An antidote to the pathologising of grief: applying the Power Threat Meaning Framework.

Abstract

Emerging theories of grief over the last 30 years have represented a shift from the healing of pathology to a focus on the adaptation to loss. Recently, however, there has been an alarming resurgence for a medicalised model of grief, most saliently evident in the removal of the bereavement exclusion from the diagnosis of Major Depressive Disorder in the DSM-V (APA, 2013) and the inclusion of Prolonged Grief Disorder in the DSM-V-TR (APA, 2022). These have predictably opened up opportunities for the pursuit of pharmacological treatment including anti-depressants and medication usually offered for recovery from alcohol and drug addiction. A pathologising approach to grief can have a significant and detrimental impact on individuals and compromises the core humanistic values that underpin my professional identity as a Counselling Psychologist. I propose that we need a radically different lens and The Power Threat Meaning Framework (PTMF), an alternative to psychiatric diagnosis developed by psychologists in the UK, offers us such an opportunity. Consideration is given to how the PTMF may be applied to grief therapy where it can embrace the uniqueness of grief responses and reframe it as an entirely understandable response to trauma and loss.

The way we experience grief following a bereavement is a unique expression of many factors including the personal significance of spirituality, the nature of the relationship, the context of the death, our previous experience with trauma and loss, the coping techniques we tend to favour and our cultural norms that we have internalised. With this vast potential for diversity in our grief responses, it seems surprising that the inclination to delineate between 'normal' and 'pathological' grief persists.

The desire to pathologise grief is not a new one. Freud's (1917) early grief theorising on mourning and melancholia, forming the basis of Western social norms of grieving, introduced the concepts of pathological prolonged attachment and the need to 'work through' grief to reach detachment. Stage theories label those who do not experience emotions in a specific time period as experiencing 'abnormal' bereavement responses (Bowlby & Parkes, 1970; Kubler-Ross, 1969). Alternative theories emerging in the last 30 years offered hope with a shift from the healing of pathology to a focus on the adaptation to loss: The Dual Process Model (Stroebe & Schut, 2001) where adaptive coping is derived from regularly shifting between loss-oriented coping and restoration-oriented coping; Meaning Reconstruction (Gillies & Neimeyer, 2006) where meaning-making efforts are thought to rebuild shattered belief systems; and Continuing Bonds (Klass, Silverman & Nickman, 1996) where maintaining a bond with the deceased is viewed as an adaptive response to grief. However, the increasingly dominant pathologising discourse in contemporary Western society (Granek, 2013, Wada, 2022) was evident in the campaigns to categorise Complicated Grief (CG; Shear et al, 2005; Shear et al, 2007; Shear et al, 2011) and Prolonged Grief Disorder (PGD; Prigerson et al, 2008, Prigerson et al 2021).

This resurgence for a medicalised model of grief initially gathered pace with arguably one of the most controversial decisions of the American Psychiatric Association (APA); the removal of the bereavement exclusion from the diagnosis of Major Depressive Disorder in the DSM-

V (APA, 2013). This reduced the time between bereavement and potential anti-depressant treatment down from 2 months to immediately following a loss. Concerns have been raised that the inclusion of new disorders, or the widening of boundaries of current diagnoses, reflects corporate interests. Despite the APA mandating financial disclosure statements for all panel members of the DSM-V in an effort to reduce financial conflicts of interest, 69% of DSM-V task force members still reported to have ties to the pharmaceutical industry (Cosgrove & Krimsky, 2012).

More recently, Prigerson and colleagues were successful in their campaign to include PGD in the DSM-V-TR in 2022. PGD is diagnosed if a grieving individual has been bereaved for at least a year and has experienced at least three of the following symptoms every day for at least a month: identity disruption, sense of disbelief, avoidance of reminders, intense emotional pain, difficulty with reintegration, numbness, feeling life is meaningless and intense loneliness. (American Psychiatric Association, 2022)

The inclusion of PGD in the DSM-V-TR has predictably opened up opportunities for the pursuit of pharmacological treatment, despite historical medical trials revealing little effect on the reduction of grief symptoms. For example, Paroxetine and Nortripyline (medicine usually prescribed for depression) had no significant effect on PGD symptoms (Zygmont et al, 1998; Reynolds et al, 1999) and whilst selective serotonin reuptake inhibitors (SSRIs) studies demonstrated moderate effectiveness, the results were compromised by poor scientific rigour and high rates of comorbid mental health disorders (Bui et al, 2012).

Based on an association of PGD with neurobiological correlates of reward and addiction, Prigerson and colleagues have proposed a model of prolonged grief as an addiction disorder (Gang et al, 2021). This addiction model of PGD positions the deceased person as the rewarding stimulus for whom the bereaved person yearns where each time the grieving

individual thinks about their loved one, they are perceived to be 'rewarded' neurobiologically. Gang et al (2021) have initiated a drug trial researching the effectiveness of Naltrexone, an opioid antagonist usually prescribed for alcohol or drug dependency, in treating PGD symptoms. Naltrexone inhibits the release of dopamine in the reward pathway which has also been found to reduce feelings of connection to one's closest others, social bonding (Inagaki et al, 2016) and cravings (Hendershot et al, 2017).

The concept of intentionally reducing one's ability to connect socially when grieving appears to be wildly counterintuitive when loneliness and isolation are very common experiences (Poxon, 2023, Stroebe, Stroebe & Abakoumkin, 2005, van der Heuwen et al, 2010). Social connection has been found to be at the very core of adjusting to bereavement where disregarding and interfering with this capacity risks 'widespread detrimental effects' on grievers (Thieleman et al, 2022) and could disproportionately affect marginalized populations who tend to rely more on informal support (Wada, 2022). Indeed, the relationship with the deceased and maintaining bonds is an 'exceedingly important focus' for grief therapy (Malkinson et al, 2006) and research has revealed continuing bonds with the deceased can be both adaptive and beneficial (Boerner & Heckhausen, 2003; Klass, Silverman & Nickman, 1996).

A pathologising approach to grief has been found to have a significant and detrimental impact on individuals as it turns the gaze of the mourner inward towards what is wrong with them for not moving on, instead of turning the gaze outward to the social norms and injustices (Granek, 2014). Social rules for grieving in Western society are predominantly implicit and imbued with a great amount of power in their ability to determine 'legitimacy' to the grief response (Harris, 2009). This 'legitimacy' is perpetuated in the dissemination of unsupported assumptions about grief in medical training manuals read by those who frequently support patients coping with loss. A systematic review of psychiatric nursing textbooks revealed 87%

of texts reported that grief follows predictable stages, 65% reported that there is a specific timeline for when grieving will occur and that a lack of expression of negative emotions indicates pathology (Holman et al, 2010). An alternative non-pathologising approach to grief is therefore sought.

An alternative lens

The Power Threat Meaning Framework (PTMF; Boyle & Johnstone, 2020) offers such an alternative to psychiatric diagnosis. In contrast to the delineation of 'normal' and 'abnormal' grief, the PTMF frames prolonged grief disorder symptoms as 'understandable responses to very adverse environments' where these responses would 'serve protective functions and demonstrate human capacity for meaning making and agency' (Boyle & Johnstone, 2020). From this position working therapeutically with clients presenting with PGD symptoms, I can recognise the client as unique, prioritise the client's subjective experience of grief, recognise the potential for post-traumatic growth and understand the client as a socially and relationally embedded individual (Cooper, 2009).

What is the PTMF and how does it apply to grief?

The PTMF was developed by a group of psychologists and service users in the UK who shared ambitious objectives to replace the psychiatric diagnostic system with a trauma-informed framework that places social justice at the forefront. It strives for a shift from the assumption of chemical imbalance where we ask 'What is wrong with you?' to an assumption of power imbalance where we ask 'What's happened to you?' (Boyle & Johnstone, 2020). The PTMF is based on the assumptions that emotional distress is understandable when viewed in the context of an individual's relationships and life events. The meaning we make from what happens to us shapes our experience of distress and new hopeful narratives can be created to find ways forward. Approaching PGD through the lens of the PTMF can be

understood by exploring the interplay between three main themes: the *power* that is operating on our lives, the *threats* that this poses and the nature of our understandable threat responses and the *meaning* we make of these experiences through the development of personal narratives.

Those who meet the criteria for a PGD diagnosis are more likely to have an anxious ambivalent attachment style, lower education levels or have experienced the loss of a child or multiple bereavements. (Prigerson et al, 2008) These reveal the imposition of power and threats, in the form of marginalisation, neglect or trauma, that have likely been experienced by these individuals prior to bereavement. Powerlessness following a sudden or traumatic loss can be a response to injustice, unsafety, abandonment and feeling out of control (Poxon, 2023). Ideological *power* is one of the least visible but most dominant forms of power experienced by grieving individuals as it sets the agenda for how we ought to think and respond to a bereavement in the guise of implicit social and cultural norms. The categorisation of PGD (DSM-V-TR, 2022) as a mental health disorder is a salient example of ideological power shaping social norms for grief.

Following a bereavement, *threats* can be experienced bodily (exhaustion and poor physical health), to our global belief systems (e.g. children should outlive their parents) and to our identity (e.g. am I still a parent if my child died?). Our response to those threats will be unique to us and the more traumatic and sudden the loss, the more our worldview and belief systems are shattered, triggering a search for *meaning* (Gillies & Neimeyer, 2006).

A PTMF approach in grief therapy asks 6 core questions (Boyle & Johnstone, 2020) as a basic structure for therapeutic assessment and treatment, allowing a bereaved individual the opportunity to view their grief compassionately, perhaps for the first time, rather than something they are 'getting wrong': 1. *What has happened to you*?,(how is power operating

in your life?) 2. *How did it affect you*? (What kind of threats does this pose?) 3. *What sense have you made of it*? (What is the meaning of the situation/experience?) 4. *What have you done to survive*? (What kinds of threat response are you using?) 5. *What are your strengths*? (what access to power resources do you have?) and to integrate all the above: 6. *What is your story*?

A Case Example

Gerald, a 65-year-old widower of mixed heritage had been experiencing severe low mood, tearfulness, insomnia and rumination since his wife of 22 years died 12 months ago. He self-referred for grief therapy reporting that his family are worried about him, but he feels 'stuck' and can't move on.

What has happened to you? Over several sessions, Gerald explored his bereavement, which he felt as a severe physical pain that never shifts. In therapy, he explored his devotion to his wife who had been "the only person in my life to show me unconditional love" and his early experiences. Gerald, a mixed heritage adoptee was raised with inconsistent affection and love by his strict White parents (who he later discovered were his maternal grandparents) in a community where he was subjected to physical and emotional racially motivated abuse. His therapist explored the possibility of an anxious ambivalent attachment style, linking it to his early inconsistent experiences of relationships. Gerald found this very helpful to understand, and feel compassionate towards, his response to the loss of his wife.

How did it affect you? Gerald grew up isolated, not belonging, ashamed, fearful of others and experienced these as regular threats to his identity, physical health, sense of community. Since the bereavement he has re-experienced all of these threats in addition to shattered world beliefs.

What sense did you make of it? The loss of his wife represented the 'loss of everything that made sense in the world'. He felt abandoned, unsafe, hopeless and excluded by people who thought he should be better by now.

What did you have to do to survive? As a child, he melted into the background and was always the 'good boy'. Following his bereavement, Gerald had withdrawn to the safety of his home where he felt most connected to his wife and had been increasing his visits to the betting shop as it wasn't associated with memories of his wife. He often struggled to eat and sleep with any regularity and worried about house chores that were not being addressed.

What are your strengths? During later sessions, Gerald's therapist explored his skills in gardening and encouraged his desire to communicate with his wife through the flowers he nurtured. He also liked to help others, so began to challenge his sense of exclusion and abandonment by helping neighbours with their gardens.

What is your story? If Gerald was treated for PGD in the medical model, he would be viewed as an addict who needed medication to reduce the symptoms he was experiencing. This would risk further isolating him from social connections. From a PTMF approach, he was able to co-create a new narrative to explore and normalise the emotional, cognitive, physiological and behavioural responses he experienced. In reframing his grief as an understandable and proportionate response to a significant loss, Gerald began to feel more compassionate towards himself and start to capitalise on his strengths.

By listening to his story and holding the PTMF as a framework, Gerald's therapist was able to achieve the difficult balance between acknowledging the very real challenges and constraints in his life alongside holding a belief that he has agency to make small changes.

Conclusion

Whilst it is valid that grief can be one of the most distressing and painful experiences that we will endure in our lifetime, the conceptualisation of any grief response as having a proscribed course or as a psychiatric disorder (specifically where the pharmacological treatment being prescribed reduces feelings of connection to one's closest others, and to one's own emotions), compromises the humanistic values that are held by the majority of professionals who offer grief therapy. I therefore support an alternative approach: The Power-Threat-Meaning Framework, that acknowledges social and cultural inequality, embraces the uniqueness of grief responses, and views grief as an entirely understandable response to trauma and loss.

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