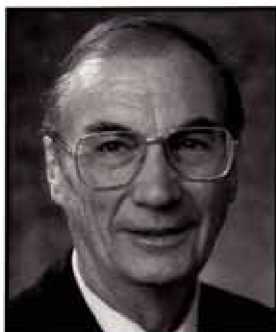
Dangerous words



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EACH ONE OF US, when we use a word, knows just what we mean by it. Unfortunately, those who read it also think they know just what we mean by it. Often they are wrong. In this paper I shall illustrate this point by reference to some words about bereavement that are commonly misinterpreted or misused. My intention is not to stop us from using these dangerous words, for most of them are very useful, but to attach some warning flags that will wave in our heads each time we meet or use the words in question, and warn us to watch out for misunderstandings.

The first, and probably most useful, word that comes to mind when we think of bereavement is **grief**. We all think we know what it means, yet there is very little agreement among experts regarding its definition. Some people use the word grief loosely to imply all of the distressing emotions that follow bereavement: sadness, anxiety, anger, guilt and much else. The problem with this is that it does not differentiate grief from the emotional reactions to other distressing events. Other people include the psychological processes through which people are supposed to pass over time, such as the so-called phases of grief. The problem here is the wide variety of opinions about these processes and the evidence that many do not follow a neat path through them.

Perhaps the most intuitive meaning, and the one that best distinguishes grief from other reactions, is also the simplest – grief is the intense and painful pining for and preoccupation with somebody or something, now lost, to whom or which one was attached. It is distinguished from 'separation distress' by the intensity and duration that results from permanent loss.

Only if we can agree on the meaning of grief will our attempts to measure it by questionnaires and other means begin to make sense. At the present time we need to be particularly careful, when interpreting the results of such research, to examine just what is being included.

Grief is often used interchangeably with another dangerous word,

'When I use a word,' said Humpty Dumpty…'it means just what I choose it to mean – neither more nor less…The question is, which is to be master – that's all.' (Carroll 1872)

mourning. This usage follows Freud's example in his famous paper, 'Mourning and melancholia' (1917). Freud's original paper was written in German ('Trauer und melancholie') and later translated by Joan Riviere. 'Trauer' is ambiguous, being used for both grief and its formal expression, thus 'trauer tragen' means 'mourning dress'. Other psychoanalysts have used the term mourning for the processes in which states of grief are eventually attenuated as the person recognises and adapts to loss' (Horowitz 1980). On the other hand, most social scientists reserve the term mourning for the public display of grief, which may have little to do with the underlying emotion (Gorer 1965, Rosenblatt *et al* 1976).

From time to time grief may take atypical forms that give rise to great suffering and disturbance of those functions that make life worth living. While these have all the characteristics of **mental disorder**, there has been much resistance to applying this term to bereaved people. Because mental disorder is equated in the public mind with madness, or psychosis, and the consequent restriction of liberties and other negative attributions that accompany madness, it is assumed to stigmatise and disempower people. In fact most mental disorders are not psychoses and the appropriate use of psychiatric diagnosis can reassure people that they are not 'mad' and empower them to get the help they need (Dyregrov 2005).

There is little agreement regarding the words to be used for the disorders of grief. **Pathological grief, complicated grief, abnormal grief** and **morbid grief** have all been used to designate more or less the same thing. They all recognise the fact that grief sometimes takes forms that give rise to lasting distress and inability to function in the ways that make life worthwhile. It is the inconsistency and lack of agreement about just what is meant that has deterred the authors of the influential *Diagnostic Statistical Manual (DSM)* from recognising any of these terms (American Medical Association, 1994).

ABSTRACT

Some of the words and terms in common usage following bereavement are ambiguous or likely to be misunderstood. Words that need special caution include 'grief', 'mourning', 'meaning-making', 'dependent', 'empathy', and various words used to describe the problems to which grief can give rise. The risk of misunderstanding is no reason to stop using these terms; problems can be avoided if we take care and clarify our usage when necessary.

As a result, people suffering from these conditions have been deprived of the privileges of medical treatment and the compensation that they may deserve when others are responsible for their loss. Recent efforts to find consensus are currently close to fulfilment and it is hoped that the most frequent complication of grief, **prolonged grief disorder**, closely defined so as to exclude those abnormal or atypical forms of grief that do not give rise to lasting suffering and impairment, will be included in the next edition of the *DSM*.

It is widely and incorrectly assumed that mental abnormalities are synonymous with mental illness, but this is not the case

The other terms should probably be dropped or retained only for forms of grief that do not meet accepted criteria. A recent edition of *Omega* discusses these issues in more depth (Parkes 2006a; Brady 2007). The psychiatric problems of major depression, anxiety disorders, post-traumatic stress disorder and other psychiatric diagnoses that may be triggered by bereavement, should not be referred to as complicated grief.

A particular problem arises with the term **abnormal grief**. It is widely and incorrectly assumed that mental abnormalities are synonymous with mental illness, but this is not the case. Indeed superior intelligence or other exceptional virtues are statistically abnormal but are not regarded as undesirable, let alone pathological. Not only are many of the abnormal or atypical forms of grief compatible with a satisfactory and well-functioning life, but some of them may even benefit society. A mother may inhibit her own grief at the loss of her spouse, in order to care for a new-born child. Her grief may then be abnormally delayed, but should not be regarded as pathological. Similarly, man-made deaths sometimes give rise to exceptionally intense but appropriate anger, which may itself lead to the righting of wrongs. Complaints against medical staff who cared for a dying person may be quite justified and should not be routinely dismissed as 'irrational'. Only if anger is unrestrained, inappropriate and likely to cause further injustice, suffering and/or cycles of violence can it be regarded as pathological.

Another word that is commonly used after bereavement is **trauma**. This term is often applied loosely to any distressing event, some reserve it for situations of danger or threat to life, while others see it as any situation that challenges our ability to cope. Behind each of these viewpoints there is a theory trying to get out. Thus people who see trauma as caused by emotions will tend to use the first definition, those who explain it by stress theory the second, and the third is preferred by proponents of coping theory. Many of these types and theories of trauma can usefully be applied to bereavement but it is wisest not to take theory for granted, but to reserve the term 'traumatic bereavement' for those bereavements that empirical studies have shown to be most likely to give rise to problems and the need for help, ie losses that are both unexpected and untimely, deaths by violence or mutilating illness, deaths by human agency, multiple deaths and disasters (Stroebe, Schut 2002).

It is not only words that confuse; non-verbal communication can also mislead us. Thus, we usually recognise emotions, and the assumptions that underlie them, by **empathy**. Karl Rogers (1961) identified empathy as one of the most important counselling skills, the means by which we get inside the head of our clients and see the world from their point of view. This is, indeed, an important thing to do, but it carries with it the danger that we may then become blind to our client's misperceptions of the world. Rogers was aware of that danger and warns against too close an identification with the client, but this advice is often forgotten. My recent studies show how frequently the problems that follow bereavement are rooted in misperceptions of ourselves and each other (Parkes 2006b). For example, the widow who sees her late husband as the tower of strength who protected her from the dangers of the world may cause us, through empathy, to accept her view of herself as a helpless, child-like person, who needs our protection. From then on our empathy will be dangerous to the client and to ourselves, perpetuating the problem of dependency. For such a person it is not our empathic sympathy that will help them, but our respect for their potential value and strength.

John Bowlby hated the word, **dependent**, mainly because it is so often used in a pejorative sense. In a society in which 'love' is a virtue, 'dependency' is a vice (1969). Yet both are aspects of attachment. 'You mustn't be dependent' we say, as if those who trust others more than they trust themselves had any option. Indeed, by rejecting the clinger we make them more insecure and they then experience the need to cling all the harder. Alternative terms such as 'reliance' are less likely to be seen as judgemental.

Many now see the main function of bereavement support as being to help people to find new meaning in their lives (Neimeyer 2001). Indeed there is something very appealing about the idea that, out of the ruins of bereavement, new meanings can emerge. The problem with **meaning-making** is that, like the word **stress**, it is so comprehensive a term that it can mean anything.

The brain is a machine for finding meaning. Each new sensation arriving in the brain is matched with memories of previous sensations to enable us to identify and attach meaning to them, thus they become perceptions and assumptions. Throughout our lives we are adding to our library of memories, expanding our assumptive world and increasing our repertoire of solutions to problems. When, as after a bereavement, we are faced with a large gap between the world that we had taken for granted (our assumptive world) and the world that now is, we are forced to review and revise those assumptions, to undertake a psycho-social transition (Parkes 1993). In other words, we find new meanings in our lives. We will do this whether we get help or not, for humans are meaning-making animals.

Viewed in this way, meaning-making cannot be an end in itself. Our problem as helpers is to ensure that the meanings that people now find are appropriate, and rewarding to them and their families. Unrewarding meanings include paranoid ideas that others must be punished for their suffering; that a dead child is more important than those who survive; or that grief is a perpetual duty to the dead. On the other hand rewarding meanings include

acceptance of death as a necessary aspect of life, and recognition of and willingness to engage with the sufferings of others. These meanings transcend the littleness of 'I' and can be seen as spiritual meanings.

One type of meaning is found by **continuing bonds** to the dead. This may be constructive if it enables people to enjoy and make use of the memories of their times together, but it can also be problematic if, for instance, they see it as their sacred duty to grieve forever as a tribute to a dead partner or child.

We must beware of over-emphasising meaning making. It may well be true that some people have the capacity to achieve great things in the face of adversity, to discover meanings that enrich their lives and those of others. But we disappoint ourselves and undermine our clients if we expect too much of them. For many it is sufficient to survive, and to be reasonably content with the restrictions of a world that is shrinking as their brains and bodies grow older. Likewise the terms **closure** and **resolution** are unhelpful if we expect the bereaved to forget the past and start again. 'The future is an illusion and the present too near at hand to be clearly understood, *only the past is real* and its reality increases as we and the world grow older' (Jackson, 1948).

Words are the symbols we use to communicate meaning. They are useful only if the meaning they convey is shared between individuals. Much of the time minor differences, shades of meaning, are of little importance; indeed those who agonise about them are accused of pedantry. We even get away with incorrect usage, such as using the word 'bereavement' to mean 'grief', when both parties understand what is intended. Problems only arise when sloppy or ambiguous language leads to misunderstandings or failure to communicate important issues. It is for this reason that we need to be on our guard.

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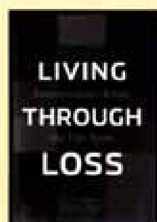
BOOK REVIEW

Living Through Loss

Interventions Across the Life Span

NR Hooyman, BJ Kramer



New York: Columbia University Press
2006
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Nancy Hooyman and Betty Kramer, two professors of social work at the Universities of Washington and Wisconsin respectively, have produced a well-researched, comprehensive and carefully crafted text. This text is the best single-source reference on a range of losses across the life span that I have had the pleasure to read in some time.

Divided into 14 chapters the book opens with an exploration of theoretical perspectives on grief and an excellent chapter on resiliency and meaning-making. Taking a life-span approach the book then has a chapter on grief and loss in childhood, adolescence, young adults, middle adulthood, midlife adults and finally older adults. Following each of these developmental periods, a chapter comprehensively addresses appropriate evidence-based interventions. I particularly appreciated their reference to individual, family, group and community-level interventions.

Each chapter is characterised by a comprehensive synthesis of current theory, empirical research and clinical practice. The authors also sensitively interweave the professional and the personal through appropriate reference to their personal lives.

The final chapter on professional self-awareness and self-care is an excellent contribution that explores the gifts and challenges of working with the bereaved. The chapter includes a useful personal assessment of self-care strategies and provides a range of concrete self-care strategies.

Although written for social work professionals this volume would make a very useful text for both the experienced practitioner and the beginning student of the field. This text takes a broad view of grief and loss and represents a major achievement and would make a valuable additional to a professional library.

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