The Birthing of a Social Worker Through a Phenomenological Study of Suicide Research

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This narrative chronicles the growth of a social work student whose first master's level social work practicum was a phenomenological study with people bereaved by suicide. The student grew not only in her research skills, but also, surprisingly, in her clinical skills. The process helped the student better use evidence-informed practice, interview clients, and understand the human condition at its darkest moments. The following is a reflection of her growth; sometimes painstakingly slow, at other times, in spurts. As with a child's growth spurt, there is often discomfort and even pain. The purpose of this narrative is to demonstrate the utility of phenomenological research in developing clinical skills, perhaps inspiring others to use the practice setting for research, and vice versa, through phenomenology.

Introduction

In Spanish, to give birth is *dar a la luz,* which literally means *give to the light.* A year ago, I (Regina) embarked on a phenomenological study with people bereaved by suicide—also referred to as survivors. I piloted a methodology I developed with a colleague where psychological autopsies[1] would be conducted phenomenologically (Aguirre, Machtmes, & Mitchell, n.d.). Phenomenology is a qualitative method used to study the lived experience of a particular phenomenon through the eyes of the person experiencing it (Moustakas, 1994). Since my interest was in the experiences of people who had died by suicide, the goal of the study was to vicariously experience the life of the deceased, coming to understand the *lived experience* through the eyes of their survivors. A series of heuristic or conversational interviews were used. The heuristic interview creates an atmosphere conducive to unhindered and unadulterated expression (Bryman, 1988). In working with survivors for almost ten years, I knew that whoever conducted these interviews—or psychological autopsies—would need to be empathetic, genuine, unafraid of tears and pain, and able to uniquely understand the plight of one grieving such a loss.

A master's-level social work student named Liz (Elizabeth) came to mind. She impressed me with her understanding of human behavior and genuine interest in others' well-being. She expressed interest in research, had experience in quantitative research, and was in the process of preparing for her first field practicum. Knowing that "The intent of field education is to connect the theoretical and conceptual contribution of the classroom with the practical world of the practice setting" (Council on Social Work Education [CSWE], 2010, p. 8), it seemed to me that the study would serve well as a practicum. Specifically, for the first field practicum, the focus is on providing the student with opportunities to apply knowledge and develop skills related to the foundations of social work, including: human behavior in the social environment; diversity; social work ethics and values; client assessment; effective use of supervision; research; social policy; populations-at-risk; social justice; and social work practice with individuals, groups, families and communities; professional awareness.

The study would incorporate most of these, so I made a request that this study be considered for approval as a first-year field practicum. Approval was granted, and I approached Liz about a field practicum consisting of a series of phenomenological heuristic interviews with multiple survivors and the phenomenological data analysis process. Her interest was piqued and, surprisingly, she too was a survivor. To protect her, we discussed her four losses to suicide and scenarios she might experience in the interviews. I was sufficiently convinced of her

level of healing and comfort with the topic to proceed.

Liz spent her field practicum conducting three interviews each with five survivors of four people who had committed suicide, resulting in fifteen interviews of about two hours in length. We met often for training, supervision, and data analysis during two semesters. At the time, I was pregnant. As I marveled at my son growing within me, I watched Liz grow, facing fears she never realized were there and realizing possibilities that had never crossed her mind. As we collaborated on publishing the results, I saw that this experience *dió a la luz* a new Liz, who was better able to embody evidence-informed practice, interview her clients, and understand the human condition at its darkest moments.

This narrative is a reflection on Liz's growth through excerpts from her field notes and reflective journaling that she has organized into themes. These excerpts are largely unedited to maintain the essence of her experiences, as is customary, with qualitative data.

As with learning any new skill, there is a developmental process. Sometimes the progression feels painstakingly slow, at other times, more like growth spurts. As with a child's biological growth spurt, there is often discomfort and even pain. That is evidenced in these journal entries. Our manuscript ends with postscripts from Liz and myself, a year after this process. The purpose of the narrative is to demonstrate the utility of qualitative research—specifically phenomenology—in developing a social worker's clinical skills.

Liz's Reflections in Her Own Words: Can't See Freedom—a Glimpse at the Pain of One Who Suicides

I was headed to my very first interview. Something caught my eye as I sat in the almost-comfortable seat of the city bus. Perched on the window sat a moth. It was so still I could have missed it. My first thought was: "How did it get in here?" My second thought was: "Why doesn't it just fly out?" I realized that the moth, so still and despondent, was not so different from the deceased I was traveling to hear about. It was trapped on a window that wouldn't open. The way out was behind it, out of the line of sight. And so it sat, immobile, trapped and hopeless, facing the cold steel and glass of its seemingly inescapable environment.

Aperture—Sharing the Survivor's "Why?"

My second participant was much more emotional than the first. At times, it was heartbreaking. During our interview, she kept her beautiful handkerchief, which seemed to bloom with pastels, in her hands or at her eyes. I see patterns as she shares her son's story. Some are common characteristics of those who suicide; others like the dream you can't remember, except for the impression or emotion. My mind is beginning to make connections that I can't yet "horizonalize."

Disturbing to me was that her loved one had seen a therapist for about a year, and had blinded the therapist to his actual feelings. She said "He B.S.'d this guy for a whole year. I don't know what he told him." It seems like an impossible task to predict or prevent suicide. Our research has the potential to help make a path through the deep water of uncertainty and ambiguity. I hope that becomes reality. My mind reels with the contributing elements, some overt and others hidden, in each survivor's words and ideas. Where is the dividing line? What happens in that moment when a person decides to suicide? How does one transition from "psychache", where one might consider suicide as an option, to the point where the decision is made and plans are formed?

Despite a plethora of research in suicidology, these questions remain largely unanswered. Some understanding gleaned from the literature indicates that there is a narrowing of perspective, similar to the aperture of a camera; the decision is rarely instantaneous (e.g., Baumeister, 1990; Joiner, 2005). At what point do the blinders become so tight that death seems the only escape from the pain? That is what we hope to learn, what I hope lies in all of these pieces; what mathematicians call a fractal—something that

grows infinitely more detailed and intricate the closer one looks.

Empathy at a Distance

The third interview was today. It was different. It was over webcam because the participant doesn't live here. It's harder to demonstrate empathy through a webcam. There is sometimes a delay in my response because of the technology, so even verbal affirmations and short empathetic statements are belated. I wish I could interview this particular participant face-to-face. She is so hurt. There are depths of emotion she wants to explore–so much she never got to say. I sense that even in her therapy there were things that may not have come up that are now emerging. She was so willing to share; to help in any way. He hurt her so badly in life and in death, yet she loves him dearly. There is much conflict within her; my heart goes out to her. I identify with some of the nuances she shared about life before his death. I hurt for her.

This is one interview that makes me think about ethics. She mentioned he had his psychiatrist fooled; he told her that her husband never mentioned suicide. She was never allowed to attend his sessions with him, though she wanted to. I felt conflicted by these admissions. Psychiatrists are human and cannot automatically discern the difference between lies and truth, however, here I wonder at the competency of the professional. I wonder that a family-oriented approach wasn't suggested, especially considering that the deceased was facing a serious physical illness impacting the whole family. She wished desperately that she had been involved in the counseling. She wondered how it would have impacted their marriage and his life. Had the psychiatrist ever suggested family therapy or a support group? Could that have made a difference?

Luminescence

I reviewed transcripts today. They take so many hours. I hear the stories over and over, and it is sometimes traumatizing. I dream about the families; about their lost loved ones. It is also enlightening. Sometimes, I hear a word or phrase and my mind comes alive with connections.

It reminds me of an experience I had on a summer trip to Puerto Rico. One summer when I was in Puerto Rico, we went to Phosphorescent Bay late one night. We took a boat into the open ocean with only the moon and stars to light the way. It was so dark. When I jumped into the water I was shocked to see thousands of tiny microorganisms light up in sequence, like lightning radiating from my every move. Activated by heat and movement, while otherwise invisible, it was as if they were holding hands waiting to be touched so they could demonstrate their electricity in an ever-increasing wave of blue-green lights from my body out toward the bay. It looked like the stars had fallen from the sky into the ocean.

Sometimes as I listen to the recorded interviews or read through transcripts, there is a similar explosion of thought, and I scribble furiously in my notebook, desperately trying to record the connections before they fade. I write down questions to ask later, and hypothesize about how personality traits and circumstances contributed: "He had a complicated relationship with his mother;" "The mood swings were so hard to live with;" "He didn't stay around long enough to let us love him;" "He said he couldn't live in a world of darkness;" "He watched a best friend sustain a traumatic brain injury;" "He suffered brain injuries as a child;" "He had the psychiatrist fooled." It will be a relief when the lightning in my mind can be bridled and committed to a clear set of horizons and themes. I sincerely want this to matter–to make a difference. It will be interesting to see what happens as we begin to "horizonalize" the interviews. If our work can save just one life, it will have been worth the hours and discomfort.

I'm also finding that I feel terrible for my family as I see how survivors benefit from support groups. I am a survivor – my great aunt and all three of her sons suicided. Though I did not know my aunt or two of my cousins, I did know the last to die and grew up playing with his children. I was shocked by his death, years after that of his mother and brother. What I've read and heard makes so much sense in

relationship to their situations; it is heartbreaking to know that they were not able to recieve counseling after my aunt's suicide. Could it have saved their lives?

A Painful Revelation

It will be burned into my mind forever: the sight of a grown man covering his face with his hands as he cried. He was recalling a last "I love you" and my heart broke. It broke for him and his loved one. He shared with a smile that I know more about his loved one than did many of his friends. I think he was telling me he trusted me with his loved one's memory and his own story of loss. I think he was trying to tell me with his clear, teary eyes that it was going to be okay. Although I mustered up as much professionalism and courage as I could, I'm sure my own eyes were a little more teary than usual. I ached for him and the unfathomable loss of one who gave up too soon.

The capacity of the soul is remarkable. It can be cloaked in depths of darkness that I will likely never experience and it can soar to heights of euphoria. It is resilient yet fragile. It is mercurial yet static. Its needs are both simple and incomprehensible. It contains our hopes and dreams, our most garish fears and nightmares. Somewhere in its complexity lies a switch that remains, untouched by most. It is fiercely guarded by the instinctive soldier called "survival" and can be turned off only by a hideous, destructive agent, who manages to override the survival instinct. What is involved in this sinister turn of events? That is what we hope to discover. We dare to investigate the dark recesses of soul and mind to expose the moments surrounding the lethal turning off of the switch. It is the tunnel in which the suicidal mind is fully plunged into a diametric state where life looks like darkness and death—like light.

Hear, Speak, See: Confidentiality

Sometimes the atmosphere around the center makes it difficult to maintain participants' privacy. Most have been part of a support group there and are familiar with the staff and each other. More than once, someone walked into the room during an interview causing the conversation to hault. Such interruptions did not seem to take a great toll on the participants' ability to resume, but I do wonder if they took a different direction after the interruption than they would have without. Also, though many have heard the participants' stories, some of the questions I was asking were things they were thinking about and discussing for the first time. An interruption during such a moment may have discouraged divulging what they had previously planned for fear of someone entering and overhearing previously undisclosed information. In that sense, I became responsible both for my ethical actions as well as those of others.

The Puzzle for the Pieces

Retrospect is a cruel thing. In each of the cases, there were signs—some nearly inscrutable at the moment, but in hindsight much easier to observe. It's hard to see people recount them: giving up too easily on a life-altering decision; fixing a drink for the first time in years; going to a movie after lying on the couch for weeks. Looking back these seem obvious, but participants'comments make it clear that only now do pieces fit together. I can see pain in their eyes, hear the tears in their voices, and sense the clutching in their hearts as the "if only's" make their unwelcome presence known.

All have mentioned a specific moment, "I know now that's when _____ decided to die." Perhaps this is the Mount Everest of suicide prevention; professionals learning to see the puzzle for the pieces and teaching the public to recognize them. Shneidman's (1996) *The Suicidal Mind* best elucidates the subject when he explains psychache–"deep psychological and emotional pain that reaches intolerable intensity" (Joiner, 2005, p. 37) is not applicable only to those who suicide. This is the existential perturbation Shneidman discusses: everyone who suicides is experiencing psychache, but not everyone experiencing psychache will suicide.

Herein lies the seemingly insurmountable task of identifying those at risk and perceiving the behavioral changes that could save lives. We have made some progress in our

understanding, however, part of the difficulty is the ability to identify those in trouble. Unfortunately, suicidal ideations cannot be detected through a blood test; they don't leave visible signs like bruises; unless the sufferer reveals it, no one may ever know. It is a secret killer, a devilish devourer, narrowing its victim's vision until it has manipulated the mind and fashioned it toward its greedy ending. In the center of its maniacal course is stigma, deterring the most willing helpers, devoted friends, and brilliant minds. Therein exists its wall of protection.

Researchers are quick to rally behind physiological diseases and disorders that destroy the body. Some are eager to study those that impact the mind; the stigma seems to lie in the choice. One cannot choose to be born with cerebral palsy or to have an aneurism, but suicide, it seems, is a decision and therefore often does not receive the same compassionate understanding. Perhaps it is the often violent nature of a suicide; a resemblance to murder. The reality is that one can only make choices when in a rational state of mind in which options are visible. In the suicidal mind, killing oneself is not about dying, but escaping unbearable pain. Whatever the reason for the stigma, we must learn to recognize the psychache and hopelessness. We must help the public understand the depth of the darkness and teach them to sort the puzzle pieces.

Professionals have a place in prevention and have no doubt saved thousands. However, it is clear from the number of attempts and those who die, that prevention must be engaged in by everyone. Teachers, doctors, family members, friends, and clergy, must learn to observe, listen, and ask hard questions. We must stop being afraid of the unspeakable and start learning, asking, and listening. Even the smallest attempt to relieve pain or "widen the blinders" by expanding the narrowed perspective might save a life.

Unique Support

I now understand the urgency felt to introduce crisis-support programs in conjunction with the police and coroner's office that send social workers (or at leastsuicide survivor-support teams) when a suicide is reported. Survivors of one who died by suicide are more likely than the average person to suicide, making it critical to address grief early and help survivors heal. The guilt associated and the leper-like treatment often experienced at the hands of the community, and occasionally close family and friends, is severe. The torturous emotions of shame, guilt, fear, anger, and loss were described by one participant as unlike any other pain: "a gnawing pain in the pit of your stomach that never stops and you never reach closure."

During her interview today, one participant shared with salience her agony and frustration during her husband's last week of life. I saw it in her face and heard it in her voice: so much anger and pain and simultaneous understanding for her loved one's convoluted reasoning. The pain was coming back. He thought the cancer was returning. He had been dropped from insurance, and was being sued for a business matter. His psychological vision was narrowed, his body in pain, he was afraid, angry, and feeling hopeless. Just a few more days, a few more weeks might have helped. He had a doctor's appointment for the next Monday. His autopsy showed no signs of returning cancer. If only he had waited for the good news. The letter of acceptance came from the new insurance company on Monday– not even 24 hours after his death. The lawsuit went to mediation. They settled for a pittance because the burden of proof won out. Days, weeks, time....would they have made the difference? Would the relief of continued remission, financial assistance, and a decent legal outcome have brought enough light to the darkness?

She recounts the history with sorrow and frustration. They argued before he died, his hands around her throat. She was lucky he didn't shoot her. And yet, she says, "I wish he would have let nature take its course. I wish he would have let us love him, even though it was getting more difficult to do that." Sometimes her voice makes me afraid she will sink into despair. So many years later and after much therapy, I can still sense how difficult he was to live with and how much she loved him anyway. He was arcane, demanding, and yet emotional at his children's

successes. He raged at her about insignificant matters, but was the magnetic personality who walked into a room and commanded attention—the kind of person whose trust you want to earn.

Some of her best memories are moments when he showed respect for her intellectual ability as the family's business accounts manager. His respect was difficult to acquire. She often threatened to leave. She threatened that day–she was packing her bags, he was loading a gun, and in an instant her life changed forever. She was beaten down emotionally for so long and now she is torn between anger and anguish. She is such a strong and wonderful person. I wonder if she sees it, or if she'll ever see it. I see how important it is to introduce quickly, support that is free of the usual stigma—complete acceptance, no blame, room for fears and tears, anger and sorrow, and a common sense of the unique feelings of loss.

The Eye is a Window

I find boundaries in research are especially difficult. Not so much in the traditional sense of self-disclosure, appropriate behavior, or dual relationships, but in the sense of the role of the researcher. We are engaging participants in a phenomenological approach to the psychological autopsy. There have been many statements of self-deprecation or loss that I wanted to address, but aside from a general statement of empathy, I could not engage the issue as my role is not that of clinician.

Emotions have also been difficult at times. I do not tend to be overly emotional in regard to tears or other physical displays. However, there have been times with each participant when I really connected with their pain, or their loved one's pain. Those were difficult times. It is hard to look into the eyes of a hurting person without experiencing some of the pain radiating from them. Eyes are a funny thing. They are like a mirror and a window, showing us the inside of a person, as well as reflecting our own image. I have looked into many eyes over the past few weeks: in the physical sense as I sat across from those sharing their stories, through pictures brought by participants, and even through verbal descriptions. It can be difficult not to abandon the research structure and address the survivors' needs. For the integrity of the study, and to ensure a greater likelihood of helpful gains in research, I must not and I have not done so beyond simple gestures of communicating acceptance and empathy. I have tried to display enough to assure the participant that I am trustworthy and invested in their story and the story of their loved one. I hope that I have been successful.

I am dreading the end of the study. At first, I thought it could not come soon enough because of the intensity. Now, I have come to greatly appreciate those involved. I like them. They like me. We have formed a trust relationship; they have shared feelings and observations with me that many others in their lives have not heard. I feel the weight of responsibility and a sense of loss as the final interview for each participant approaches. It was important to fully engage myself in this for the outcome to be successful; I believe I have. However, that does not make it easier to say goodbye to such incredible people who have chosen to share their deepest fears, hurts, and family secrets to benefit others. It causes me to even more desperately hope that what we learn will somehow, somewhere save a life. Just one life makes everything worth it.

Know Thyself

Suicide is not easy to address. It has been interesting and challenging to be constantly self-evaluating through this process. After reading Raines' (1990) article about noting visceral reactions during client interaction, I began to identify similar reactions in myself. There have been times during interviews when something said by a participant sparked a reaction in me. Often this elicited an emotion, thought, memory or even a physical response. Sometimes I suddenly had a cold feeling in my stomach, or my heart rate increases.

Although I was already minimally aware of these sensations, I have become more so after reading the previously mentioned article. I now attempt a constant state of self-awareness while interviewing. I try to note when these reactions occur and ascertain why. This is difficult when I am listening intently to

a participant. I must form questions in response to what they are telling me and simultaneously percieve my reactions.

In some ways the boundaries of the research method are a protective barrier. The nature of the research method prohibits me from interjecting where I might otherwise be inclined to do so. I must maintain as neutral an attitude as possible, which requires that I control the display of extreme emotions. Although it can be appropriate to become a bit tearful when listening to a description of tragic events, even such a normal emotional experience needs to be limited. I have found myself digging my fingernails into my leg to quell a surge of empathy. I allow myself only to speak simple supportive words such as "that must have been difficult" in response to a participant. It has become exceedingly clear how important it is for me to know myself well. It is vital to examine what triggers reaction in me and have a plan for how to internally address triggers before they interfere with client interactions.

Brothers and Sisters

I interviewed a new participant this week. I have interviewed his mother, so I know his brother's story well. When I met him, I felt I was meeting his brother. Out of all the siblings in the family, he and his brother were the most alike. It was eerie as we sat down to talk and he began to share insight about his brother's life.

Once again, self-awareness came into play. My younger sister and I are extremely close and have a relationship that resembles the affection described by the participant. The story was devastating the first time I heard it from the deceased's mother, but even more so from his sibling. He made statements I connected with. He commented that when he and his brother were reunited after a long absence, he had the feeling that "everything was as it should be." It made him feel like the "boys were back in town." I watched his eyes fill with tears as he tenderly spoke those words; my heart melted. For a second the crack in my professional armor opened and I allowed the "what if" scenario to sting–one of those moments where fear grips and your stomach turns cold. The gravity and depth of his loss ricocheted in me in what suddenly felt like an echoing, empty space.(I suppose I would call that an intense empathy moment and concurrently a revelation of personal sensitivity.)

I quickly regained my thoughts and emotions. I doubt he knew anything he had said raced through my mind in that way. It all happened so fast–like being hit in the stomach and receiving an electric shock all at once. How is it possible to see these things coming? I know I love my sister, but how could I know that I would so suddenly be struck by fear at the hypothetical thought of losing her? Why had this not struck me during the two previous interviews with the deceased's mother? Why would that fear arise when she is not, nor has ever been, suicidal?

As I think about the future, I realize how important it is to record such reactions and deal with them at a later time. Thankfully, my previous career had involved dealing with people, and I had learned to quickly and imperceptibly disguise such discomfort. I do, however, recognize that no matter how I may perfect such a skill, I would not be doing myself a favor to internalize those reactions permanently. To do so would certainly engender burnout, or at the very least, great stress. I have much to learn about self-care in the future.

This summer I have begun to experience how vital it is for a social worker to be aware of personal limitations and to use that awareness to their benefit in the same way they would for a client. I believe that to help anyone else, you must first have a definite sense of and respect for the self. Part of the art of being a social worker lies in the personhood of the helper. Even for the most willing, empathetic, or gifted social worker, the self must be protected, nourished, and grown.

Stress and Burnout

I am tired. Balancing work, family, practicum, class, and volunteering is beginning to overwhelm me; only a few weeks left and so much to do. I am not worried about completing the required hours—I am on schedule. What concerns me is the amount of

work left. I determined at the beginning of this practicum to throw myself into the process no matter how nervous or afraid it made me. To the best of my ability, I have done so. Although the primary outcome will hopefully be a good research product, the secondary effect is that I have become very personally invested.

The participants unilaterally expressed hope that our research will produce dynamic effects in the field. They are passionate about the lack of research. Discouraged by the trepidation of public entities, they hope our pieces will contribute to increased knowledge and renewed concern for educating the public. The stigma associated with suicide is devastatingly harmful to survivors and prevention efforts.

The imposed silence surrounding suicide is deafening. Tolerance for related discussion is short-lived, as if talking about it might cause a tidal wave of darkness. As I describe to friends and family what I am studying, I notice this. As the word "suicide" comes out of my mouth, facial expressions freeze. Following, eyebrows lift, and I hear the obligatory: "Wow, that must be hard." Then comes the silence—that beleaguering silence—as if those who suicided and their survivors belong to a cult. I am not sorry for that awkwardness. I try to push through, making the case for how families feel when they are treated in such a manner. Could I handle a career in this field? Perhaps the social discomfort is only manageable for me because it is a project that will end. I have no doubt that the inability to talk to others about what I am experiencing without their inevitable avoidance would contribute to stress and burnout.

Cultural Competence

Cultural competence takes many forms. Though ethnicity and religion come to mind, there are other factors to consider. The participants in our study have been relatively similar in ethnicity; religion has only marginally been mentioned. However, there are other cultural issues that have emerged.

Cultural considerations also involve generational difference and demographic location. One victim's parents were described as being of the generation where the "man is the breadwinner and the woman tends to the home." His father left early on the train to go to work and came home late. He paid little attention to his son and was absent in his life, viewing his hard work as his contribution. His mother was a harsh, argumentative woman with whom he had a mercurial relationship. At times they were kind to each other; more often their relationship involved arguing, blaming, guilt, and distance. The survivor shared that she felt the relationship, or at least the defined roles of each parent, was typical of the time period and area in which they lived.

That type of family dynamic was foreign to me. My first instinct was to view the stories from my point of view, imagining what I would have felt in his place. The reality is that I wasn't in his place. What may seem abhorrent to me may have been culturally acceptable to that family. There was no apparent physical abuse and the deceased was always provided for by his family. So, although the nuances of his relationship with his parents seem unacceptable to me, it is important that I objectively determine if it was indeed inappropriate or simply a generational and cultural difference. In a generation where feelings, emotions, and parental involvement have become paramount in parent-child relationships, it is important to ask whether behavior is actually deviant, or just different.

Notes

I read my first suicide note this week. The participant was willing to make a copy. I am glad I waited to read it until I had been through four in-depth interviews about his life. I don't think I would have felt the gravity of it without the understanding I had of his life. She also brought the eulogy his brother gave—a nearly unbearable combination. I think I held my breath the entire time I read.

Although I heard many of the things in both before, I was not prepared for the impact. The suicide note was a rare one. It contained two parts: the front of the note was the original, written ahead of time; the second and much shorter note was written on the back during the process of the suicide. The writing changed in the second note; it was frantic with spaced out, sloppy letters. He had first cut his wrists.

When that didn't work, he bought pain relievers from a store near the hotel and, according to the toxicology report, took enough to end his life. Impatient and fearing that would not work, he tried a third and final time by hanging himself. Somewhere during that process he wrote the second part of the note which contained more personal comments to his family than did the first.

This scene was playing through my mind as I read. I imagined the severity of his psychache, circumstances, life, and the imbalance of the bipolar condition in his brain. Parts of it still echo in me. I feel I know him so well I can hear him say it: *"The howling in my head has taken over...I have run out of dreams."* That kind of despair is frightening. What was more alarming was that he obviously did not write the note during a manic episode; he was not out of control. He had considered his options and found nothing else viable. He was resolute in his thinking, *"There is nothing anybody could do to help me...please know that I go in peace. The pain is over."*

Termination

I am surprised at how difficult this feels. I have finished final interviews with three participants; it was difficult to say goodbye. They have shared the most personal and emotional things anyone ever could and I may never see them again. The informed consent outlined the limitations of our contact and we've been counting down by interview along the way. But I was not prepared for what it would feel like. I felt sad as I walked to my car. These people have greatly impacted me. They have taught, inspired, and encouraged me. Their trust makes me that much more determined to honor them and their loved ones in completing the project.

It helps to know I will maintain some level of contact because we have promised to keep them informed about publication and presentation of the study. However, I do find myself wishing I could continue to meet with them occasionally, even though I know the likelihood of doing so is slim. It brings great comfort to know they value the work we are doing. Each gave their words of encouragement as we parted from the last interview, and I look forward to hearing their reactions when the project is complete. I hope they feel we have honored their loved ones' memories and contributed to a sorely lacking collection of research. I have new heroes; their faces, voices, and tears will continue to hold me up as I pursue the truth.

I have also learned much about research this summer—some things related to technology, others to methodology—and inadvertently, I have gained clinical skills as well. The phenomenological interviews resembled client interviews in many ways, and the nuances both seem similar. I have learned to protect the integrity of a study and the confidentiality of a participant. I have learned to listen and to ask. I better understand facial expressions, body language, and tones of voice that communicate, "Go ahead, I trust you" or "That's too close; back off." I have learned a macro-related lesson about the nature of research. Some might ask what place research has in the field. Many find it to be a more scientific than social endeavor. However, I argue that if social work is indeed defined as concerned with the "personal needs of individuals, families, and groups," as well as with social action and reform, then research cannot be identified as a fringe effort. It follows that research should be central to social work; it is (or should be) the basis for excellent practice, as well as the podium from which we challenge our world to change.

Liz's Postscript

A year has passed since the interviews. Time has flown; many lessons have been learned—some only in retrospect. The value of the experience is clear as the skills and perspective gained have filtered through months of advanced courses and, most especially, another practicum. The ability to read clients' facial expressions and body language in regard to comfort and willingness to share takes practice. As I work with clients with painful stories or complicated family situations, I feel less daunted by completing a psychosocial assessment and asking hard questions. I have already asked the hardest ones; heard the worst stories. I have seen the darkest places of the human soul and mind. I

have learned that just asking and listening can heal or enlighten another. When I began my social work education, asking people probing questions about their personal lives, financial situations, and legal or medical history was terrifying. I felt they would have every right to look at me as though I were crazy for asking for such personal information. Now, as I combine experiences from this project with my second practicum in the medical setting, I feel I can approach those conversations confidently. I discovered the beginnings of my style—my version of art versus science.

Because I am research-minded, I feared I would lack clinical abilities. I have found that phenomenological interviewing (and perhaps interviewing clients) is, as Janesick (1994) terms it, "a dance." I learned a delicate balance of leading and following. A conversation would walk down the path of pain, into the recesses of soul and mind and bare the truth. The scientific challenge was to remain engaged while choosing not to interfere with the movement or interject direction. The art involved being present and connecting enough with the pain to know when it was appropriate to help, providing momentary relief through an empowering comment, finding a positive aspect and highlighting it, or demonstrating empathy. My ability to perceive when this was needed, and how to effectively provide it, was sharpened. I find the value of a phenomenological psychological autopsy lies not only in the potential depth and breadth of information, nor in development of the researcher, but also in the cathartic benefits to the participants. Each participant involved in this study divulged that the interview process itself provided healing. One participant shared:

> *"I know that I can speak for many of my friends that the work you are doing will greatly help in the efforts of dealing with suicide and its devastating affect on the survivors. As I told you, your interviews were better than several expensive sessions with a therapist."*

Regina's Postscript

When I embarked on this study with Liz, I knew it would impact us both. I knew the process would be an excellent first practicum for a master's-level social work student. What I did not fathom was how much the things we learned would impact our respective practices. I am grateful to both Liz and our participants for what they have brought to this project. Not only did it result in the birthing of an excellent social worker in Liz, but that it also resurrected the lived experiences of the deceased loved ones whom we studied. Their stories have changed us for the better and, hopefully, we will use that to help others in the darkness of psychache to live through it.

In having Liz share her reflections in this article, it was my goal to *dar a la luz* the three conclusions: 1) certain research studies are apt to serve as field practicums; 2) phenomenological studies with heuristic interviews, specifically, are very effective in nurturing clinical skills; and 3) the awesome impact phenomenological psychological autopsies can have on both the interviewer and interviewee. Liz's growing pains as a researcher and as a social worker illustrate common ethical issues for social work research and social work education, such as the tension between the social work role and the research role; termination with clients; cultural competence; and counter transference. I hope her largely unedited reflections demonstrate how research and practice intimately have fed each other and birthed a well-prepared social worker. Perhaps too, this study will inspire other researchers to use the practice setting for research and other practitioners to use phenomenological research in their practice through phenomenology.

Conclusion

We have many hopes for the wealth of information that came from this study—the ultimate, of course, being that of saving lives. There is much to learn about survivors and what is helpful to their healing. We hope that this article, as well as others that will come, will serve to support the multi-dimensional value of phenomenology in social work research.

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(Footnotes)

[1]Intense, psychological pain that seems inescapable (Shneidman, 1996).