

Impairing Social Connectedness: The Dangers of Treating Grief with Naltrexone

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Cite as:

AMA:

Thieleman K, Cacciatore J, Thomas S. Impairing Social Connectedness: The Dangers of Treating Grief With Naltrexone. *Journal of Humanistic Psychology*. May 2022. doi:10.1177/00221678221093822

APA:

Thieleman, K., Cacciatore, J., & Thomas, S. (2022). Impairing Social Connectedness: The Dangers of Treating Grief With Naltrexone. *Journal of Humanistic Psychology*. <https://doi.org/10.1177/00221678221093822>

Abstract

A study is currently underway in the United States using the opioid antagonist naltrexone to treat prolonged grief, which is conceptualized in the study's proposal as an addiction disorder (Gang et al., 2021). The researchers' stated intention is to use the pharmaceutical agent to disrupt the griever's capacity to engage in social bonding in order to eliminate craving for the person who died. We believe this approach is misguided for a number of reasons. It demeans the importance of the relationship between the bereaved and the deceased loved one, further isolates grievers from the very social support networks that could help facilitate adaptation to bereavement, and could have a disproportionate negative impact on marginalized communities, who tend to rely more heavily on informal sources of support. We argue that social connection is at the very core of healing and that disregarding and interfering with this capacity could have widespread detrimental effects on grievers.

Keywords: grief, bereavement, social connection, naltrexone

Impairing Social Connectedness: The Dangers of Naltrexone for Grief

Grief and death studies have benefitted from the contributions of many fields, including psychology, social work, anthropology, sociology, nursing, psychiatry, and more. Given this breadth, it is, perhaps, unsurprising that there are often divergent views on how to best view grief and the role of interventions for bereavement. In this piece, we hope to initiate a conversation and share our concerns about a recently published protocol for a randomized controlled trial to treat grief, conceptualized as Prolonged Grief Disorder (PGD), with the pharmaceutical agent naltrexone, more commonly utilized in substance abuse treatment. While we wish to critique this proposal, we honor the desire to help alleviate suffering that is no doubt guiding the proposal's authors. Furthermore, we recognize that our perspective is one among many and we invite the larger community, including researchers, practitioners, and bereaved individuals, to join this conversation.

The proposal is authored by Gang, Kocsis, Avery, Maciejewski, and Prigerson (2021), in collaboration with the National Institutes of Health (NIH) and the National Cancer Institute (NCI)¹, and the study is currently in progress. In their proposal, the researchers argue that the yearning for a deceased loved is a form of craving observed in addiction and liken the pain of separation from a loved one who died to drug withdrawal. In their view, memories of the person who died person act as “the rewarding stimulus” (p. 2) that maintains the addiction. The researchers note that “naltrexone reduces feelings of social connection, especially to one’s closest others” (Gang et al., 2021, p. 3) and suggests that this feature of the drug will sever social bonds with the person who died, thus alleviating the craving for them. The proposal advocates

¹ Clinical Trials Identifier NCT04547985

this impairment of the capacity to socially bond, which is usually viewed as an adverse effect of the drug, as the desired mechanism of action, predicting that “naltrexone will provide a pharmacological way to dampen the benefits of social bonding” (p. 5). The rationale guiding the study is that “Reduced positive associations with significant others, especially the deceased, may make bereavement feel less lonely while diminishing the reward derived from reminiscing about the deceased” (Gang et al., 2021, p. 4).

While the motivation to alleviate suffering is noble, we believe the study’s approach is misguided, and even dangerous. To begin, the comparison between longing for a loved one who has died, a unique individual with whom one had a deep, multifaceted relationship, and a drug addiction demeans the importance of the loving relationships that sustain us and is not yet well supported. Even if the conceptualization of grief as an addiction gains further empirical support, the authors’ proposal for treating this supposed addiction is not sound. For instance, the claim that “detachment from the deceased is a necessary first step towards being able to connect with living others” (Gang et al., 2020, p. 6) is questionable. This statement seems to be based on Freud’s theory of cathexis and decathexis, in which ties to the deceased must be severed ([1947] 1994). It is now well-documented that this is not necessary for adaptation after grief and that, in fact, continuing bonds with loved ones who have died are normative (Klass, 2006).

However, more troubling is the rationale for using naltrexone to *intentionally* disrupt feelings of social bonding. In their proposal, Gang et al. cite a study by Inagaki et al. (2016), which showed that naltrexone reduces feelings of social connection. However, Inagaki et al. recognized the necessity of social bonding, stating “Critical to these bonds are feelings of connection, the positive, contented feelings that come from being close to others” (2016, p. 734). Furthermore, Inagaki et al. view the diminishment of social bonding as an unwanted adverse

effect and state “Social support is especially important during times of need...such as when struggling with an addiction and as such, any negative changes to how one perceives their network may introduce unintended barriers to recovery” (2016, p. 734). We believe this caution also applies to bereavement, a time when humans are uniquely vulnerable and often already perceive inadequate social support (Cacciatore et al., 2021).

Naltrexone will not selectively target bonds with the loved one who died. Its mechanism of action would potentially disrupt social connection more broadly. As reported by Inagaki et al. in another study, naltrexone “reduced feelings of social connection toward the close others (e.g., family, friends, romantic partners)” (2020, p. 732). In fact, the effects may extend beyond one’s social network, as opioid antagonists like naltrexone are not specific to social stimuli and may reduce desire in other areas, such as food (Inagaki et al., 2016). The widespread effects of naltrexone on social bonding could have a range of unintended, harmful consequences, as research has demonstrated the positive effects of social support. For instance, Vanderwerker and Prigerson (2004) found that perceived social support correlated with better quality of life and was protective against complicated grief, posttraumatic stress disorder, and depression. A lack of meaningful social connectedness during bereavement could thus further complicate the experience of grief. The impairment of social bonding could also have adverse effects on others in the bereaved person’s family, such as dependent children. Research suggests that forming and maintaining strong family bonds helps promote resilience in children after the death of a parent (Sandler et al., 2013). It is not difficult to imagine the detrimental impact on a child if the surviving parent’s capacity to bond with the child is impaired, leaving the child with an emotionally unavailable parent when warmth, safety, and support are most needed.

While there is the potential for great harm from impairing social connectedness, it is not clear how diminishing feelings of social connection would benefit the population under study, which is assumed to be experiencing PGD, when one of the defining symptoms of this proposed disorder is an inability to feel connected to others. Further impairing the capacity for social connection would deepen a griever's sense of loneliness and social alienation. Experiences during the COVID-19 pandemic have highlighted the risks posed by loneliness and other consequences of social isolation (Killgore et al., 2020; Lee et al., 2020; Li & Wang, 2020). Additionally, loneliness has been established as a risk factor for mortality in bereavement (Stroebe et al., 2007). The use of naltrexone would likely exacerbate this problem by impeding the capacity to seek sources of social support and to experience the benefits of social bonding. The approach advocated by Gang et al. (2021) comes at great cost, undermining whatever sense of social connection the bereaved might be experiencing.

Furthermore, disrupting social connectedness may be especially detrimental for members of marginalized and oppressed groups, such as BIPOC (Black, Indigenous and People of Color) communities, as well as sexual orientation and gender minorities. These groups are greatly under-represented in the grief and bereavement literature, where studies are often conducted with elderly, cisgender, heterosexual individuals of European descent experiencing conjugal bereavement. However, existing research points to the importance of social support in bereavement in these communities. For instance, Burke et al. (2010) found that Black grievers in the United States accessed a wider social network than White grievers, and that having a larger system of supporters available correlated with lower levels of complicated grief and depression. Cacciatore and Raffo (2011) documented the lack of adequate social support of lesbian mothers after the death of a child, and a systematic review of bereavement among LGBTQ+ adults

identified barriers influencing adaptation to the death of a partner, including lack of relationship recognition and homophobia in healthcare settings, as well as the “shadow” of HIV/AIDS (Bristowe et al., 2016, p. 736). Intentionally undermining the ability for social connectedness could have a disproportionate negative impact on these communities, which may rely more heavily on informal sources of support (Mossakowski & Zhang, 2014).

Historically, the healthcare system has been viewed with distrust by those of marginalized experiences and identities for many reasons (Armstrong et al., 2007; Shen et al., 2018), including a perceived lack of compassion, the denial of patients’ experiences of pain, inadequate medication for pain management, and the marginalization of victims of oppression through the mental health industrial complex (Green, 2019). Such negative experiences are not limited to race. For instance, 70% of gender minorities have experienced some level of discrimination in healthcare (Human Rights Campaign Foundation, 2018). Discriminatory experiences impede culturally competent healthcare, defined by Henderson et al. (2018) as the ways healthcare services meet “the social, cultural and linguistic needs of patients” (p. 591).

BIPOC communities, in particular, rely more heavily on natural healing with an emphasis on ancestral healing and breaking generational trauma by reconnecting with the past. Community-based frameworks, such as healing and disability justice, emphasize how the recognition of oppression and inequality are central to healing and at the forefront of sustainable treatment that promotes agency in minority groups. The focus of these interventions is to *encourage community connection* and to empower those who are negatively affected by oppression to participate in changing the system (Chavez-Diaz & Lee, 2015; Ginwright, 2015).

Pharmacologic disruption of essential social ties within non-dominant groups may further diminish trust of the medical community by those with a strong reliance on community care for

their survival, healing, and wellness. Culturally competent care requires providers to create and implement services that meet clients where they are, as opposed to imposing a medical solution which compromises one of their primary means of salutary coping: community support and connection grounded in the “fundamental human need to belong” (Frost & Meyer, 2012, p. 36).

Based on these concerns, we disagree with Gang et al.’s assessment that “the risks posed to participants are low” (p. 12). We would argue that the risks of treating griever with naltrexone are, in fact, quite significant and that the stated benefits may not be worth the risk, considering the degree of potential for harm. Bereaved people already report some degree of isolation in their grief, especially when others do not understand or know how to react to their loss (Thieleman & Cacciatore, 2020). We question an intervention which would lead them to feel further disconnected from their families and communities. Furthermore, grieving individuals are already vulnerable and subject to societal demands that require them to repress or minimize their emotions to maintain the comfort of those around them and meet the economic demands of productivity and efficiency (Harris, 2010). These unreasonable expectations imposed on grievers have likely been exacerbated by recent trends in psychiatry toward pathologizing certain experiences of grief, even though research shows that some losses tend to evoke more long-lasting and intense grief (Morris et al., 2019). Treating grievers with naltrexone further expands the mental health industrial complex (Greene, 2019) into the realm of bereavement, where grief at the death of a loved one is viewed as just one more form of pathology to be treated with pharmaceutical agents, with no consideration of the context in which grief occurs, including the relationship to the person who died, the circumstances surrounding the death, the history and quality of the relationship, or the degree of attachment to the person who died.

People experiencing intense and long-lasting grief do need support. However, the nature of this support needs to be carefully considered, especially in light of the recent decision by the American Psychiatric Association to add Prolonged Grief Disorder to the Diagnostic and Statistical Manual of Mental Disorders (DSM 5-TR), which will likely usher in further attempts to medicate grief (Barry, 2022). We believe interventions should focus on helping people heal in relationship with others, not on impairing the very capacity for social connectedness.

Bereavement-related interventions should be rooted in compassionate, attuned support and allow grievers to share their stories, struggle with questions of meaning, and build their capacity to hold their pain, not through attempts to minimize, deny, or medicate away their pain and grief. Being fully alive means being willing to feel what needs to be felt under conditions of safety, including the pain of the death of a loved one, not further alienating oneself in an attempt to numb the pain. Perhaps the ultimate goal of bereavement-related interventions is to help people recognize their capacity to become whole, if broken-hearted human beings.

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