

From Healer to Transformed Healer: Relearning Lessons in Grief

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Abstract: Neophyte and experienced clinicians alike often question whether so-called “wounded healers” are more effective therapists than those who cannot personally relate to what clients have experienced. This narrative discusses my professional and personal development in the field of death and dying from the perspective of an individual academically proficient in grief theory but devoid of personal experience, to that of intimately informed bereaved mother. The healing effects of narrative, personal observations of grief, and implications for clinical practice are discussed. Please note that some details from clinical practice, all names and identifying features of patients have been altered to ensure complete confidentiality.

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We are all called to serve as agents of change for various reasons. I have spoken with colleagues who experienced significant childhood trauma and thus were motivated to work in Child Protective Services (or, conversely, avoid this area of social work and seek employment in agencies focusing on serving the elderly or medically compromised, for example). I know of others who battled eating disorders and determined that their most significant contributions to the field would be housed within residential day programs for similar populations. In school, we’re often evoked to discuss the “wounded healer” paradigm: is personal experience of a particularly tragic event, hardship, or life transition a prerequisite for becoming a gifted clinician? Alternatively, is it enough for clinicians to maintain an active, empathetic presence with patients and clients as they reveal their stories, ask for details, and work to ensure that they are truly heard, even if we are not personally familiar with the paths they have walked? How much self-disclosure is too much? When does the therapeutic relationship become the narrative of the clinician, and not the populations we serve?

These questions are not unusual, and when I initially embarked upon a career in social work, I had very little context of being “wounded.” Admittedly, in adolescence I struggled with self-image and an endemic form of Obsessive-Compulsive Disorder that has snaked through the genetics of my ancestors and has been repeatedly passed down along the line, but I subjectively never felt I had experienced Hardship with a capital H. I have always carried a deep love and respect for others who struggle, and just as strong a desire to alleviate suffering and inequity.

Why did I become a social worker? The answer to that comes down to one word: Death. As a young

child growing up surrounded by a loving family, I often stayed up late into the night pondering the meaning of life and my own existence. What would happen when I died? Was there truly an afterlife? What did eternity mean, and what would happen to my soul when the sun died out, the earth turned cold, and there was no habitual planet to hold my eternal energy? One night, I ran into my parents’ bedroom after the thought of it made me physically sick.

“What happens when we die?” I asked my parents, shaking them awake. Their room was dark and clammy, but their bed sheets felt oddly cool.

“What are you doing awake right now? Go back to bed.” My father’s response came more from the instinct to rest and, perhaps, far too many late nights of doing parental duty tending to one of three children.

“I’m not going to be alive forever. What happens when the sun blows out?” I asked, ignoring his instructions. I could never just return to bed. Despite losing my dinner, my stomach still felt heavy and my mouth was sour. “I don’t want to die,” I began to cry. “No, make time stop. I don’t want to die!” I was young, but the memory is powerful. I remember the frantic, helpless feeling that something was very wrong and I was unable to fix it. My parents were giants, they were smarter, worldlier. Maybe they had the solution?

By that time, I’d had my father’s attention. He peeled back the covers so that I could snuggle in between him and my mother, and I was enveloped in the safety of their smells and their welcoming arms. For the first time, but not the last, my father explained many theories of death: from the mystical: “some say the soul has a certain weight, and when a person dies, the body weighs that much less” to the spiritual: “I know a

man who drowned as a child. He said he went to heaven and was never afraid of death again” to the one that made me the most frightened: “Jews don’t believe in an afterlife. We become dust. That’s why living this life to the fullest is so important.”

I did not want to be Jewish if this was the case. How could I be so very alive, only to turn to dust? It sounded like a cheap deal. I was more comforted by the possibility of the afterlife and hoped there was one. By the time I completed college I was so consumed by these questions that I decided the only way to understand death was to get as close to it as possible. In response, I embarked on a career in social work, specializing in death and dying. I spent my early career working with adult and child oncology patients, neonates, and survivors of horrific forms of trauma. I became intimately acquainted with the process of dying itself. I watched the young and old pass away before my eyes.

At the beginning of my clinical journey, I was fresh to the world of pediatric oncology, and optimistic that I could make a difference in the lives of the suffering children I met. I have many happy memories from my clinical beginnings of “tattooing” stars and hearts on the bald heads of teenaged girls with the help of liquid eyeliner pencils, of sharing the poetry of Pablo Neruda with lovesick patients who longed for intimacy that didn’t put their delicate immune systems into haywire. I felt connected to most of my patients. But one death stands out to me as a moment of self-discovery and perhaps of brushing by a soul transitioning to something intangible: that of a child who had barely turned twelve at the time of her passing.

Maria had been hospitalized on and off with a very severe and rare form of cancer since she turned 10. She was a quiet girl, and was often unaccompanied during her admissions due to her mother holding two jobs to support the family. Whenever I entered her room, I was struck by the powerful alone-ness of this child: she lay in her bed, staring at the ceiling, silent tears streaming down her face. I wanted so badly to connect with her, make her laugh, infuse her with some joy to counteract the toxic brews snaking through her body for the purpose of extending her life. Maria barely ever responded to me. I bought her music, did art projects with her. She accepted my presence but truly, never spoke. I

perceived her as a child in slow motion: every move was labored, every inhalation felt dense and every exhalation fell to the floor. Inside her room, time stood still. The colorful paintings of children playing that decorated her wall served as a stark contrast to the child in the bed before me. The artwork felt mocking: here were colorful characters twirling, upside down, without bodily restrictions: and there was Maria, invisibly chained to her bed. I sang her songs and she stared at me. I helped her get dressed, pulling her IV to the bathroom, her tiny naked bottom exposed and she without worry for it. I held her under her arms as she balanced on the toilet, imagining her bones as frail as a baby bird’s, hollow, and threatening to collapse beneath the weight of my fingers.

As the cancer became more invasive, Maria would cry and scream on her way to the operating room, filled with terror, but no parent by her side to smooth her forehead or kiss her fears away. I would experience the return of that sick, heavy-stomach feeling from childhood: that I was powerless to stop this event from happening, that Maria was dying, would soon cease to exist. The surgeons attempted to carve the cancer out of her, but it grew and she became infected, the unseen viruses rampant in hospitals feasting on her vulnerable physical status. When I was called to the intensive care unit because she was dying, I knew Maria would be alone.

She wasn’t. A small cousin, no older than ten, was by her side, eyes wide and terrified. I searched for the parent who had brought the cousin here, and when I found him I was told for reasons that were not clarified that Maria’s cousin deserved to be there. I’d never met the cousin before, and felt that this kind of exposure to Maria on her deathbed would be traumatizing for the cousin. I argued that the cousin not be present, or that the parent, who himself could not be in the room, come to Maria’s room to assess the situation. He would not and told me that I would have to “deal with” the cousin. In my newness as a social worker, I helplessly retreated to Maria’s room, and together the cousin and I watched her vital signs drop. We watched her heartbeat fall. We heard the high-pressure ventilator pummeling Maria’s lungs with air, a sound I can only liken to that of a car on a bumpy, uneven road. The cousin reached for Maria’s hand. I said “go ahead, hold her hand while she goes”, and we both did, just as the cousin’s father came in and began to wail hysterically. It didn’t feel real to me. Perhaps it was the shock and sadness of this very

isolated child, dying without her mother nearby, or the sounds of the machines working to preserve her fleeting life. Perhaps it was my anger at family being present to witness her death, but not her life, and that it was family I never knew existed. With the sound of the machine still bumping away into Maria's now-dead body, I stopped thinking and started feeling. There was a wordless transition happening there, one that if I rationalized or tried to explain too much, I would miss altogether. I maintain to this day that Maria's soul left her body, and I caught the slightest feeling of that happening while I held vigil by her bedside. I was sad but on a level that evaded words, I knew that in some way, Maria's life endured.

Two weeks later I would watch another child die: this one, a formerly happy and vivacious baby with a brain tumor that transformed her into an angry, aggressive, screaming bundle of a little girl. I watched her take her last breaths, unconscious yet automatic, as her mother and boyfriend cried over the loss of life, potential, and hope that engendered their beautiful daughter. I kissed her cold forehead goodbye. She was still, pale, with purple lips and I was reminded of Maria's transition: this little girl's body felt like a shell, a deeply-loved shell, but her true essence, the immeasurable stuff that made her wobble on unsteady legs, pull at my hair, giggle at the ducks in the hospital pond, was now somewhere else.

I watched death happen: I held departing hands and said prayers with their families. I carried tiny bodies to the morgue. I remember the details of each death, the stark division I felt between living and dying, the pain I felt for mothers, fathers, and siblings, and the desire to say just the right thing when I knew there was nothing truly right that could give my patients and families what they wanted above all else. Nevertheless, by the time I completed my doctoral degree, I considered myself somewhat of an expert in dying, and had comforted so many family members that I felt I truly understood the grief process. I supervised new clinicians and always encouraged limited self-disclosure, allowing patients and families to speak freely, for themselves, without the burden of knowledge of a clinician's loss. Ultimately, my dissertation about adolescent sibling bereavement was a testament to my perceived expertise in death, dying, and bereavement. It was a conceptual approach to summarizing and

categorizing the grief of teen siblings in multiple research studies, creating new pathways of identity that teens developed as they struggled to cope and move forward with life. I knew there would always be important grief work to do, and I continued to feel called to it as I embarked on my new career as an Assistant Professor of Psychology at a small college north of Philadelphia and maintained my work as a private clinician.

The Appeal of Narrative

Throughout my career, as patients and families in medical environments told me their stories, I searched for the best methods to ensure trusting, caring relationships that facilitated the flow of narrative that helped my clients create meaning and understanding from their personal experiences. My mother is a storyteller, with a doctorate in education earned after her children were grown. Throughout our lives she focused on storytelling, whether through reading the work of others, creative writing, or invoking the spontaneous creation of songs on long car rides. Her influence sparked within me a true appreciation of the importance of storytelling. Narrative brings meaning to life; truth is unfolded as we tell our stories, and we create perspective as our words, artwork, poetry, and song unfold.

When I became a clinician, the narrative approach felt "just right." I appreciated its foundation drawn from the philosophy of a post-modern approach to clinical practice (Caverhill, 2002). Within the therapeutic relationship, the use of narrative allows a space for the co-construction of reality between client and clinician, where events of the past are enacted to inform the present, and collaborative efforts are embarked upon to interpret meaning (Leighton, 2008). Content within narrative is empathic, boundaries are malleable, and the context within which a story is told is avoidant of hierarchy (Caverhill, 2002).

Yet, I never believed that I would find myself in the position of formulating my own tale of loss and healing. This is ironic, due to my history of specializing in grief and loss. However, I must be honest with myself, and therefore, with my audience: I fell into that trap that so many clinicians do: I thought my life would never be personally touched by death.

Perhaps much of it was ignorance, and having been blessed with a genetically healthy family, losing

grandparents to the illnesses and complications inherent in old age and being very sheltered from premature deaths by caring parents. Still, I believe that some of it was a defensive reaction: I needed to be immune to death to do my job, while also living with it very closely. I regarded death much as a colleague or scientific specimen to acknowledge and gain mastery over in order to be an effective clinician. As a professional I had familiarized myself with the bereavement literature of the giants in the field: Kenneth Doka's (1989) *disenfranchised grief*, Neimeyer, Burke, Mackay and van Dyke Stringer's (2010) *reconstruction of meaning*, William Worden's (2008) *four tasks of mourning*. In studying teens, I especially valued Hogan and DeSantis' (1992) *ongoing attachment studies*, where the authors expressed that for grieving adolescent siblings, death occurs within a context of continuing bonds between brother and sister. Despite the loss of a physical presence, teens in Hogan and DeSantis' (1992) research actively worked within a present framework to integrate grief by regretting, endeavoring to understand, catching up, reaffirming, influencing, and reuniting. I appreciated in my academic research and clinical practice that Hogan and DeSantis' model was applicable to more than just teenagers. So, I was enriched by many discussions and theories of death, and death was not an enemy: she was a permanent fixture in my life and work. I toiled alongside her eventuality, with the goal of comforting my surviving clients as best as possible. I believed, at the time, and still believe that this form of professional distancing is common and often necessary in order to be as attentive as possible to those who needed me. Finally, I think I was so steeped in the theory of loss that I never truly thought about my own *practice* of it. I was young, happy, and at the beginning of my career. Where would death fit into that?

It's true, many deaths are expected. We hold vigils over the bedsides of the old, the terminally ill, the young who tragically fall victim to horrible circumstances. And still other deaths are more sudden: they traumatize us with their shocking immediacy, without time to prepare for the event. I suppose my loss falls into the latter category.

From Caregiver to Patient

Contentedly married, I was five months pregnant with my first child when we received the devastating

diagnosis. Prior ultrasounds revealed a healthy, appropriately-developing and active baby. My husband and I visited my hometown of Toronto where we were privileged to have an early anatomy scan, hoping to find out more about our little one. We made small talk with the ultrasound technician, who jauntily waved her magic wand over my gooey belly, and produced images that she deemed were "cute." I felt my first ever experience of parental pride: my fetus was cute! Surely not every ultrasound could reveal that. Our child must be special indeed. When the exam was complete, without an inkling of worry on her face, the technician rose and told us she was going to show the doctor the images.

We waited, and waited, and waited. The night before I had told my husband, "I worry something's wrong with the baby." He dismissed my fears as typical Erica anxiety, and told me "you'll see the baby tomorrow and you'll see that everything is fine." Now, caged in this sterile diagnostic cube, with the blue of the exam room sheets creating shadows on the wall, I asked my husband: "Do you think there's something wrong? Or are we victims of the slow pace of the Canadian healthcare system?" My husband, ever practical and rational, assured me it was the latter. The technician popped in about an hour later and apologetically told us, "I'm so sorry for the wait! It won't be much longer." Much longer turned into another hour and a half. When the doctor finally arrived with a fresh-faced medical student in tow, I breathed a sigh of relief.

I was in no way prepared for the doctor's gentle disclosure. He had a soft Swedish lilt to his English and he gently placed his hand on my arm. "Your baby has a very serious birth defect. It is called Tracheal Atresia, or CHAOS, which stands for Congenital High Airway Obstruction Syndrome." He flicked on the computer by the exam table and an image of my baby's throat zoomed into view. The doctor pointed at the image as if it were so obvious, anybody could see the defect. "Here. You can clearly see here, he has no airway. Where his airway is supposed to be, the tissue is completely sealed. And here"- he flicked on another image: "do you see the diaphragm? It's upside down. The lungs are full of fluid, strangling the heart, and inverting the diagram. Do you see?" I nodded that I saw. But what was visible to me was only bright white lines against inky black, like those nighttime traffic photographs, where the cars are perceptible only as indistinguishable lines of colored headlight.

I felt the need to tell the doctor that I had worked in a fetal surgery center, and that I had a master's degree in bioethics. I wanted to tell him that I'd encountered CHAOS before but the truth was, even with my exposure to neonatology and birth defects, CHAOS was completely new to me. I clung to my rational, academic side, trying to form the words to ask the important questions. I wanted to know if my baby would live or die, what his life would look like if he didn't have the anatomy of an airway. But instead, I felt a shade of embarrassment when I asked, "is it a boy or a girl?", as if I hadn't heard what he had said and if my child was a boy or girl, he or she was a person whose light couldn't just be so easily extinguished. It was magical thinking on my part: that a gender, a name, an identity could ward off the evil eye. I recalled my parents' stories of Jewish lore, that the sick and dying were often renamed to fool the angel of death. It didn't make rational sense, but not much felt rational and I was looking for something tangible to cling to, other than the deadly diagnosis that was invisible to my eye.

The doctor flipped to another image. "Congratulations," he said. "It's a boy." Congratulations. Your son is dying inside you.

The day sped up as we shuttled to genetics to learn more about the diagnosis. Congenital High Airway Obstruction Syndrome (aptly nicknamed CHAOS), affects 1 in 50,000 births and there are very few survivors documented in the limited clinical research on the disorder. CHAOS, like other birth defects, occurs on a continuum and some babies have better outcomes if there is enough tissue to create an airway at birth. These more fortunate babies must still be delivered by a revolutionary form of C-section, the EXIT procedure, under high-risk conditions, spend several months in the neonatal intensive care unit, and, if they do not die of infection and are not cognitively impaired due to lack of oxygen to the brain, must spend life with a tracheotomy. The windpipe is reconstructed throughout childhood in many painful surgeries, but as of yet no child born with CHAOS has survived without a permanent "trach." We were told that our diagnosis was on the early side, and thus, all the more fatal. After embarking on an intensive route of assessment that included fetal MRIs, echos, ultrasounds, and genetic testing, we were told that while the diagnosis was a "fluke," our son's case was very severe and fetal or perinatal surgery was

not recommended. He was going to die, and our decision was, in a sense, one of those made with the assistance of palliative care teams for those who are on the other side of the womb: did we want our son to perish in-utero as his heart was forced into silence by ballooning, menacing lungs? Did we want to attempt birth with a likely result of a brain-dead child who would likely require the withdrawal of life support within months of his birth? Did we, unfathomably, prefer to terminate the pregnancy of a much-loved, and much-wanted, child? All of the plans we made for the birth, for the arrival of a healthy baby, disappeared. We phoned my parents, and I told them through tears: "The baby has a birth defect. It's called CHAOS." I relayed the details to my father when he came to pick us up after nearly twelve hours at the hospital. He asked, "Are you going to terminate the pregnancy?" I wanted to slap him in the face. He was reeling from shock, too. But this was my son. It wasn't "the pregnancy" and he wasn't something I could just end. Up until that day, I was prepared to have a healthy, living baby. It was a given. And then, suddenly, my son became a cluster of symptoms, a ticking time bomb. Something that I could choose to end.

Ultimately, our son, our forever adored first child, who we named Darby Joss, died shortly after his diagnosis. To say that we were devastated, heartbroken, and crushed, would be an understatement.

As a result of Darby's death, I was plunged into a newer, deeper, more intimate understanding of bereavement than ever before. I found that all of my years of expert experience amounted to very little. Having academic knowledge of bereavement, and even experience as a counselor and abiding with the dying and their survivors, did not prepare me in the least for my own grief. The pain was deep, isolating, and very physical. As I bore witness to my aching soul, I could recall counseling so many other grief-stricken parents: "It's normal to feel physical pain after a loss. Your body is exhausted. You have experienced the physical departure of someone you love. That loss is absolutely physical. And that emotional pain can be expressed as real, physical pain in your body." Yet, still I was so surprised by how very much my entire body hurt. The muscular aches and pains lasted for well over a month, and occasionally these 'grief aches' come back, almost two years after his death. My husband flitted in and out of our bedroom, sometimes holding me, sometimes sitting with me, telling me that I could take all the time

I needed, as if there were a finite amount of grief available to me, and I would naturally know when closure occurred. I stayed in bed and while two of our three dogs refused to come near me, our gentle, brindle rescue pit-bull mix curled up in bed beside me. He was seeking more than a warm spot on a comfortable duvet. He rested his great head on my shoulder and I wrapped my arms around his patient neck, sobbing into his greasy coat. He would sigh, ruffling his oversized lips and tickling my hair, withdraw to lick a few tears off my face, sigh again, and nuzzle closer.

Initially, in a haze of frustration and anguish, I turned on myself. I determined that I had never been a good therapist; I was naïve and couldn't have possibly helped those who walked the path before me. In the true fashion of cognitive triad (Beck, Rush, Shaw, & Emery, 1979), I felt hopeless, acted hopeless, and believed that I was. There were so many dark days.

Personal Reflections and Validations

As the initial grief evolved into longing, heartache, and an asking of deeper spiritual questions, I began to turn away from self-loathing to learn again. In hindsight I was able to see that some validations of theories of and responses to loss I had learned before my son's death held true. I have listed a few of these below, though with the forewarning that I am making some generalizations based on my own clinical practice and the specific nature of my prenatal loss. I cannot apply these conclusions across the board regarding grief and to do so would be ignorant and insensitive.

Peer support is invaluable. Early in my process of bereavement, I stumbled upon an online forum for women who have experienced a similar type of loss as I have. I believe that the community I found there was a key factor in my healing process. Therein, I encountered friends who reserved judgment about me, to whom I expressed my deepest, darkest, most honest contemplations about grief. They understood and supported me. On one occasion, wracked with guilt, I posted my "confession" that one night near the end of Darby's life, I felt him kick. There he was, swimming around in the womb, living and dying all at once. I hated the kick. I hated the imminence of all of it. I thought,

"Stupid baby." And then, I felt horrid, cursing my son in such a way, not tenderly appreciating our limited time together or receiving his kicks as a boon. I carried this self-disgust to the chat room, where I was sure that I'd be called a monster. But I was met with understanding. Kindness: "You are not alone. I hated the kicks too. Hated that my child was living even though he'd soon be dead." I was told, "You loved and love your son. The thoughts you had do not mean you didn't love him." They normalized my experience and reflected it back, advising that I wasn't alone in my symptoms of suffering. There were many tough days when I posted just asking for support, with tears clouding my vision. I was buoyed by outpourings of messages encouraging me with strength, compassion, and unlimited understanding. I felt true kinship with strangers, who truly "got it." My peer group provided me with a safe space and a language to explain my feelings to my husband. I told him about my "stupid baby" comment. He said "While Darby was inside you, he was a scuba diver with a lifeline to mommy. It was false. The kicks made him seem like he was healthy but it was you, for as long as you could, keeping him alive." I was grateful for his depth of understanding.

I grieved differently than my husband did. My husband was deeply saddened by my sadness. His was a more physically detached grief, as he had not carried our first child and experienced the union of life within oneself. Certainly, we both grieved over the destroyed potential of our little boy's life that would never grow before us, but my husband's bereavement was enhanced by feeling he was ill-equipped to comfort me. Having spoken with other mothers in my shoes, I can acknowledge that many (though once again, not all) of them have noticed the diversity of ways their husbands or partners grieve. Male partners became more task-oriented, and coped with the loss by resuming with the rituals and routines of life and work as powerful distractions. We bereaved mothers, on the other hand, tended to be physically and emotionally immobilized by our grief. Some of us found it hard to get out of bed, let alone go back to work immediately. My husband's brain appeared to process the grief in binary equation of zeroes and ones. There was cause and effect, past and present. It was efficient and effective to return to previous, consuming tasks and achieve results. My brain was holistic and like an old tree with many roots

tangled beneath the surface: what was the meaning of this loss, why did it happen, what were the implications on future pregnancies, and how could I recover while maintaining an appreciation for what I had lost?

There is a significant amount of guilt attached to healing. Preferring to return to work six weeks after our loss, I immersed myself in the tasks of being a professor: creating syllabi, attending committee meetings, and making time for students. Suffice it to say, Darby was a fixture at the forefront of all my thoughts in those early days, but there were times when I needed to move his memory or my grief aside in order to focus on issues that arose around other aspects of my life. This was very challenging. I felt that if I was not keeping a constant mental vigil over my son's life and death, I would somehow lose him, forget about him, or feel unfaithful to his memory. I silently apologized to him every time I looked away from his ultrasound picture on my wall to tend to an email. When my husband and I started talking about trying to conceive again, I felt I was betraying our angel boy. He warmed up my womb for 5 months. He could never be replaced. It took a significant amount of self-forgiveness and tenderness to move away from these angry and judgmental feelings. Most of my colleagues did not speak about my loss, with some exceptions. One day at a faculty meeting, where I situated myself near the back of the room, an older professor came and asked when the baby was due. I told her we'd lost the baby and she was silent for a moment and then said, "Well, I didn't know", got up, and moved away as if I were contagious. Whether her reaction was motivated by the triggering of her own intimately painful personal losses, a cultural tradition that encourages individuals avoid deeper discussion of death, or feeling ill-equipped to respond to my pain, I cannot say. But I stumbled to the refreshments table blinded by tears and embarrassment for feeling as though I had made her uncomfortable, frustrated that I had been so honest and wondering what I should have said instead. At that moment, another colleague, a male, came up to me and patted my hand. "I'm so glad to see you. I'm so glad you're here," was all he said, but somehow, it was exactly what I needed to hear. The return to work was challenging and the self-loathing I felt

was not helpful in my healing process. With time, I have also come to realize that nothing and no one could make me forget about my son and that moving forward does not mean moving away from him.

Loss can cause a reevaluation of close friendships and relationships in life. I was, and remain, surprised by who was helpful and who was not, and my loss forced a serious recalibration of my friendships and relationships. My cousin, all the way out in California, whom I hadn't spoken to in some time, emailed me every single day. She elicited my reactions and responses, and had a desire to understand. She took everything I gave her, and came back for more. She asked if she could help out with the practicals: "Have you signed up for a daycare waitlist, or a baby registry? Would you like me to take care of it?" She broached the taboo questions: "Are you looking forward to trying again? Is it a scary thought or a welcome one?" She helped me cope with the mundane: "I can't even imagine how difficult everything must feel right now. Small tasks must seem so unimportant and insurmountable. And leaving the house sounds like a minefield where you have no idea whether you'll see someone who makes you terribly upset because their pregnancy is a bitter, in-your-face reminder of the unfairness of it all." She spoke the unspeakable: "NOTHING you did caused this. I don't think anyone could go through something like this without having their faith severely tested. This isn't fair, and you and hubby are good, caring people who don't deserve this (not that anyone does), and the search for a reason 'why' simply leaves you with no answers. I hope you aren't hearing the 'everything happens for a reason' thing from people, that is something people say when they don't know what to say, but it just doesn't seem helpful or productive."

While I treasure those emails and the unlimited understanding extended my way, some of my best friends, who gently inquired at the beginning how I was doing, fell to the wayside and didn't pick up the phone or write back. Some were therapists themselves and had the same theoretical training as me. It was deeply painful, but I also believe it was painfully necessary to know who would be an advocate and a supporter during my time of need, and who only showed up in a superficial way.

Time does not heal, but it does help in some ways. It is very commonly asserted that time heals all wounds. Antiquated grief theory tells us that our sadness should be resolved. Grievers should experience closure of symptoms, and relocate the dead to their proper place that is incompatible with the world of the living. Today, thankfully, clinicians and academics know better. We understand that grief is a process and those of us coping with loss often seek continuing bonds with our departed loved ones, just as Hogan and DeSantis (1992) suggested. However, I have noticed that as time has marched on, my loss has transitioned from a raw, open, and bloody wound to developing a protective scab to a scar that is still visible for me, but less visible to others. The pain is more of a dull ache, though at times the scar tissue is opened anew (usually by a hurtful comment) and I bleed out and throb once again. But for the most part, with the passage of time, I was able to celebrate the 5-month pregnancy and lessons learned therein. I have reached for meaning, implications the death holds for my professional practice, and ways to memorialize Darby and explain his brief life and death to my son, Rhett, who came a little less than a year after the loss.

Implications for Professional Practice

My life and practice have been enriched by a new narrative. While I maintain my post as an assistant professor and now department chair of psychology, at the time of this writing I still carry a clinical license and over the past two years have provided therapy as a member of group practices and as an individual provider of pro-bono services to needy community members. Given the triad of roles I now serve as mother, wife, and academic, I maintain a very small caseload and am very selective regarding the types of cases I accept. Naturally, I'm still most drawn to death, dying, and bereavement though with a new perspective. I would hesitate to call myself a "wounded healer" because while Darby's death shook my foundations, I do not envision my scar tissue as an evident wound for all to see. I prefer the term "transformed healer": while I have now experienced loss, this loss has provided me with a deeper, richer perspective to approach patient narratives. I am transformed by my grief and believe I better understand the experience; however, my clinical practice techniques themselves have not

truly changed. Surprisingly, perhaps, I adhere to many of the maxims in clinical practice that I once followed as a personal-death-inexperienced provider. Below is a brief discussion of how my practice has remained virtually unchanged. Again, this is not meant to generalize to cases outside my own. For the purpose of my narrative, these observations constitute my own perception of reality:

Self-disclosure is still limited. I do not believe that my clients need to hear my story in order to perceive that I understand theirs. My eye contact, body language, probing, gentle questions, and reasoning may indicate to them that I have experienced a devastating loss, but I am still as careful as I always was to let client narratives form on their own. The questions I ask are informed, at times, by my own experience, but I very rarely tell clients of the loss I experienced. One time, I was hired by a woman who had been given a serious diagnosis late in her pregnancy. At 8 months' gestation, she told me: "Nobody could ever understand how I feel. Not my husband, not my mother. She said she knows how it feels because she had a miscarriage. It's not the same. I feel so alone." I had heard this many times from many patients. Still, my heart ached for her and I yearned to wrap her in my arms and say, "I get it. It happened to me too. I understand." I wanted to ask her how she felt when the baby kicked, and tell her I'd had moments of overpowering anger. I wanted to tell her I knew. And yet, my child did not have the same diagnosis. We did not have the same kinds of relationships with our families. We weren't equal members of an online peer support forum. To tell her that my story was equivalent to hers seemed to be a desire on my part to find a kindred spirit, as opposed to provide her with therapeutic assistance. I avoided telling her Darby's story, though I did tell her that I had lost a child and though I could not ever experience grief exactly in the same way she had, I could appreciate how it felt to feel so very isolated and misunderstood.

More than ever, I believe in disenfranchised grief (Doka, 1989), since the loss of a child in the second trimester is not readily acknowledged by society. Individuals struggle with language: was he a fetus? Symbolic of something more? How do we address him? Why did he have a name? And the solution is usually to avoid uncomfortable answers by never

speaking of Darby at all. Similarly, in clinical practice I now endeavor even further to name the grief my clients experience, whether over the suicide of an ex-boyfriend, the loss of a childhood pet, early miscarriage, or other less societally-sanctioned events of grief. I more strongly encourage narrative and the creation/validation of my client's lived reality: by abstaining from judgment and labeling grief, I find the individuals who sit across from my chair feel free to celebrate, memorialize, and give voice to their own stories of loss.

I still search for support group resources, and I still encourage marital counseling when appropriate. I appreciate the diversity of approaches to grief therapy that includes the collection and dispersion of a variety of resources, from peer support to additional reading and homework exercises. I did this before, with a constantly-updated list of files to refer to when clients required supplemental support. Now, however, I'm even more aware of how valuable these resources truly are.

As a supervisor, I reinforce the importance of eliciting narrative and the co-construction of reality with a patient. My core belief that storytelling is the stuff of life and healing has not changed. Neophyte clinicians who abide strictly by interventions that follow rigid homework, scheduled interventions, or approaches that rely solely on quantitative research methods are encouraged to explore the value of qualitative approaches to healing. Of course, there is tremendous value in evidence-based interventions and the research behind them. However, I encourage flexibility in my supervisees and a willingness to explore storytelling through methods that include poetry, dramatic reenactment and Gestalt empty chair techniques to enhance the logotherapeutic, meaning-making aspect of coping with loss. I have struggled with supervisees' desires to tell their own stories, to self-disclose and turn the session into a healing one for them alone. Working with a new social worker who was also a recovering addict, my supervisee once expressed frustration at how, in his work as an emergency room mental health clinician, the same addicts came in near-dead from overdoses and always said they'd go to rehab but would

return to their lives on the streets. My supervisee told me, "I think it's time to tell him my story." He felt that by self-disclosing, explaining how he got sober, he might provide inspiration and true motivation to change. I asked my supervisee to recount his story for me once more, though I'd heard it several times. As he recounted his narrative, I gently pointed out the circumstances of his recovery that might be challenging for his patients to appreciate: my supervisee was white, upper-class, well-educated. He had never been homeless. He had engaged in some very risky and self-destructive activities, but was faithful to the tenets of his twelve-step programs and had a good support network of sober friends. His reality and his struggle was a poignant narrative in itself, but I was unsure as to whether his decision to self-disclose was appropriate or would be well-received. I asked him: "how might a disenfranchised, chronically homeless patient feel about the inspiration factor of your story? You've told me that the repeat offenders, as you call them, are high school dropouts who make a good living selling drugs. They don't have family support the way you do. How might hearing your narrative elicit change from their end?" My supervisee considered this and we discussed post-modernism, differences in perspective, and whether self-disclosure was the right road to travel down. Together, we decided on a path of eliciting the life narratives from some of his clients who continually returned to the emergency room, exploring strengths, significant relationships, areas for problem-solving, and of course, recounts of grief and loss. It was our hope that asking for stories: life stories, death stories, and stories of addiction: this would be the connecting piece that, if nothing else, allowed my supervisee to experience a shift in how he conceived of his "repeat offenders": as real people with their own tales of love, loss, and hardship, that were so much more than abusers of the healthcare system. I can appreciate how this element of practice can be challenging for clinicians in managed care environments, where standards are dictated by evidence-based outcomes, time limitations, and paradigms that have not evolved to include an appreciation for the rich flow of unstructured narrative. This is an area of advocacy, and one that is deserving of further research, which we must continue to promote and encourage among new practitioners. Simply including the question, "Tell me your story" on an

intake form may open doors for creating meaning, connection, and better therapeutic outcomes.

To sum it all up, very little about my approach to clinical practice has been altered from when I first entered the field. This in itself validates that my approach was effective: I didn't need to change how I sat with the bereaved, observed their losses, and encouraged them to tell me more. My own loss only reaffirmed what I knew all along.

I do believe that, through my experience, I have become a deeper and more compassionate woman, professor, and therapist. I have promised Darby that his brief life will not have been for nothing. Truly, while his life and death have deeply enriched my own, the gift of his journey, and mine, was in the message that from the beginning, whether wounded or not, my calling to help the bereaved and observe the dying was the right path for me. Now, as an educator and administrator, too, I hope to transmit this knowledge and love of clinical practice to my students, regardless of their own personal experiences.

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