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Walking Through the Valley:  
Lessons Learned in the Shadow of Death

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ABSTRACT

On January 15, 1998 the authors were forever changed both as people and as professionals due to the unexpected death of our daughter. Although we tried to consult the established literature for some guidance during that time, we found very little information and most of what we did locate qualitatively characterized the loss of a child as a devastation from which parents could not experience resiliency. In contrast, what follows is a description of each of our experiences of loss and examples of how, despite being fundamentally changed, resiliency did ultimately ensue and many important lessons were learned.

KEY WORDS: therapist variables; professional development; stillbirth; bereavement

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Fully nine months pregnant, I had been told for nearly seven weeks that labor could begin “any day” and was as prepared as I could be to experience the birth of my first child. The only unknown variable, I thought, was the sex of my child. It seemed so romantic to wait for the surprise in the delivery room that we had previously chosen not to have the sonographer inform us of our baby’s sex.

*The calm before the storm.* My labor got off to a picture perfect start at 1:30 in the morning. I woke my then husband but told him to go back to sleep until it was time to go to the hospital. Clearly disoriented when I woke him, he actually was able to go back to sleep. Over the next few hours I faithfully charted the length of time between contractions and happily envisioned that the following night I would be getting up to feed my newborn. I entertained myself by fantasizing in detail every developmental milestone that would be forthcoming. I was about to give birth to a future president, Nobel Prize winner, unsung hero, or artist. But before all that, I would have the most beautiful, most loved infant ever. When the contractions were close enough together to merit going to the hospital it was, of course, a blizzard outside. That was the beginning of the end to my fantasized labor and delivery.

*Denial.* The road to the hospital was agonizing. As I waited for snow and ice to be removed from the car, I became incredibly cold. Actually, not cold. Freezing. I was fully clothed, heaped with blankets, and standing inside yet I still found myself shivering uncontrollably. A sense of urgency overwhelmed me and I silently pleaded for the car to become ready faster. The car bounced from pot-hole to snow drift the entire length of supposed road leading to the hospital. When I finally arrived the contractions were subsiding and the

chills were markedly improved. I assumed I must be succumbing to expectancy effects and was both amused and pleased that I was able to have such insight while in labor.

When the nurse was unable to find a heartbeat for my baby, she reassured me that the fetal monitor had been malfunctioning that day; an explanation that I accepted without question or second thought. The nurse called for a portable ultrasound and repeatedly apologized for the delay as I waited for an attending physician to be awoken from sleep. I reassured her that the delay was not a problem and waited patiently. Once the physician began examining my baby on the ultrasound I noticed that he rubbed his eyes frequently. I assumed that the glare of the ultrasound monitor was hard on his tired eyes and felt sorry for having awoken him.

*Reality.* I am sure the physician followed custom and immediately introduced himself, but I paid no attention. To me, he was just another hospital worker involved in getting me settled. He was not my physician. He was not the doctor with whom I had carefully designed the birth plan. To me, he was, essentially, transitional and of no consequence. Transitional doc turned out to be the person who would voice the most significant words of my life: “I’m sorry; your baby has died.” It was 5:30 a.m. and my daughter, Samantha Taylor Dittloff, had silently passed.

*Sur-reality.* A flurry of emotions whirled around me in the room, but I seemed to be standing still in them. Just as quickly as the flurry began, it stopped. To everyone’s surprise, the telephone in my hospital room was out of service and my then husband had to call family and friends from a public phone in the hallway to notify them of our unexpected loss. He left. The transitional doc left. The nurses left. It was 5:35 a.m. I was alone. As I waited in solitary I tried to solve the impossible question of “why?!” and determine the meaning of my life. I had no profound insights. No deep thoughts. No solace. Instead, I had an immediate personal

understanding of suicide. Remission of such an intolerable level of pain was unfathomable. I actually found myself stunned that the medical staff had left me in privacy for so long with so many potentially self-destructive resources available. But as I looked at all the ways in which I could cease to exist I realized that acting on any of those thoughts would ultimately invalidate my daughter. If I was not honoring her memory, it would be as if she had never existed. With that realization, a mother was born. A short time later the attending physician arrived, ordered innumerable tests, and reluctantly alerted me that I was at heightened risk to die during my daughter's delivery. I could not have cared any less. Six hours later, in a delivery that probably appeared superficially typical, Samantha arrived into the world. But when her first cry should have sounded, only deafening silence emerged. Now the medical staff also began referring to me as a mother. However, the state I lived in did not consider me a mother. From their position, I could not be a mother because I did not have a child. Birth certificates were issued only for live births and without a birth certificate there could be no certificate of death. As a result, in the eyes of the state, not only was I not a mother but, even worse, my child never existed.

#### Mother's Lessons Learned

*Think carefully before questioning beliefs.* The belief that I was a mother afforded me with safety, but this crucial belief was not confirmed by the state. Thankfully, no one pointed that out to me at the time. What I learned is that it is important for me to understand the function a belief serves for a client. I try to never cavalierly pursue defeating a seemingly distorted belief. A belief that provides hope when it is needed, or enhances the subjective sense of well-being, is sometimes best left intact, at least temporarily, due to its potential utility in promoting long-term resiliency.

Loss is ongoing. Although Samantha died that morning, my desire for a future including her did not die. In fact, it still has not. I know that it is impossible. No medical miracles can revive an infant buried for 10 years. I have no delusions on this point, but I do still envision what might have been. While pregnant, I did not know whether my baby was a boy or a girl. As a result, my fantasized future was void of certain details. Over time, those details automatically continued to fill in. For example, at some point after Samantha died I learned that during prenatal ovary development the germinal cells that mature into eggs are already formed. Not knowing that fact, or that the baby I was carrying was a girl, I had not previously realized that the potential of future grandchildren had existed before my daughter's death. In learning that, a new loss was realized. Other moments of loss are more mundane, but no less significant to me.

Acute pain may be recurrent. After the birth of my second child, Alexandra ("Ali"), we knew that we would someday have to tell her about her "big" sister. In hopes of making this eventual revelation less shocking to her, we kept a photo book of Samantha out where Ali's toddler hands could reach it and we spoke of her sister to her. I do not think Ali can identify a time when she did not know that she had a sister who died. However, knowing and understanding are very different.

When Ali was nearly four she had a period of four months in which several of her favorite sources of affection in her life died very suddenly: first, the family dog, then her maternal grandmother, and finally the family cat. She quickly grew to have her own personal understanding of what death meant. The loss of her sister was so central to Ali's worldview at that time that she assumed every person she met was aware of Samantha. Even at four though, she was able to quickly learn that not everyone was approachable to discussing death with her and she consistently felt people out before bringing up her sister to them. As her mommy, the

fixer of all things, I desperately wanted to fix her pain and answer all of her questions. Of course I could not, and Ali learned that mommy is not omnipotent and could not guarantee her safety. This insight caused us both pain. As a result of both my learning and watching Ali learn, I am now more attentive to the importance of remembering. I am careful to reference the deceased by name, to show my client that *I* remember; that their loss is important to me. In remembering I also hope to convey approachability so that my client will alert me to acute feelings of loss that may surface at both unexpected and anticipated moments and not feel as though they need to protect me from their pain.

*Avoid social comparison.* While pregnant with my second child, I stumbled upon an online email support network for people experiencing a subsequent pregnancy following loss. One otherwise uneventful day, the emails erupted with highly charged emotions as heated exchanges argued as to what type of loss was “most” painful. Passionate emails suggested that miscarriage was the most painful loss since the parents never saw the child. Equally passionate replies said that stillbirth was the worst because a fully formed and delivered infant was lost. Still others considered parents who experienced miscarriage or stillbirth “lucky” because the parents did not have to watch painful, ultimately useless, medical procedures inflicted on their dying child. From this I learned that attempting to hierarchically arrange pain is useless. Pain is entirely subjective. Nothing good can come from accusations that some pain is more deserving of attention than others. In my view, people do not typically seek my professional assistance unless they are in pain. For me to determine that an individual’s pain is not bad enough is to deny their subjective experience of life. The person engaged in an existential search for meaning is as worthy a client as any; all pain is worthy of efforts at providing relief.

Defining success. I now understand that some things *never* get better. Full recovery is not always possible, or even desired. While I continue to use my objective measures to track progress, I now do a better job of incorporating client values and preferences. In working with a person who is depressed and has a schizotypal personality, for example, I am better able to appreciate the person's desire to be less depressed while not desiring any attempts at fostering "recovery" from their schizotypal personality. I no longer label people as bad/defensive/reluctant clients simply because they disagree with my recommendation that they address the personality disorder. I am better able to hear my clients when they are trying, generally subtly and politely, to tell me that they have no intention of doing the technique I have suggested. I work harder *with* my client and focus less on providing *to* my client. The lack of any quantitative provision that includes client priorities or values in outcome tracking represents an unfortunate oversight and a quantitative challenge that researchers must consider carefully.

Phenomenology versus reality. When I reflect on my personal experience, the importance of my phenomenological perspective is clear. Clearly, actual facts were initially comparatively less influential. When I noticed, for example, that transitional doc was excessively rubbing his eyes it never occurred to me that he was struggling with how to tell me that my child had died. In that moment the truth, to me, was that we were making the requisite benign delivery preparations. My truth was a far distance from the objective reality. As a result, I strive to understand the phenomenological experience of my client and defer judgment as to whether their behavior is rational until I more fully appreciate their very personal perspective.

I am always a psychologist. As I grew into a professional identity, I slowly became accustomed to being viewed as a psychologist wherever I go. But I am also still me wherever I go and this can create confusion. Perhaps the best illustration of this is the occasional hair cut.

The loss of my daughter changed even this routine aspect of my life. As is customary, while I sit in the chair I am asked, “do you have children?” I have given this question a lot of thought over the years. If I say I have two children they will ask the ages of my children and become uncomfortable when I tell them that one is deceased. But to take the easier path of saying I have one child makes me feel like a bad mother to Samantha. Consequently, the answer I use is some variation on acknowledging that I have two daughters but my first child is deceased. The other apparently requisite question is, “what do you do for a living?” As my personal experience and professional role merge together for the inquisitor, discomfort frequently emerges. I have heard a range of responses, but unfortunately an expectation is often conveyed by the inquisitor that because I am a psychologist I must be above emotional pain. I wish to ask them if they also consider physicians to be immune to illness or whether they consider appendicitis and resultant appendectomy to be less painful to a physician patient. Frequent exposure allows me not to react to such comments but they also cause me to be mindful of the continuing stigma attached to emotional distress. I strive to be a better citizen psychologist in combating such stigmas.

#### Father’s Lessons Learned

The three days immediately after Samantha’s death remain a blur and, in fact, much of the year following her death still remains sketchy. I mostly remember what occurred during those three days, but not in a linear or chronological order. Instead, those three days blend together into one long, surreal day. In some ways, Samantha has become my greatest teacher about life...and about therapy.

*Changes in personal philosophy.* Samantha’s death rendered me vulnerable for what seemed to be the first time in my life and challenged the very foundation of my personal philosophy. I was powerless to stop her death and yet I had always believed that I was in control

of my life and what happened in it. I began questioning whether I had been wrong about the rules governing life and, if so, for how long? I realized that if I did not perceive reality accurately I could not trust myself to draw the right conclusions in the future. The only thing that seemed certain to me was what it meant to be powerless and without control. This frightened me and it took time before I was able to feel as though my personal philosophy was still meaningful and that Samantha's death was an aberration. Samantha is, and will always be, my daughter and a part of my life. Her death is also a part of who I am, but I recognize that exclusively defining my life around her loss is not what Samantha would want of me. I also have learned that no one, no matter how strong or powerful, is exempt from the pitfalls of life. Power is merely an illusion; personal control a mirage.

*Remembrance brings comfort.* Over the years, I have paid tribute to Samantha in a variety of ways and I find that talking about her brings me comfort. I wore a pearl earring and an angel pin on my shirt for five years after her death. We both kept a picture of Samantha in our offices and wear a baby ring on necklaces identical to one Samantha was buried wearing. Clients have told me that they like my loyal remembrance of Samantha and convey the sense that they thought I would also be loyal and devoted in our work together, even if at times it did not go well.

*Blame is tricky.* Because the cause of Samantha's death was never determined, assigning blame was not easy. We found it much easier to blame ourselves than one another and, in discussing that, we learned that by accepting blame we were attempting to create a perception of some control over the situation. Doing so seemed to be a futile effort at making her death easier to accept and lessen fear in subsequent pregnancy. I draw from this experience and find that I better understand why clients may irrationally blame themselves for traumas inflicted on them.

While I do not pretend to know what meaning a survivor should derive from his/her experience, I can help survivors create their own narrative to make sense of what occurred.

Anger. A few years after Samantha's death I realized I was angry with her. I began to wonder if she had fought hard enough to live and was angry that she had ruined my plans to be her father. Yet, I also felt a great deal of guilt for feeling angry. I learned how difficult it is to express anger and guilt directed at deceased loved one and, at times, I overtly give grieving clients permission to be angry at their deceased loved one as a facilitative avenue in addressing their myriad emotions of loss.

Grief. Grieving is not a linear process. One is never certain when or where something will trigger the grieving process. For example, one night a favorite movie of mine, "To Kill a Mockingbird" was on television. I began to cry, recalling that I had planned to read this book to Samantha. I consequently encourage clients to experience feelings as they emerge from unexpected triggers and reassure them that grieving is not a nice, neat package with a six month duration as the diagnostic criteria of the DSM-IV would have you believe. For me, the entire first year was awful. I never noticed so many babies in my life; everywhere I went it seemed like there was a baby. It seemed that the year was filled with some type of anniversary of an experience related to Samantha.

Fear. After Samantha's death I was not willing to go through another pregnancy. I was certain that I could not survive the loss of another child. With the cause of Samantha's death undetermined it seemed likely it to occur again no matter how much the physicians told me this was not true. I was acutely aware of how powerless another pregnancy would make me feel, but ultimately I changed my mind because I realized I had never allowed fear to make decisions for me. My fear did not end though. After our second child was conceived I developed an anxiety

disorder, manifested in alternate bouts of crying and temper tantrums. Needless to say, my empathy for clients with anxiety disorders deepened considerably. I found myself more patient and understanding of the frustration felt by clients who were working hard with few results. I began to more specifically focus on the lack of trust in one's self and the impact of fear on decision making in persons with anxiety disorders.

*The importance of social support.* After Samantha's death was determined, we were left alone in the delivery room for several hours as the medical staff waited for a nurse with bereavement training to arrive. While most of the staff had likely experienced personal or professional loss, clearly no one knew quite what to say to us. Unfortunately, the helplessness in such moments often results in people staying away from the bereaved. I have learned that even if I do not know what to say, simply being with clients in a moment of need is important. I also rededicated myself to more carefully listening to clients. My experiences in providing support to, and receiving support from, my then wife also led me to keep a closer eye on the listening skills of couples in treatment. By recognizing the importance of talking and setting time aside to do so no matter how tired, we were able to use each other extensively.

*Boundaries.* When I returned to work, most of my clients had already learned of my daughter's death. Most were compassionate and supportive, but not all. Indeed, several let me know that they found Samantha's death to be an inconvenience and a source of irritation due to the need to reschedule sessions. Some were even quite hostile in sharing these thoughts and feelings. I learned that I had to set boundaries with both types of clients. For the compassionate and supportive clients I learned that it was important to help them appreciate that they, not me, were still the focus of our sessions together. For those that were less than supportive, I learned to

tell them that they hurt my feelings and that hostile expressions were unacceptable if we were to continue working together.

### Conclusion

Both authors describe a struggle to reestablish a sense of well-being, despite experiencing a range of distress, and note being changed both as people and as professionals. Indeed, several commonalities in the reported experiences are evident. Both authors note that positive social support can be potentially facilitative of resiliency, contrasting it to potentially damaging negative social support, and encourage clinicians to assess for the quality of social support in clients' lives. Further, both note that pain or grief tends to resurge over time and encourage those working with bereaved individuals to create an approachable demeanor and strive to carefully remember and acknowledge the individual's loss.

Although the same devastating event was shared, it is clear that our experience of loss and the lessons learned were distinct. Some of the differences in experience may be due to obvious gender and parental role differences, but others (e.g., change in personal philosophy, suicidal ideation, etc.) are of less clear etiology. The authors encourage clinicians to treat their clients as individuals within a context and cautioned not to presume to fully understand the nature of the client's experience based on personal experiences or aggregate data sets.