inquiry. Because all participants are entitled to an opinion, then fairness is the extent to which different constructions and their underlying value structures are requested and honored within the inquiry process (Lincoln & Guba, 1985). In short, each participant's input must be presented, clarified and checked, and taken into account in a balanced and evenhanded way. Fairness ensures that different constructions, perspectives, and positions are not only allowed to emerge but are also seriously considered for merit and worth. Fairness is an issue of voice (hooks, 1989), thus, the possibility of majority and minority reports.

I strove to guarantee that all participants had equal opportunity to express their voice. Meaning, particularly as expressed by those whose voices have been silenced in an effort to deny their perceptions, is uncovered through dialogue and negotiation (Kvale, 1996). The process of listening to and portraying voices is fraught with difficulties. "Who speaks, for whom, to whom, for what purposes" (Lincoln, 1995, p. 283) are questions that were examined for uneven power relationships. For instance, it was hard for some female participants to believe me when I talked as a man

about issues of sexuality, pregnancy, and patriarchy as they relate to HIV/AIDS. Some thought my intervention was fake and/or constructed to please them. Some others thought I needed to adopt the popular male position vis-à-vis women's issues and to speak as such. Fairness was documented in the feedback I received from the selected participants who participated in the final member check.

It was wonderful to see how through interactions participants understood a broad range of issues that they had earlier failed to grasp and to see them coming out of this experience with a better understanding of living with AIDS and of making reproductive decisions while infected with HIV. As the study progressed, it became clearer to some participants that when their partners refused to wear a condom for their protection, it was their duty either to use female prophylactics to prevent the possibility of HIV infection and of conceiving a child or to abstain from sexual intercourse.

Despite the fact that all the primary participants were African American, I was very sensitive to how I asked my questions and how I reacted to their responses. Each time we talked about HIV prevention, we translated the information given in medical jargon in our vernacular English into small and doable steps. The translation of medical term into doable steps enabled participants to reassess situations in their lives that could have put them at risk of HIV infection. All the participants, stakeholders, and I acquired an increased respect for the meaning these women assigned to pregnancy in the context of their individual illness. We were all afforded the chance not only to understand the dynamics of HIV infection in the African American community but also to integrate the principles of HIV prevention into our daily behaviors. Participants realized that unless they took their medications very religiously, they were putting their unborn infants at risk of HIV infection. Empowerment occurred when some participants were invited to participate in condom negotiation exercise and when I invited them to contribute to the writing of the case study report.

As I neared the completion of my inquiry, I also started to prepare for the "hermeneutic circle." In esthetics, the phrase "hermeneutic circle" refers to the circle of interpretation involved in understanding some work of art. According to this theory, one cannot understand any one part of a work until one understands the whole, but one cannot understand the whole without understanding all of the parts (Kockelmans, 1985). In constructivism, the hermeneutic process is interpretive, depicting individual constructions as accurately as possible. The dialectic process compares and contrasts individual constructions so that a newer, more informed construction is generated (Guba, 1990; Rodwell, 1998). I acted as the conduit through which new and/or different constructions were shared with all participants, who could in return react to each other's interpretations. In other words, the knowledge acquired from the first interview was not only shared with the rest of the participants but also continued to be refined as the study progressed (Rodwell, 1998).

Because the primary participants and their stakeholders needed to apply their stamp of approval on the case study report, they needed to agree with the content of the case study report. This is called member checking, and it is done by returning to the participants to verify if the researcher accurately understood and reflected his or her participants' constructions (Barbour, 2001; Cohen & Crabtree, 2006; Doyle, 2007). In this case, I always reflected back to the participants what they had said and sought confirmation for the accuracy of their interpretation. Member checking started occurring right from the first interview up to the time I wrote the draft of the case study.

As soon as the first draft of the case study was ready, I went back again to the participants for the final member checking. The final member check is the final step because after it participants have no other chance to add to or subtract information from the study before its dissemination. Selected participants were provided with a draft case study report and asked to affirm if the report was an accurate reflection of their perspectives about HIV infection and pregnancy. A group of six women and stakeholders representing all areas on the continuum of the description of the meaning of pregnancy were invited to the final member checking. These were two primary participants, one policy maker from the Department of Health and Human Resources, one African American health care provider, one husband, and one African American minister. In other words, the selection of these participants was made in such a way that all standpoints discussed during the inquiry were represented. These participants were people who could be found and who were still physically strong to take part in a discussion. It should also be understood that because of the nature of their disease, the rate of attrition was very high and unpredictable; some participants were admitted in hospital for a complication, some relocated to areas close to family, whereas some others had passed away, worn out by the disease.

During final member checking, each selected participant received a copy of the draft case study for review, clarification, and suggestions (Lincoln & Guba, 1985). An introduction restating the purpose of the research and describing the participants prefaced the copy given to the participants. It went with a set of questions asking the participants to ratify if the report accurately reflected their perspectives, if they gained new insights as a result of reading the report, and if there were any data they wanted to add or remove because of changes that might have occurred since data collection. A self-addressed stamped envelope was provided with instructions about how to return the material.

Two participants emailed me back their feedback. The remainder had a one-on-one meeting with me. We reviewed their answers and briefly discussed if their personal perspectives were embodied in the study. To my surprise, they all recognized themselves in the narrative of the story, pointed out an idea or two they might have discussed during the interviews, and were mostly satisfied with my rendition of

their stories. Using their feedback, I made all the necessary adjustments to the case study and submitted it to my auditor for final review. The audit confirmed that my case study report was consistent with constructivist research practices, that the case study offered a thick description of the troubled context of pregnancy in the context of AIDS amid infected African American women, and that my research findings identified themes and subthemes as patterns of association, rather than as causal relationships (Halpern, 1983).

As soon as I received the auditor's feedback, I made the final adjustments to the draft, printed a copy, and submitted it to my chair. Like my peer reviewers, feedback from my chair consisted of commendations for everything that was positive and caveats for sections I needed to retouch in preparation for the dissertation defense.

The Lessons Learned

This section completes the criterion of "thick description" of the research interpretations, that is, description of the inquiry site, the description of the phenomenon being discussed, and the lessons learned (Rodwell, 1998). The lessons I learned are neither normative for all African American women living with HIV in the United States nor are they generalizable to all women infected with HIV around the world. The eradication of the epidemic will come from observing and analyzing the specific situations of infected women worldwide and from providing remedies to their designated shortfalls. If my research process was authentic and if the reconstruction of the participants' data was accurate, then following are some of the lessons acceptably derived from this inquiry:

a. If HIV prevention programs have been well-implemented in various communities and if the rate of infection is reaching a plateau in certain communities, then these women have mastered the message of prevention but have failed to translate that knowledge into ways to avoid infection. Total adherence to medication should have eliminated the transmission of the virus from mother to child, whereas better condom negotiation could have reduced the number of new infections or reinfections.

b. Our story here is a story of lack of support across the board. With or without HIV, these women struggle with the pregnancy and with motherhood. Their HIV status just represents a bigger burden. We are equally concerned about the children who are HIV positive and who do not know because they have not yet been told. This lack of disclosure is taking away the children's voice in the very same way that these women have no choice about disclosing their HIV status. Parents, especially mothers, have lamentably failed to explain to these children the reason for the many visits to the Infectious Diseases Clinic and the reason for so many blood tests.

c. Although some women were not aware of their individual infection, the lack of support across support systems is making it difficult for these women to disclose their status. Churches are encouraging the nondisclosure by not making it easy for anyone to come out of the closet. The welfare department is utterly dismissive of poor women, Black women, and the health care system does not appear to worry much about the children's knowledge and subsequent need for protection.

d. From the start of this study, I was constantly aware of my specific status as a researcher and its implications. I was both a researcher investigating issues of HIV/AIDS and pregnancies in African American women and a man entering this milieu without the fitting cultural background. Building my dissertation committee and achieving dissertation committee support required a substantive overview of the process and the methodology to allow committee members an understanding of a setting and a dissertation experience that is unfamiliar to them. It is in this vein that I conducted a feasibility study to gauge my access to the right participants and the application of constructivist paradigm to this specific context. The contribution of African American peer reviewers was instrumental in my data collection and helped me understand the phenomenon.

Conclusion

The purpose of my thesis was to uncover the meaning that these women assign to pregnancy and to understand how they use these meanings to influence their decision to carry or not to carry a pregnancy to term. The ultimate objective, though, was to listen and to give a voice to these women's experiences so that their lives may inform our prevention programs of mother-to-child transmission of HIV. As I listened to these women's experiences, I gradually uncovered that these women live in a very troubled context of the AIDS disease where they have little support from their nucleus and/or extended family. I later found among the lessons learned that societal structures that were supposed to help them seem to be less sensitive and sympathetic to their needs.

One of the concerns that attracted my attention while interviewing these women was the blatant lack of informational support that they encountered both before and after their infection with HIV. Talks on social determinants of HIV/AIDS revealed unequal relationships between men and women, meaning that sexual intimacy does not always happen in an atmosphere of mutual respect and that women are usually subdued into having unprotected sex, thus the high magnitude of HIV in our communities. The life story of these women challenges us as social workers to reassert our commitment to the promotion of social justice and social change on behalf of these women and to put an end to the discrimination, oppression, and poverty that these women face in their daily lives (National Association of Social Workers [NASW], 1999).

However, the purpose of this article was to teach doctoral students to carry out research using the constructivist paradigm for research. Using my dissertation into these topics as a framework, my study describes in a step-by-step fashion the various stages I had to go through to complete the inquiry. Writing my dissertation was an uphill battle because of the rigor and trustworthiness the process required. I endured the frictions of dealing with gatekeepers and at times the reluctance of contributors to participate diligently in the process of the project. However, it should be noted with a lot of appreciation that the participants went beyond expectation: (a) they were ill, (b) they were dealing with a stigmatized condition, and (c) they were dealing with the side effects of their medications. Yet they agreed to work with me. Tracking their stakeholders, another vital element of constructivism, was somewhat hard. Some stakeholders were not sure about issues of privacy and confidentiality and demanded to talk with their primary participants before they could discuss anything with me; some others were so extremely brief in their interaction with me that one could not get enough pertinent information about their participants.

Issues of data collection, storage, and analysis were another hurdle. Data needed to be stored separately and understood as part of the entire project. The process of deconstruction and reconstruction required patience and intellectual integrity. It meant dealing with all possible sources of information while constructing and telling the resultant story. This was the place where both the participants and I were interdependent and where our sophistication about this phenomenon was clearly manifested. As researcher and participants, we all emerged from this experience matured and sophisticated due to the knowledge that we had owned and shared.

During the process of this study, I learned more about the importance and utility of member checking that starts with the first interview and ends with the final member check. Luckily, I learned a lot from peer reviewing when carried out both by one person and by a group of peers. Writing the case study report translated for me into a social and discursive practice (Kamler & Thomson, 2006) where people make meaning through reflection, collaboration, and personal ownership in learning. As a researcher, I was greatly enriched personally and professionally. As we worked through the research, the participants and I learned more about each other, identified our similarities and dissimilarities, gained more shared experiences, and changed each other and our relationships in the process. Research such as this, therefore, requires commitment, perseverance, and a determination to undertake a journey that will continually prove challenging. I learned from the experts and garnered the tools I needed to make my continued engagement in qualitative research a rich and rewarding experience.

Declaration of Conflicting Interests

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