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Coláiste na hOllscoile Corcaigh, Éire
University College Cork, Ireland

**Psychological Justice: Addressing Drug-Related Deaths as a Health
and Social Risk for Families, Communities, and Services**

Thesis submitted by

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for the degree of Doctor of Philosophy

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2024

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Declaration of Academic Honesty

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism and intellectual property.

Daniel O'Callaghan,

School of Applied Psychology,

University College Cork,

2024

To aunty Jane.

To those lost and to those left behind.

This thesis is dedicated to families, friends, healthcare workers, and anyone whose lives have been touched by those who have left us too soon. I have had the privilege of meeting so many wonderful people who shared their stories of grief, and I am forever grateful for such bravery and kindness.

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Publications from Thesis

Peer-Reviewed Journal Articles

1. O'Callaghan, D., & Lambert, S. (2022). The impact of COVID-19 on healthcare professionals who are exposed to drug-related deaths while supporting clients experiencing addiction. *Journal of Substance Abuse Treatment*, 138, 108720. <https://doi.org/10.1016/j.jsat.2022.108720>
2. O'Callaghan, D., Lambert, S., Conway, N., & Frost, N. (2022). Posttraumatic growth following a drug-related death: A family perspective. *Death Studies*, 47(5), 574-584. <https://doi.org/10.1080/07481187.2022.2108943>
3. O'Callaghan, D., & Lambert, S. (2023). The experience of drug-related client loss for healthcare professionals who support people in addiction. *Journal of Substance Use and Addiction Treatment*, 158, 209236. <https://doi.org/10.1016/j.josat.2023.209236>
4. O'Callaghan, D., & Lambert, S. (2024). The internalization of stigma and the shaping of the grief experience for peers bereaved by a drug-related death. *OMEGA – Journal of Death and Dying*. <https://doi.org/10.1177/00302228241275728>

Contribution of First Author

As the first author for each of the peer-reviewed journal articles listed above, they are presented within this thesis as specific chapters demonstrating the empirical work carried out for this PhD by publication.

For publications 1, 3, and 4, I carried out the fieldwork and data collection, conducted the qualitative analysis, and led the paper writing for each study. I acted as the lead and corresponding author throughout each publication process. My primary supervisor, Dr Sharon Lambert, provided guidance in the conceptualisation and research design of each study, and provided critical and evaluative feedback on each paper prior to publication.

For publication 2, due to restrictive public health barriers, ethically and safely conducting socially engaged research during the COVID-19 pandemic was not possible. I conducted a secondary data analysis on qualitative interview data that was previously collected by Dr Sharon Lambert. Together, we conceptualised the research question, and I chose the analytical approach, conducted the analysis, and led the paper writing. I acted as the lead and corresponding author during the publication process. Nora Conway contributed to the conceptualisation of the research question and provided feedback on drafts of the results section. Dr Nollaig Frost provided feedback on drafts of this paper.

List of Abbreviations

CDC	The Centre of Disease Control and Prevention
DPM	Dual Process Model
DPM-R	Dual Process Model-Revised
DRD	Drug-related death
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
HRB	Health Research Board
HCP	Healthcare professional
ICD-10/1CD-11	International Classification of Diseases 10 th /11 th Revision
NDRDI	National Drug-Related Death Index
NFSN	National Family Support Network
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta Analyses
PRISMA-ScR	PRISMA Extension for Scoping Reviews
PTSD	Post-traumatic stress disorder
SREC	Social Research Ethics Committee
UNODC	United Nations Office on Drugs and Crime

Abstract

Drug-related deaths represent a significant practice concern for global public health, and a continual increase in associated fatalities presents acute social and health challenges for families, communities, and services worldwide. Amid the urgent requirement for adaptive state policy responses to address rising death figures, each number represents the loss of human life that embodies a social identity as somebody's loved one. Behind the statistics, countless individuals grieve the untimely loss of a child, a parent, a client, a sibling, or a friend. Lamentably, many are forced to grieve in silence, as drug-related bereavement can foster a disenfranchised grief that requires therapeutic intervention but concurrently inhibits access to support through shame, isolation, and self-blame. If unprocessed, people who grieve a drug-related death are at increased risk for harmful short- and long-term health outcomes, including increased risk of death.

People who use drugs navigate a range of social, health, and justice contexts, forming various levels of sustained personal and professional relationships. When a person dies, people within this social context are left to mourn the loss of life and the loss of potential represented by a premature and preventable death. However, grief can manifest differently dependent on several interpersonal, relational, and contextual factors. To appropriately target grief supports, it is important to discern how drug-related determinants interact with, and influence, bereavement processes. Thus, this doctoral thesis addresses a gap in the literature, identified within a scoping review (Chapter 2), by examining the grief experiences of three subgroups who are at risk for experiencing a drug-related death: peers in active addiction, families, and healthcare professionals.

Through a series of peer-reviewed academic articles, this thesis shares the voices of 38 drug death bereaved individuals who represent family members, staff within various healthcare professions, and people who experienced the death of a peer during their own active addiction. Theoretically grounded within the dual process model of coping with bereavement, each study employs an in-depth qualitative methodology to explore complex and multifaceted grief experiences. Chapter 4 conveys the experience of posttraumatic growth for families, identifying key facilitators of resilience. Chapter 6 and Chapter 8 address bereavement for healthcare professionals, spanning occupations in social work, addiction, and emergency medicine. Chapter 6 explores their complex grief reactions, while Chapter 8 identifies the challenges of working with clients who died during the COVID-19 pandemic. In Chapter 9, people who were in active addiction report how their grief experiences were shaped by stigma following the death of a peer.

This research identifies the drug-related death of a loved one as a critical period for intervention where suitably targeted supports are currently profoundly limited. The work presented in this thesis contributes to the validation and recognition of diverse grief experiences for groups that grieve in silence, providing a more holistic understanding of complex inter- and intra-group grief processes. In providing actionable recommendations, this thesis aims to improve standards of evidence to support the implementation of adaptive and heterogenous drug-related bereavement policy and practice responses. Tailoring evidence-informed bereavement supports to address the specific needs of the bereaved is crucial, potentially lifesaving, particularly as social positioning and relational capital play a significant role in the manifestation of grief responses.

Chapter 1: Introduction

“There is no grief like the grief that does not speak.”

— Henry Wadsworth Longfellow

Grief, as the echo of our affection, reflects the enduring love we carry for those who have passed. When we grieve, finding solace in reminiscence, keepsakes, or shared memories with others can ignite our healing process as we begin a journey of adaptation from a significant loss. As fortunate as many people are to be surrounded by loved ones during such difficult times, there are also those who experience a grief concealed in solitude, symbols of remembrance and restoration tainted by judgements and a longing for potential stolen far too soon. A reticent sorrow that weighs heavy on the heart, the loss of a loved one to a drug-related death is a silent grief shrouded in unspoken sorrow and rumination.

The number of people who have died from drug-related circumstances has seen a global surge in recent years (HRB, 2023; EMCDDA, 2024). In this thesis, I search beyond the statistics to bring forth the voices of people who grieve devastating losses in silence. Through applied research, grounded within psychological theory, this thesis gives reverence to the humanity of those who have died while enhancing standards of evidence for care practices that address the complex needs of the bereaved. In this chapter, I will introduce, define, and explore the unique characteristics of drug-related deaths which informed the conceptualisation of this thesis, followed by an overview of the aims, contributions, and structure of this body of work.

1.1 Current International & Domestic Status

Drug-related deaths are a considerable public health concern with global implications for sociological health and community welfare. Despite recent epidemiological advancements in drug research (Owolabi, 2022; Volkow & Blanco, 2023), worldwide drug use and related deaths have continued to trend upwards, acting as a leading cause of death and presenting diverse cross-disciplinary challenges to social policy and health practice (Lo et al., 2020). With increased healthcare service demands, elevated economic costs (Florence et al., 2021; Lo et al., 2020), and the year-on-year detection of new psychoactive substances and synthetic opioids (EMCDDA, 2024), evolving mortality risks have urgently necessitated adaptive drug policy and increased access to therapeutic pathways to prevent the loss of life.

As international state agencies endeavour to establish best practice responses to changing trends in drug use, global data continues to demonstrate harrowing death totals. The Centre for Disease Control and Prevention (CDC) reported an estimated 107,543 drug overdose deaths in the United States in 2023 (CDC, 2024), and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) estimated that 6,392 overdose deaths occurred in Europe in 2022 (EMCDDA, 2024). In Ireland, specifically, the latest figures reported by the Health Research Board (HRB) recorded 806 drug-related deaths in 2020 (HRB, 2023). Comparatively, the most recent statistics from the Road Safety Authority reported 137 deaths from fatal collisions on Irish roads in 2023 (Road Safety Authority, 2024), for which road safety agencies have developed national awareness-raising campaigns in response. However, drug-related deaths remain a hidden harm despite the stark death totals, and the report on the 2024 Citizen's

Assembly on Drug Use highlighted a significant increase in drug-related deaths in Ireland, considered to be “alarming levels” of death (Citizen’s Assembly, 2024, p. 9).

Each figure within the acute death totals represents the tragic loss of human life; life that existed in the context of families and communities as parents, children, siblings, friends, or clients. Approximately 10-15 people experience the negative sequelae associated with the bereavement of a single drug death (Dyregrov & Selseng, 2022), and the stigmatised sociocultural perception of drug use often forces bereaved individuals to contend with shame, isolation, and a lack of social support while grieving (Hicks et al., 2024; Stout & Fleury-Steiner, 2023; Templeton et al., 2017). Uniquely identified as “special deaths” (Dyregrov et al., 2020; Lambert et al., 2021; Titlestad et al., 2020), understanding the intricacies of such complicated grief experiences and identifying key indicators for change is paramount to the development of appropriate bereavement intervention frameworks.

As the prevalence of drug-related deaths increases, communities are experiencing a consequent rise in the number of people grieving their loved ones. Yet, the contextual, psychosocial, and health correlates of drug-related bereavement have remained largely unexplored, resulting in a dearth of evidence-informed practices to address and assist in the mitigation of complex grief outcomes. When this doctorate commenced in 2019, a systematic review by Titlestad et al. (2019) identified a significant gap in the family literature, reporting eight studies of strong methodological quality exploring the impact of drug-related deaths on families. Grief in the broader social context of drug use, inclusive of healthcare professionals (HCPs), peers, and other

groups, has been subject to even less inquiry, demonstrated in a scoping review presented in Chapter 2 of this thesis.

To date, the acceleration rate for publications on this topic has marginally increased, primarily generated within a European research cluster and in the United States, providing critical insights into the unique complexities of grieving a drug-related death. However, given the volume of data that exists on other stigmatised and/or complicated bereavements such as death by suicide and road traffic accidents, and the importance of this research for policy and practice, it is imperative that drug death bereaved individuals are sufficiently represented within the literature. Bereavement consequential of drug use is inherently complex, calling for the establishment of a rigorous and robust evidence base to inform, cultivate, and improve standards of care for people who grieve in silence.

1.2 Drug-Related Deaths: A Conceptual Definition

Significant variability exists in how drug-related deaths are categorised between different jurisdictions and international reporting agencies, hindering the comparability of cross-cultural datasets and presenting challenges for consistency in the reporting, certification, and coding of death cases (Robertson et al., 2019; Stam et al., 2019). Consequently, the empirical classification of drug-related deaths also varies in the literature, drawing definitions from national health directorates (Titlestad et al., 2020), ICD-10 codes (Christiansen et al., 2020; NISRA, 2024), or from participants' own interpretations (Perrin, 2023). The scope of exploratory research in the area, therefore, addresses grief and bereavement linked to a multitude of fatal drug-related

complications, inclusive of death by opioid overdose and drug toxicity (Bottomley et al., 2023; Sterling et al., 2022), long-term effects of alcohol dependency (Standing et al., 2019), suicide (Feigelman et al., 2011), or violence (Selseng et al., 2023; Titlestad et al., 2022). Evidently, the term “drug-related death” encapsulates a broad spectrum of causal circumstances dependent on its definitional origin.

In Ireland, drug-related death totals are collated by the National Drug-Related Death Index (NDRDI), established in 2005 as a response to Action 67 of the ‘National Drugs Strategy 2001-2008,’ opting for the development of a systematic method of recording national drug death statistics (Kelleher et al., 2024). The NDRDI accounts for drug and alcohol-related deaths nationwide, utilising a dual categorisation protocol to classify each death (HRB, 2019): poisoning deaths are directly consequential of drug and alcohol toxicity (e.g., overdose), and non-poisoning deaths are deaths linked to drug and alcohol use through trauma (e.g., death by suicide) or medical circumstances (e.g., cardiac issues). To ensure clarity and consistency of scope in the work presented in this thesis, which is generated within an Irish context, a preliminary aim of the project was to standardise a definition for drug-related deaths that operates at the confluence of Irish policy while actively contributing to the broader evidence base.

Internationally, several studies focus specifically on bereavement from drug-related deaths linked to opioids (Hill & O’Brien, 2024; Kolla et al., 2024; Sterling et al., 2022), of pertinence as two thirds of worldwide drug-related deaths are consequential of opioid intake (The United Nations Office on Drugs and Crime (UNODC), 2024). Other research efforts more broadly investigate “substance-related deaths,” which are generally differentiated in the literature by the additional inclusion of those bereaved by

alcohol-related losses, aligning directly with the inclusion criteria for the NDRDI (Morris et al., 2021b; Standing et al., 2019; Templeton et al., 2016; Valentine et al., 2018; Walter et al., 2017). However, the growing evidence base demonstrates that bereavement outcomes are heavily influenced by categorical factors such as the type of drugs involved, particularly between alcohol and other drugs (Cartwright, 2019; Valentine et al., 2018).

The legalisation of alcohol and the criminalisation of other drugs within legislative structures generates variability in addiction stigma, constructing distinct social narratives and societally collective moral schemas surrounding the use of, and mortality associated with, different drug types (Sumnall et al., 2023). Empirically, the literature to date highlights that stigmatisation is likely to manifest differently and more intensely for those bereaved by illegal drug deaths and the non-medical use of prescription drugs (i.e., opioids) than those bereaved by alcohol as a singular cause of death (Christiansen et al., 2020; Titlestad et al., 2019). Additionally, opioid related deaths are more likely to be violent, sudden, or suicide-related (Templeton et al., 2016), involve police searches and engagement with criminal justice systems (Valentine & Walter, 2015; Templeton et al., 2017), foster a higher prevalence of guilt for the bereaved (Cartwright, 2019), or have somebody else implicated in the death (Templeton et al., 2017).

The variance in bereavement experiences necessitates well-defined parameters in empirical research to comprehensively convey the grief-related complexities experienced by different subgroups. In a European context, opioids were estimated to be involved in 74% of fatal overdoses in 2022 (EMCDDA, 2024), and a leading European

research cluster based in Norway have progressively developed a large-scale study on drug-related bereavement titled “The END-study” (Dyregrov et al., 2022; Titlestad et al., 2019). Within this project, drug-related deaths are defined as deaths that occur directly due to the intake of narcotics/opioids, but also may be linked to these substances as a result of violence, suicide, infectious disease, or other health disorders (Titlestad et al., 2019). The series of publications stemming from the Norwegian research efforts have continued to provide a critical insight into the experience of families and friends bereaved by such deaths and have accentuated the requirement for further inquiry.

Opioids have consistently been the most common singular drug implicated in Irish drug deaths for many years (HRB, 2019; 2023), and the HRB recently disclosed 409 poisoning deaths in Ireland in 2020, excluding alcohol as a singular cause of death, with an additional 397 non-poisoning deaths (HRB, 2023). Given the rising ubiquity of opioid-related deaths both nationally and worldwide, and the subsequent impact on the bereaved, this thesis will thereby focus on drug-related deaths linked to opioid intake and the non-medical use of prescription drugs, adopting definitions from the HRB that are also in line with European research trends (Dyregrov et al., 2022; Titlestad et al., 2019). Therefore, within this thesis, drug-related deaths (**henceforth: DRDs**) are classified as follows:

Deaths due to the intake of opioids or the non-medical use of prescription drugs, either by poisoning (e.g., overdose, polydrug use) or non-poisoning deaths linked to drug use such as suicide, violence, or medical complications (HRB, 2019; Titlestad et al., 2019).

1.3 A Note on Complicated Grief

The death of a loved one is an emotionally painful and psychologically intense occurrence that most adults will experience at least once during their lifetime (Wilson et al., 2022). Grief, as a response to bereavement, is a deeply individualised process (Khalaf et al., 2018; Shear, 2015; Tedeschi & Calhoun, 2004) influenced by several personal and environmental factors that interact within social, cultural, and political contexts (Bonanno et al., 2007; Breen & O'Connor, 2007; Overad & Wagoner, 2020; Stroebe et al., 2007). Manifestations of grief are unique to each individual, influenced by the complex interplay between relational factors such as one's connection to the deceased (Mason et al., 2020; Turnbull & Standing, 2016), contextual factors such as the circumstances of the death (Feigelman et al., 2011; Overad & Wagoner, 2020), and interpersonal factors such as the quality of social support (Breen & O'Connor, 2007). Normative grieving trajectories typically result in the reduction of grief symptoms over time, and although the bereaved may experience severe distress, they gradually adapt to life without the deceased and reorientate to standard daily functioning (De Stefano et al., 2021).

Conversely, DRDs are associated with prolonged grief disorder (O'Callaghan & Lambert 2022; Titlestad & Dyregrov, 2022; Titlestad et al., 2022b). Commonly referred to in the literature as complicated grief, it is characterised by a more intense and debilitating grief experience that does not naturally subside, requiring adaptive intervention protocols to mitigate enduring symptoms (Bellet et al., 2020; Mason et al., 2020; Wilson et al., 2022). Assigned a diagnostic code in the ICD-11 (Wilson et al., 2022), complicated grief is pervasive, persists for more than six months, and yields

outcomes of clinical consequence such as intense longing for the deceased, persistently low mood, guilt, and severe impairments in social and occupational functioning (Bellet et al., 2020; Wilson et al., 2022; World Health Organisation, 2022a). The recent recognition of complicated grief as a disorder in diagnostic systems is pivotal to the provision of appropriate support, particularly as symptomatology for complicated grief is distinguishable from other bereavement outcomes, such as depression (Neimeyer, 2019).

Various factors that inhibit, disrupt, or halt the grieving process can contribute to the development of complicated grief, such as deaths that are unnatural, sudden, violent or traumatic (Buur et al., 2023). Unprocessed complicated grief is associated with long-term health outcomes such as post-traumatic stress disorder (PTSD), anxiety, depression, physical illness, substance dependency, and suicidal ideation (Christiansen et al., 2020; Mason et al., 2020; Mitchell et al., 2005; Shear, 2015) and requires therapeutic intervention to support positive adjustment. Understanding key indicators for the risk of complicated grief is crucial to avoid the pathologisation of normal grief experiences (Buur et al., 2023; Rosner et al., 2011), but also to highlight opportunities for intervention associated with bereavements that carry unique social and health challenges.

1.4 Distinct Social and Health Challenges of DRDs

Thanatological literature demonstrates that responses to death are universally complex, adopting various customs, rituals, and meanings shaped by cultural practices (Kofod & Brinkman, 2017). Accordingly, while inherently individualised, the

bereavement experience is personally and culturally defined (De Stefano et al., 2021; Khalaf et al., 2018), socially constructed by how an individual is situated within a nexus of societal constructs, norms, beliefs, and spiritual values (Mason et al., 2020).

Consequently, the sociocultural script that conventionally positions addiction as a taboo within the social domain can influence and impact grieving processes associated with drug use. To date, the knowledge base surrounding drug-related bereavement is primarily situated within a familial context (Titlestad et al., 2019; Urmanche, 2020), providing fundamental insights into the distinct grief correlates that engender a complicated bereavement at the interchange of morality, culture, and loss. Thus, this subsection will draw from the family literature to outline the key distinguishing factors that characterise drug-related bereavement; a process that is uniquely shaped by the coalescence of distinct pre, peri, and post-loss factors related to drug use.

To provide a holistic and structured overview of the key DRD risk factors for complicated grief outcomes, this section draws from the available evidence and systematically situates these determinants within a theoretical and integrative risk factor framework. This framework, developed by Stroebe et al. (2006), aims to provide a comprehensive understanding of the various interconnected factors that individual differences in adaptation. Conceptually, risk factors are contextual, personal, and relational characteristics that may contribute to increased vulnerability to more severe bereavement outcomes (Stroebe & Schut, 2001, as cited in Stroebe et al., 2006; Stroebe et al., 2007), for which the model contains five interlinked dimensions (Stroebe et al., 2006, p. 2444):

- Category A: Nature of the Stressor
- Category B: Interpersonal Resources
- Category C: Intrapersonal Resources
- Category D: Appraisal and Coping Processes
- Category E: Outcomes

To date, the identifiable risk factors for complicated grief associated with DRDs have not been mapped on this framework by any other authors. While Stroebe et al. (2006) acknowledge that the model may require alteration when applied to different experimental circumstances, the framework provides a strong tool for methodically categorising interrelated risk factors. To provide further evidential support for the integration of drug-related bereavement risk factors into this model, and their association with complicated grief, I have supplemented the work of Stroebe et al. (2006) by referencing the model in conjunction with a systematic review by Buur et al. (2023). This systematic review, utilising the integrative risk factor framework, charted risk factors for prolonged grief symptoms by framing them across the five categories, providing a concise overview of key determinants and their predictive strength (Buur et al., 2023).

1.4.1 Nature of the Stressor: A Double Death

The nature of the stressor encapsulates variables such as the relationship to the deceased, the type of death, economic challenges, and caregiver burden (Buur et al., 2023; Stroebe et al., 2006). DRDs are abrupt losses that occur through non-natural causes, and are often traumatic due to the untimely, violent, or sudden nature of the loss

(DaSilva et al., 2007). In the systematic review by Buur et al. (2023), the death of a close relationship was significantly associated with complicated grief, and across the DRD literature, the bereaved represent a multitude of close relationships that have been impacted by traumatic deaths. With parents as the majority cohort reflected in the evidence base (Christiansen et al., 2020; DaSilva et al., 2007; Morris et al., 2021b; Templeton et al., 2017), research has also explored the impact of DRDs on population samples including siblings (Dyregrov et al., 2022; Lorås et al., 2024; Meen et al., 2024; Templeton et al., 2017), partners (Cartwright, 2019; Selseng et al., 2023), and grandparents (Guy, 2004; Sperandio et al., 2021).

The concept of a ‘double death’ (Christiansen et al., 2020; Templeton et al., 2016; Valentine et al., 2018) or ‘living bereavement’ (Standing, 2019; Templeton & Velleman, 2017) encapsulates how caregivers mourn the loss of their loved one to drugs prior to their biological death (Christiansen et al., 2020; Sampson et al., 2023; Turnbull & Standing, 2016). During life, people in active addiction exhibit complex and unpredictable support requirements which yield health implications for others within their social context. Living with active drug use presents acute challenges for families, who may experience chronic socioemotional turmoil and profound financial strain in their efforts to address their loved one’s addiction (Lindeman et al., 2022; Moriarty et al., 2011). Family members may also witness multiple non-fatal overdoses in the home (Resko et al., 2024), unaware of how to respond and intervene (Templeton et al., 2017).

The tumultuous nature of addiction, indeterminate care pathways, and the loss of social connection to the person using drugs (Sampson et al., 2023) can result in prolonged cycles of uncertainty, fear, stress, and hopelessness as families search for

treatment options amidst overwhelming concerns about their loved one's safety (da Silva et al., 2007; Guy & Holloway, 2007; Titlestad et al., 2019; Turnbull & Standing, 2016). Intra-familial roles and identities reorientate around drug use as family members undertake extended care and parental involvement in the lives of their loved ones (Lorås et al., 2024; Titlestad et al., 2021). Lorås et al. (2024) investigated 14 siblings' experiences of family relationships before a DRD through interviews, noting that living with active substance use altered family systems, with siblings often forced into care-giving roles. Such caregiver strain is associated with poorer adaptation following the loss of a loved one (Stroebe et al., 2006), and although not included in the initial framework, Buur et al. (2023, p. 8) noted that the risk factor for complicated grief with the largest effect size in their analysis was "pre-loss grief symptoms."

1.4.2 Interpersonal Resources: A Stigmatised Loss

Within this framework, interpersonal resource risk factors account for circumstances such as social support, family dynamics, and cultural settings (Stroebe et al., 2006; Buur et al., 2023). In investigating drug-related bereavement in the context of family dynamics, Lambert et al. (2021) reported that familial relationships were renegotiated in the aftermath of a death with subsequent breakdown of some of these connections. Highlighting that DRDs can incur additional social losses, the severance of family ties can often be a consequence of secrecy, unresolved or unspoken conflicts, or disputes about levels of care provided while their loved one was alive (Lambert et al., 2021). Corroborating these findings, siblings interviewed in the study by Lorås et al. (2024) reported taking measures to protect themselves by not meeting with their sibling or by moving away, with negative effects on family structure. However, such decisions

fostered a sense of ambivalence regarding the care of their loved one and wellbeing of other members of their family (Lorås et al., 2024).

Social support can act as a protective factor against complicated grief outcomes, highlighted in research that addresses death by suicide (Levi-Belz et al., 2019) and DRDs (Reime et al., 2024a, 2024b). In general bereavement literature, the most useful forms of support are reported to be informal supports such as family and friends (Aoun et al., 2018). However, the rearrangement of roles, identities, and relationships during a loved one's life, and following their DRD, can significantly alter family systems and create divisions within familial structures (Lambert et al., 2021; Lorås et al., 2024). The amalgamation of damaged social relationships and economic stressors, such as incurring financial debt (Turnbull & Standing, 2016; Valentine et al., 2016), can thereby contribute to reduced social and professional support access even prior to a death. Furthermore, those bereaved by a DRD generally have low access to contact with people experiencing a similar situation (Reime et al., 2024a).

Culturally dominant social norms and macrosocial inequities, such as stigmatising societal and legislative structures (Muncan et al. 2020), can also act as significant risk factors for reduced interpersonal resources. Drug use is associated with a high degree of moral stigmas, primarily stemming from the negative beliefs and stereotypes that perpetuate shame for people who use drugs and associate them with criminal behaviour (da Silva et al., 2007). In this regard, drug use is primarily addressed within the criminal justice system, which results in correctional drug laws as the principal approach to navigating drug-related societal challenges (Scher et al., 2023). Regulatory structures that criminalise drug use can perpetuate these societal stigmas and

adverse systemic belief systems (Scher et al., 2023), neglecting to account for the social and health correlates of addiction.

People who use drugs are often viewed as engaging in unlawful behaviours or perceived as making poor lifestyle choices, with those who use opioids such as heroin among the most stigmatised (Sumnall et al., 2023). This judgement, stigma, and condemnation often extends to their family, who may have already experienced stigma prior to the death (Valentine et al., 2018). Thus, family members are often marginalised, criminalised, or viewed as complicit in the death while grieving a tragic and complicated loss, with subsequently negative repercussions for support (Lambert et al., 2021; Titlestad et al., 2019). Crucially, Buur et al. (2023) reported lower perceived social support as a significant risk factor for prolonged grief.

Media coverage and representation of drug-related concerns can also exacerbate grief outcomes and act as a perpetual risk factor for adverse bereavement experiences. The publicised nature of such deaths can often rescind the right to privacy for people grieving a DRD, further impeding opportunities for social support as reports of these deaths occur against a backdrop that criminalises their circumstances (Guy & Holloway, 2007). The negative labels used by media, and, at times, justice sectors can often reflect broader cultural perceptions (Valentine et al., 2018), which the bereaved then internalise as substantiated. The importance of a cultural shift towards recognising DRDs as a health concern is reflected in its implications for policy reform, to which public support is a crucial component (Sumnall et al., 2023). However, the cycle of stigma often adjudicates the public perception of who is deserving of support (Sumnall et al., 2023).

Evidently, drug-related stigmas can emerge from various institutional and social domains, acting as an organising framework in shaping the lived experience of people who use drugs, as well as those who are bereaved by drug-related circumstances (Muncan et al., 2020). As stigma is so deeply rooted into the phenomenology of addiction, it is a multifaceted experiential framework that can generate cultural prejudices and heavily influence how individuals interact with the world, engage with others, and shape their sense of self. In this way, anticipated stigma can manifest as an expectation of prejudice or future discrimination based on previous knowledge or experience of the social exclusion of people who use drugs (Lo Hog Tian et al., 2023; Muncan et al., 2020).

Anticipated stigma is an intrapersonal phenomenon associated with reduced adherence to healthcare procedures such as reduced help-seeking behaviours due to fear of ill treatment (Lo Hog Tian et al., 2023). In addition, DRD bereaved families who are connected to people who use drugs may also experience a high degree of internalised stigma, which is the acceptance or endorsement of self-devaluation due to negative perceptions emerging from socially or institutionally constructed attitudes towards drug use (Muncan et al., 2020). Internalised stigma can significantly impede healthcare engagement and is also associated with reduced psychological resiliency and self-esteem (Lo Hog Tian et al., 2023). Such layered experiences of stigma are reflected in the experiences of DRD bereaved families, who encounter barriers to support due to fear of judgement for their loss, uncertainty around their right to grieve, or failures of compassion from peers and professionals (Lambert et al., 2021; Valentine, 2018; Valentine et al., 2018).

1.4.3 Intrapersonal Resources: Compromised Wellbeing

Many intrapersonal risk factors with implications for adaptation emerge from the interaction between individual characteristics, vulnerabilities, and attachment styles (Buur et al., 2023; Stroebe et al., 2006). Personal factors such as pre-existing mental health conditions, coping mechanisms, capacities for emotional regulation, and relationships can shape the bereavement experience (Bonanno et al., 2007; Shear, 2015), where grief manifests at the interchange of antecedent personal, health, and environmental factors (Khalaf et al., 2018; Shear, 2015). Additionally, individual factors such as gender, educational attainment, age, religiosity, personality, income, and history of previous losses can influence adaptation (Buur et al., 2023; Kaltman & Bonanno, 2003; Stroebe et al., 2006; Tedeschi & Calhoun, 2004). For example, Buur et al. (2023) reported that people in later stages of life may have a smaller social network to mitigate against complicated grief outcomes.

Drug-related variables can further complicate this mediation, as individuals situated within the sociocultural and political context of drug use may have their intrapersonal risk factors exacerbated by societal stigmas and reduced support. Family members who spend extended periods navigating such complex emotional landscapes, either during active addiction or bereavement, are at increased risk for the development for poor health outcomes, such as anxiety or increased substance dependency (Christiansen et al., 2020). Furthermore, children living with active drug use in the home also have a higher risk of developing a wide range of adverse health and social outcomes, including substance use disorders (Dube et al., 2003; Meulewaeter et al., 2022). Consequently, many family members may begin to grieve the loss of their loved

one with their health already compromised, corroborating the delineation of pre-loss grief symptoms as predictors of complicated grief (Buur et al., 2023).

1.4.4 Appraisal and Coping Processes: A Disenfranchised Grief

Illustrated through the previous categories, the dynamic nature of the integrative model demonstrates how risk factors interrelate to generate complex grief correlates. To facilitate adjustment, Stroebe et al. (2006) outline that the bereaved must engage in cognitive and behavioural processes to evaluate their coping strategies and assess the personal significance of the loss (Buur et al., 2023). Fundamentally, the model integrates cognitive stress theory (Lazarus & Folkman, 1984, as cited in Stroebe et al., 2006) and the dual process model of coping with bereavement (Stroebe & Schut, 1999; Stroebe et al., 2006), in its approach by accounting for oscillation between appraisal and coping processes.

When experiencing reduced protective factors such as social support concurrent with a rise in stigma-related risk factors such as societal condemnation, people bereaved by a DRD often endure a disenfranchised grief (Doka, 1999, 2002). Disenfranchised grief is a grief that is not socially sanctioned, recognised, or publicly mourned (Doka, 1999, 2020). The amalgamation of internalised stigma, societal invalidation of the loss, and a lack of social support can lead to increased isolation that compounds an already complicated grieving process. Disenfranchisement, therefore, can be experienced as a combination of internal factors, such as shame or guilt, and external factors inclusive of norms crafted in the social domain (Standing, 2019). When grief becomes disenfranchised, it significantly complicates an individual's appraisal and coping

processes as social judgement and condemnation eclipse the personal significance of their loss (Doka, 2020).

Drug-related bereavement is strongly associated with disenfranchised grief, with families reporting difficulties with openly expressing their grief and accessing supports (Thatcher, 2022; Titlestad et al., 2019; Valentine et al., 2016). The emotional burdens carried by families are, therefore, exacerbated by the dismissal of their experience, forcing the bereaved to grieve in silence. Consequently, as they attempt to appraise their coping opportunities, the process of rumination is a common grief-related outcome in DRD bereaved individuals (O'Callaghan et al., 2022; Titlestad et al., 2020). Often associated with poorer adaptation and increased risk for prolonged grief (Milman et al., 2019; Stroebe et al., 2006), the process of rumination is understood as contemplating the inconsistencies between two separate cognitive models of the world; one which existed before the death, and one with new information and assumptions following the death (Michael & Snyder, 2005, as cited in Milman et al., 2019). Rumination does not typically support the bereaved in resolving their grief, as it commonly maintains a repetitive focus on negative emotions and circumstances, such as the injustice of the loss (Eisma & Stroebe, 2017; Milman et al., 2019).

The unique stigmas associated with DRDs also have implications for meaning making processes. As a reflective and purposeful mechanism (Milman et al., 2019), meaning making involves making sense of the loss, which can be attained through positive reappraisal and identity reorientation (Gillies & Neimeyer, 2006). Fundamentally, Thimm & Holland (2017) describe meaning making as the psychological integration of a collective network of concepts relative to the death, which

serves as a core facilitator of cognitive reorientation and is a predictor of adaptive bereavement (Neimeyer, 2019; Stroebe et al., 2006). However, the premature or traumatic death of a loved one can disrupt our assumptive and relational world, inhibiting the capacity of the bereaved to make sense of the loss (Neimeyer, 2019), and poor meaning making is associated with complicated grief (Buur et al., 2023; Neimeyer & Thompson, 2014; Thimm & Holland, 2017).

For DRD bereaved individuals, struggling to find meaning in the loss is a significant predictor of complicated grief (Walter et al., 2017), where DRDs can shatter their assumptive world and their social identity (Guy & Holloway, 2007; Walter et al., 2015). As a significant inhibitor to positive coping and appraisal, attempts find meaning in loss may be opposed by cultural stereotypes, media representation, stigmatised beliefs (Turnbull & Standing, 2016; Valentine et al., 2016). Furthermore, the bereaved may have to integrate new details of their loved one's lived experience before death, or encounter peers or associates they had not met previously (Guy, 2004; Walter et al., 2017). Reconstructing the relationship through positive reappraisal is crucial to the meaning making process (Neimeyer & Thompson, 2014; Valentine et al., 2015), but DRD bereaved individuals may struggle to piece together and separate their positive memories from those associated with drug use (Lambert et al., 2021).

1.4.5 Outcomes

With consideration for the aforementioned risk factors, people bereaved by a DRD are a high-risk population for the development of complicated grief (Titlestad & Dyregrov, 2022; Titlestad et al., 2022b). Outcomes within the framework (Stroebe et al., 2006) address the intensity of grief, mental and physical health, and the impact on the

interpersonal environment of the bereaved (Buur et al., 2023; Stroebe et al., 2006). DRDs yield a profound impact on each of these concepts, where the disenfranchised nature of the bereavement presents unique challenges to social and health policy, as well as bereavement support services. Given the variability in how drug-related compounding factors can exacerbate various facets of grief, traditional bereavement supports may not appropriately address the complexities associated with such losses.

Recognised as a ‘special’ grief (Lambert et al., 2021; Titlestad et al., 2021), parents who lose a child to a DRD report more profound grief outcomes and mental health needs than parents who are bereaved by accident or natural cause death (Bottomley et al., 2021; Christiansen et al., 2020). With a higher risk for developing complicated grief, parents bereaved by a DRD demonstrate increased levels of social isolation, depression, and PTSD when compared to accident and natural cause deaths (Christiansen et al., 2020; Yule & Levin, 2019). Death by suicide, also recognised as a traumatic death, similarly fosters a high prevalence of complicated grief (Feigelman et al., 2011; Levi-Belz et al., 2019; Valentine et al., 2016). However, while diagnostic criteria for complicated grief now exist (Wilson et al., 2022), literature has called for diverging therapeutic approaches in the design and delivery of support for both groups (Feigelman et al., 2023).

Bereavement outcomes are consequential of multiple pre- and post-loss factors, including anticipatory grief before the loss (Feigelman et al., 2023), and feelings of shame, guilt, blame, and rumination following the death (Lambert et al., 2021; Valentine et al., 2016). Socially constructed belief systems regarding people who use drugs engender disenfranchisement for the bereaved, negatively characterising the deceased

and inhibiting the availability of external social support (Dyregrov & Selseng, 2022). With an increased risk of PTSD, generalised anxiety disorder, substance use disorder, physical illness, and natural cause mortality (Bottomley et al., 2022; Christiansen et al., 2020 Lambert et al., 2021), targeted and timely bereavement supports are pivotal to the mitigation of detrimental health outcomes.

1.5 Healing, Adaptation, and Posttraumatic Growth

Distressing life experiences can generate significant personal adversities that challenge an individual's sense of identity and disrupt their assumptive worldview (Walter et al., 2015). Evidently, drug-related losses can engender unique and complicated grief symptoms which introduce further nuances to the bereavement experience and the process of post-loss adjustment (Bellet et al., 2020; Wilson et al., 2022). However, as several studies have identified strengths-based and reflective meaning making processes as facilitators of positive adaptation (Delgado et al., 2023; Neimeyer, 2019), further research in the traumatic death literature has demonstrated the transformative potential of context-appropriate healing strategies when addressing complicated grief (Delgado et al., 2023). In essence, intervention strategies that target complex grief outcomes have the potential to create pathways to posttraumatic growth for the bereaved (Calhoun & Tedeschi, 2018; Tedeschi & Calhoun, 2004).

Posttraumatic growth can be understood as the positive psychological change that occurs due to coping with challenging life events such as bereavement and loss (Delgado et al., 2023; Tedeschi & Calhoun, 2004). While both complicated grief and posttraumatic growth originate from traumatic life circumstances, the latter refers to the

positive changes following such adversity. Adaptive coping strategies may mitigate the impacts of complicated grief and facilitate a transformative process of growth (Calhoun & Tedeschi, 2018). Posttraumatic growth manifests in a variety of context- and person-dependent ways, but the Inventory of Posttraumatic Growth (Tedeschi & Calhoun, 1996) highlights five key domains in which it can be measured or observed, supported by subsequent literature: an increased appreciation for life, strengthened meaningful personal relationships, increased personal strength, changed priorities and new pathways in life, and a more enriched spiritual life (Calhoun & Tedeschi, 2018; Tedeschi & Calhoun, 2004).

As demonstrated within the evidence base, DRDs carry unique social and health challenges. To best support the bereaved through their process of post-loss adjustment, is it imperative to understand the key indicators of, and pathways to, posttraumatic growth. To this end, research efforts should continue to highlight the direct impacts of DRDs across diverse social contexts while underscoring facilitators for recovery which can inform therapeutic intervention.

1.6 Thesis Conceptualisation and Aims

In conceptualising the direction and contributions of this thesis, it became evident that there is a critical societal failure to sufficiently acknowledge, validate, and address the experiences of those who are bereaved by a DRD. As so many grieve in isolation, there is an urgent requirement for comprehensive strengths-based and compassion-focused societal responses at the intersection of health, justice, and social systems. Furthermore, service oversights are compounded by significant research gaps,

where research funding should be allocated to the creation of evidence-based, multisectoral interventions. Thus, this thesis presents the argument for psychological justice for those who are impacted by such losses.

1.6.1 Psychological Justice

The fundamental values of psychological justice conceptualise psychological wellbeing as a basic human right (World Health Organisation, 2022b). The work presented in this thesis adopts this position, aiming to challenge stigma and discrimination, promote the values of community inclusion, and encourage person-centred services for people bereaved by a DRD (World Health Organisation & United Nations, 2023). The joint report on mental health and human rights by the World Health Organisation and United Nations (2023) specifies that the development of any new mental health-related and person-centred services require active engagement from those with lived experience. In sharing the voices of the bereaved throughout this doctoral thesis, I do so in line the global vision for mental health support by encouraging communities and services to work towards cultivating a socially enriching society free from discrimination (World Health Organisation 2022b).

Overall, this thesis was formulated with the aim of informing services for the bereaved, shaping policy to respond to their needs, and subsequently highlighting the avenues for increased access to therapeutic pathways. In allowing individuals to flourish, attaining psychological justice involves “equipping individuals with a fair complement of the psychological features that our society demands...a proper fit between individuals’ psychological capacities and the social environment” (Wakefield, 2013, p. 133). Such a stance is particularly pertinent in relation to the DRD bereaved, as

people who are stigmatised will often feel forced to experience distress as opposed to facing discrimination when attempting to access services (World Health Organisation, 2022b).

1.6.2 Justification of Approach

Upon engaging with the literature, it became clear to me that those who are bereaved by a DRD face extremely difficult challenges when attempting to overcome such debilitating losses, but also in preserving the honour of their loved one. Most crucially, however, they live within social systems that deprive them of their agency in the grieving process, dictating their right to mourn and marginalising them beyond their control. While much of their experience speaks to the broader requirement for a cultural and sociopolitical shift towards recognising addiction as a health issue, there are significant steps to be taken in the process to ensure the bereaved are protected and supported within the current societal paradigm. In conceptualising the direction of this thesis, I recognised the importance of highlighting opportunities for change, and two significant points of concern emerged from a rigorous exploration of the evidence base.

Firstly, given the rising DRD totals both in Ireland and in the broader global context (CDC, 2024; EMCDDA, 2024), the lack of appropriately targeted supports for those left behind highlights a significant gap in care practice. Existing research continues to demonstrate the unique challenges faced by families, but when beginning this doctoral thesis, their stories of healing went unheard. Thus, I sought to explore the experiences of posttraumatic growth for bereaved family members and identify key facilitators for adaptation. Determining these factors plays a crucial role in the development and cultivation of context-sensitive support. Intra-family supports are often

among the most helpful for bereaved individuals (Aoun et al., 2018), but Lambert and colleagues (2021) identified relationship breakdown in family structures following a DRD. Stroebe & Schut (2015) reinforced the conceptualisation of familial grief as a process where individual and relational factors operate simultaneously and must be considered as such. Therefore, in this thesis I examine posttraumatic growth in the context of family dynamics, exploring how the bereaved integrate their grief and heal as a family unit (Chapter 4).

Secondly, the broader social context of drug-related bereavement had not been considered in the literature. People who use drugs exist within a complex social sphere (Velleman et al., 1993), engaging with services in overlapping health, social, and justice contexts. During life, they interact with several healthcare professionals (HCPs), peers, and other members of the public and form sustained connections (O’Callaghan & Lambert, 2023). When a death occurs, it signifies the physical termination of these relationships and, principally, these social contacts exist within the same sociocultural environment that criminalises families in the aftermath (Guy & Holloway, 2007). Staff in areas such as suicide and homelessness report profound grief-related following a client’s death (Fairman et al., 2014; Lakeman, 2011; Valente & Saunders, 2002). Burnout is strongly associated with client death for HCPs (Boerner et al., 2017; Green et al., 2020), characterised by exhaustion, detachment, depersonalisation, and diminished quality of care practice (Maslach et al., 1997; Shanafelt et al., 2009). Accordingly, I aimed to elucidate the impact of drug-related client loss for HCPs. In this thesis, I investigate the complex intersection of grieving the DRD of a client while socially positioned as a professional (Chapter 6).

Conducting much of this research during the COVID-19 pandemic presented significant delays and challenges for the research process. However, such unforeseen circumstances also generated important research opportunities to future-proof services against circumstances that inhibit service delivery. Arising from my engagement with HCPs during the lockdown period, I conducted additional research investigating the challenges of supporting people in active addiction during the COVID-19 pandemic (Chapter 8). Furthermore, the study acknowledges the challenges of overcoming loss during such unprecedented times.

Additionally, HCPs in Chapter 6 identified people in active addiction as an under-acknowledged and stigmatised group in the aftermath of a peer's DRD, calling for wider recognition of their grief. Furthermore, this group are sparsely investigated in the literature. Thus, in Chapter 9, I investigate how the internalisation of stigma shapes the grief experience for peers in active addiction. Overall, my research encapsulates the experience of drug-related bereavement mapped across three interrelated social groups: peers in active addiction, HCPs, and families.

1.6.3 Thesis Aims

This thesis aims to map the social context of drug-related bereavement by researching grief-responses across three specific subgroups. Overall, this thesis contains the voices of 38 bereaved individuals, with whom the following questions are investigated:

1. How do families bereaved by a DRD experience positive adaptation following the loss of a family member?

2. How does drug-related client loss affect healthcare professionals who support clients in active addiction?
3. What were the unique challenges of supporting clients, and dealing with loss, in addiction-related services during the COVID-19 pandemic?
4. How does the experience of drug-related peer loss affect individuals who are also in active addiction at the time of death?

1.6.4 Structural Outline of Thesis

Through a series of peer-reviewed academic publications, this thesis presents one scoping literature review and four empirical research papers that serve as individual chapters in this document. The papers are presented sequentially in the order of their conceptualisation, beginning with families and extending to the wider social context to address HCPs and peers. All four empirical papers have been peer-reviewed and published in international addiction- or grief-related academic journals.

Chapter 2 presents a scoping review of the literature which informed and focused the direction of this thesis. While a comprehensive and directive systematic review on DRD bereaved families had been published by Titlestad et al. (2019) at the very beginning of my doctoral programme, I considered it important to scope out the literature on the broader social context of drug-related bereavement. This was done in consideration for others who may have been impacted by a DRD, and although sparse at the time of writing, the existing research provided direction for the ongoing empirical work in this thesis.

Chapter 3 of this thesis functions as a Methodology chapter for my empirical work. While the specific procedural details for each empirical project are outlined in their respective chapters, Chapter 3 presents the core methodological and ethical principles to which I adhered for conducting socially engaged research. This thesis was supported by engagement with several community partners throughout various stages of the research process, and I discuss research design practices with respect to these partners. Additionally, the chapter contains an overview of the theoretical framework underpinning my research, known as the dual process model of coping with bereavement (Stroebe & Schut, 1999, 2010). With the concept of psychological justice acting as a foundational basis for the research, I detail my ongoing efforts to utilise this work to facilitate change through traditional and non-traditional dissemination methods. Lastly, I provide a reflection on the experience of conducting this doctorate and working with such a sensitive topic.

Chapter 4 presents the first of my empirical studies, ‘Posttraumatic growth following a drug-related death: a family perspective.’ The first study conceptualised for the purposes of this thesis, the COVID-19 pandemic generated significant challenges to ethically and safely engaging with bereaved families. However, upon co-authoring a paper by Lambert, O’Callaghan, & Frost (2021) titled ‘Special death: Living with bereavement by drug-related death in Ireland’ (Appendix VIII), the opportunity to conduct a secondary data analysis on existing qualitative data emerged. Thus, this chapter covers the journeys of healing for seven family units who lost a loved one to a DRD. **Chapter 5** provides additional context to the findings of this paper in line with Stroebe & Schut’s (1999) dual process model of coping with bereavement, with

consideration for their updated family-based interpersonal coping framework (Stroebe & Schut, 2015).

In **Chapter 6**, I present my second empirical study, ‘The experience of drug-related client loss for healthcare professionals who support people in addiction.’ Initially planned for conduction upon completion of the family study, COVID-19-related complications impelled me to pivot my planned structure for the doctorate. Thus, I conducted online interviews for this project as the first stage of data collection for the thesis. This research contains the voices of 15 HCPs across professions in addiction, social work, and emergency medicine, exploring their experience with client loss associated with drug use. However, as this research occurred during the pandemic, I viewed it as an academic responsibility to also account for their experiences during such unprecedented times, with the aim of informing structures to future-proof service delivery. Thus, **Chapter 7** contains a reflection on conducting research during the lockdown period, and **Chapter 8** presents the academic paper ‘The impact of COVID-19 on healthcare professionals who are exposed to drug-related deaths while supporting clients experiencing addiction.’

In **Chapter 9**, I present my final empirical paper, ‘The internalisation of stigma and the shaping of the grief experience for peers bereaved by a drug-related death.’ Throughout interviews with HCPs, they acknowledged peers in active addiction as an unrecognised group impacted by grief when a DRD occurs within a community. Alongside their lack of representation in the literature, I was motivated to highlight their experiences and advocate for increased grief support and recognition. For this project, I conducted an interpretative phenomenological analysis on the experience of 6 people in

recovery who experienced the DRD of a peer while in active addiction. This project was incredible formative for my personal and academic development and encouraged me to continue to recognise the value of psychological justice in supporting people to flourish and reach their potential.

In **Chapter 10**, I critically appraise the contributions of this body of research in a thorough discussion of the theoretical and applied implications for policy and care practice. I provide recommendations for future research and practice and conclude this thesis with closing remarks through a reflection on this process.

1.6.5 Thesis Contribution

This thesis contributes valuable knowledge and practice insights regarding the experiences of a significantly under-represented population in research, policy, and implementation. Exacerbated by a lack of social visibility and formalised support pathways, people bereaved by a DRD are at increased risk for acute psychosocial and physical health challenges. By foregrounding their experiences, this research advocates for the development of compassionate community and organisational practice responses that challenge stigma and facilitate resilience for the bereaved.

Chapter 2: Bereavement in the Social Context of Drug Use: A Scoping Review of the Literature

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2.1 Abstract

Drug-related deaths (DRDs) are a rapidly rising concern for international health, placing people bereaved by DRDs at an elevated risk for complicated and disenfranchised grief outcomes. Empirically, the psychological impacts associated with these losses remain understudied, but recent research efforts have begun to focus on the experiences of DRD bereaved family members. As people who use drugs exist with a myriad social, healthcare, and justice settings, this review examines the status of DRD bereavement literature within the broader relational context of drug use. Abiding by the PRISMA extension for scoping reviews (PRISMA-ScR), the current study presents a scoping review of the literature surrounding the impact of DRDs on the wider mesosystem of the deceased. A search of online database records accessible from 1990-2020, with a secondary search including material from 2020-2021, identified five studies directly examining drug-related bereavement beyond the family system. These studies cover two social groups: people who use drugs that experience the DRD of a social contact, and healthcare professionals that lose a client to drug-related circumstances. While severely

limited in volume, a cross-study analysis of common patterns and themes identified grief reactions, challenges to support, and an interrelated social context for both groups. The review identifies a significant gap in the evidence base, demonstrates the importance of generating more robust evidence, and provides recommendations for future research directions.

2.2 Introduction

Drug-related deaths (DRDs) are a rising global health concern associated with substantial levels of mortality worldwide (Titlestad et al., 2019; Yule & Levin, 2019). With considerable implications for public health, international cross-disciplinary research efforts have generated practical contributions to understanding the various risk factors associated with these losses. While much of the research has been generated across epidemiology (Slavova et al., 2017), legislation (Erfanian et al., 2019), pharmacology (Emery & Eitan, 2019), and public health (Kolodny et al., 2015), DRDs are considerably under-represented in the social sciences.

The body of empirical research surrounding DRDs is historically extensive and, to date, maintains a central focus on death prevention by addressing a multifaceted combination of addiction-related factors. Broadly, these variables include causes of death (Webb et al., 2003; Nordstrom et al., 2013), barriers to naloxone administration and overdose reversal (Strang et al., 2019), and biological indicators of drug use and associated outcomes (Joffe et al., 2014; Wolff et al., 1990). With an aim towards supporting clinical practice, some of the earliest studies addressing DRDs examined the prevalence of death among medical inpatients in clinical settings, identifying risk factors

that may alert clinicians, social workers and other service providers to potential adverse drug-related outcomes (Porter & Jick, 1977; Ebbessen et al., 2001).

Correspondingly, empirical research from a range of disciplines has been chiefly concerned with people who use drugs and those who have died from drug-related circumstances (Feigelman et al., 2011; Titlestad et al., 2019). While this research remains crucial to the development of pragmatic DRD prevention strategies, there has been a lack of parallel research efforts which address DRDs from a postvention perspective. More specifically, the mental health and wellbeing outcomes of DRDs for those who are grieving such losses has failed to generate interest amongst researchers (Lambert et al., 2021; Titlestad et al., 2019).

2.2.1 Review Context

Consequential of circumstances that are societally perceived as unlawful, drug-induced deaths carry significant moral stigmas (da Silva et al., 2007). This stigma emerges from the social misconstruction of the nature of addiction across multiple cultural contexts, where it is systemically positioned as an immoral criminal justice issue and perceived as a lifestyle choice (Turnbull & Standing, 2016). Such belief systems yield substantial implications for the bereaved as their grief manifests against a sociocultural backdrop that criminalises the person who uses drugs (Guy, 2004). Negative societal depictions of the deceased are further reinforced by multidirectional characteristics of the social culture in which the bereaved are situated inclusive of the media and legislative policy (Templeton et al., 2017). Consequently, when an individual dies in this way, the bereaved must contend with a socially stigmatised representation of their loved one (Guy & Holloway, 2007).

2.2.1.1 Variance in Definition and Outcomes

The lack of an intercultural and standardised definition of DRDs presents significant challenges when discerning their true prevalence. Misclassified toxicology reports and underreported death totals yield fundamental policy and practice consequences, particularly when assessing trends, evaluating the optimisation of prevention initiatives, and allocating governmental funding (Ruhm, 2019; Stam et al., 2019). The definition of DRDs also varies across the literature, with some existing studies focusing on the broader concept of “substance-related deaths” (Templeton et al., 2016; Valentine et al., 2018; Walter et al., 2017) inclusive of drugs and alcohol, and others focusing more specifically on the illegal use of drugs such as opioids (Titlestad et al., 2019). However, these definitions are employed inconsistently throughout the evidence base.

Without a categorical separation between different types of drug deaths, postvention responses are at risk of being incongruous to the specific support requirements of the bereaved. Participants in each of the studies addressing “substance-related deaths” report deeply complex grief reactions across those bereaved by alcohol as a singular cause of death, opioids, or a combination of drugs referred to as polydrug use (Cartwright, 2019; Templeton et al., 2016). However, when applying a more concentrated lens, there are divergent bereavement characteristics that warrant more intricate investigation. For example, the literature suggests differences in the experience of stigma between people bereaved by alcohol-related deaths and those bereaved by a death associated with illegal drugs (Templeton, 2016; Titlestad et al., 2019). This may be particularly true in the case of involvement with criminal justice systems (Valentine

& Walter, 2015). Substance-bereaved participants in an interview study by Cartwright (2019) also reported significant stigmatisation outside of counselling, which was more prevalent for those who were bereaved by a death involving the use of drugs other than alcohol.

2.2.1.2 Current Focus of Existing Evidence

While there is limited research available, a slowly expanding body of research has focused on bereavement following a drug-induced death in family members, with two literature reviews that collate the evidence to date. A scoping review by Valentine et al. (2016) identified 4 studies that specifically address bereavement associated with a substance-related death, three with a qualitative design (Guy, 2004; Grace, 2012; da Silva et al., 2007) and one exploratory survey (Feigelman et al., 2011). The review provides a comprehensive overview of substance-related deaths and the complex bereavement outcomes associated with these losses. However, given the lack of available literature, the study also draws on what is known about other socially censured deaths such as suicide or manslaughter to provide further context (Valentine et al., 2016).

In 2019, a systematic review by Titlestad and colleagues examined drug-related bereavement in a family context and synthesised common themes across eight studies which, according to the search criteria, were of strong methodological quality with a low risk of bias. Seven of these studies were qualitative in design, and one was an exploratory survey. Some of these studies overlap with the research identified by Valentine et al. (2016), but Titlestad and colleagues (2019) additionally included studies written in languages other than English, of Norwegian and Danish origin. Overall, the

eight identified papers were produced in the United Kingdom (2), the United States (3), Brazil (1), Norway (1), and Denmark (1).

As both reviews provide a critical and timely insight into the experiences of bereaved families, they also differ in focus. Reflective of the variance in research regarding DRDs, and despite the overlap of some of the identified research papers, both reviews adhere to different parameters when examining the cause of death. Titlestad et al. (2019) adopt their definition from the Norwegian Directorate of Health, defining DRDs as deaths consequential of the use of narcotics (i.e., opioids) and may also be a result of violence, accidents, or health complications linked to drug use. As a systematic review, the review protocol was also pre-registered (Titlestad et al., 2019). Conversely, while no strict definition is provided, Valentine et al. (2016) more broadly encapsulates substance-related deaths inclusive of alcohol as a singular cause of death. Furthermore, the authors do not outline the search strategy involved in scoping the literature.

Both reviews acknowledge studies that focus specifically on families, inclusive of parents, grandparents, partners, siblings, and children (Titlestad et al., 2019; Valentine et al., 2016). Prevailing themes across these reviews included relationship strain from living with active substance use, stigmatisation of the bereaved, complex emotions, a lack of help when in crisis, and the value of social support (Titlestad et al., 2019; Valentine et al., 2016). Most crucially, however, both reviews collectively highlight the significantly under-researched nature of this phenomenon and the lack of available evidence to facilitate the development of support protocols. Titlestad et al. (2019) suggested further qualitative and quantitative inquiry to develop a more profound

foundation of evidence, as families bereaved by a DRD are a critically understudied population.

Following the publication of the scoping review by Valentine et al. (2016), a broad study initiative was launched across England and Scotland to address bereavement from drug- and alcohol-related deaths (Templeton et al., 2016). This research collaboration interviewed 106 DRD bereaved adults connected to the deceased inclusive of parents, children, and partners, and has produced several publications on the topic of substance deaths and bereavement (Templeton et al., 2017; Valentine et al., 2018; Walter et al., 2017).

2.2.1.3 Conceptualising Bereavement Outcomes

One of the earliest studies to directly examine drug-related bereavement was published in the United Kingdom (Guy, 2004), who explored the grief experiences of a mother, father, sister, and grandfather who had lost a loved one to a DRD. The social censure surrounding drug use was identified as a key inhibitor to healing from the loss, which engendered a profound lack of social support (Guy, 2004). Participants also reported feelings of shame while situated within their own communities, and a lack of confidence in their familial role as a carer (Guy, 2004).

Such patterns of grief are echoed by participants throughout subsequent research efforts that have emerged in more recent years. For many, the grieving process begins prior to the death of a loved one as families often face difficult circumstances when their loved one is alive. The unpredictable nature of active addiction can permeate the family structure with fear, uncertainty, and significant distress (Valentine et al., 2016). This experience can be compounded by the loss of hope, which emerge as a form of

anticipatory grief (Turnbull & Standing, 2016). Anticipatory grief can be a response to the loss of their loved one's identity, or the possibility of their death (Shore et al., 2016), given the interaction between the loss of hope and the increased mortality risks associated with addiction. Such a "veiled preparation" can foster a complex blend of relief and ambivalence when a loved one passes away (da Silva et al., 2007).

Conversely, situations may also arise where a family is unaware of their loved one's drug use until their death, which can exacerbate feelings of guilt and create difficulties reconstructing the memory of their loved one as they may discover new details at inquests and funerals (da Silva et al., 2007). However, this domain remains understudied, with da Silva et al. (2007) conducting the only known comparative study in this context. Furthermore, deaths after a period of abstinence are also a predominant concern, often due to issues with decreased tolerance, which can compound the trauma of the loss as parents perceive their loved one to be safe and may not feel any degree of emotional preparation (Guy, 2004; Templeton et al., 2017).

When a death occurs, families bereaved by a DRD are at increased risk for complicated grief outcomes, which is a grief that does not naturally remit over time and can prevent a person from adapting to their bereavement (Tobin et al., 2020). Incongruencies between one's own memory and society's interpretation of the deceased can lead to complicated bereavement outcomes, as people who mourn DRDs must psychologically negotiate dominant sociocultural norms against their personal loss (Valentine & Walter, 2015). These stigmas can manifest externally as the bereaved experience a lack of social support (Titlestad et al., 2019), which can be further exacerbated by the mental internalisation of negative cultural stigmas (Valentine et al.,

2016). Grief consequential of drug use can become disenfranchised, which is a loss that is deprived of wider social acknowledgement and cannot be publicly mourned (Doka, 2002). There may also be additionally traumatic circumstances attached to the death, as participants in an interview study by Templeton et al. (2017) reported severely traumatic reactions to finding the body of their loved one.

Drug-related bereavement is, overall, characterised by stigmatisation, emotional and existential difficulties, and hindered support in both social and professional dimensions (Valentine et al., 2016, Titlestad et al., 2019). Families bereaved by a DRD are met with many unique challenges specific to their bereavement and, in a survey study, Feigelman et al. (2011) found that those bereaved by a drug-related death experienced more intense grief and reported more severe mental health difficulties than those bereaved by accidents or natural deaths. Christiansen et al. (2020) reported that parents bereaved by a DRD are at increased risk for substance dependency, long-term psychological outcomes, and natural cause mortality. The predisposition of drug use as a criminal activity in most sociocultural contexts heavily inhibits grief processes for those grieving a drug death, with clear implications for their health (Feigelman et al., 2020).

Despite rising trends in drug-related harms and mortalities worldwide (EMCDDA, 2020; HRB, 2019), and the identification of complex grief reactions for families bereaved by a DRD as early as 2004 (Guy, 2004), the health outcomes of drug-related bereavement have remained critically underexplored. Furthermore, for every DRD, approximately ten people are bereaved (Dyregrov et al., 2018, as cited in Titlestad et al., 2019), which may include numerous individuals outside of the family system. As people who use drugs travers a range of healthcare and social contexts, consideration for

others who may be impacted by their deaths is of critical importance. Furthermore, each of these potential social contacts exist within the same sociocultural frame of existence that criminalises drug use. This broader relational context warrants further investigation, which provides the foundational basis for the current review.

2.2.2 Review Rationale

In selecting an appropriate methodology for searching and reporting, important considerations were made regarding the suitability of various review strategies. The objective of this review is largely exploratory in nature, aiming to discern the scope of populations addressed in drug-related bereavement research and identify gaps in the evidence base regarding their experiences. The recent systematic review by Titlestad et al. (2019) reported on existing methodologically robust studies addressing drug-related bereavement in families, highlighting significant empirical oversights when addressing the experiences of this population. Building on this knowledge, the current review aims to discern the availability of evidence regarding bereavement beyond the family system; within the social context of people who use drugs.

As a specific focus was not defined a priori, such as a fixed population within the relational context of the deceased, a scoping review emerged as the most suitable approach (Tricco et al., 2016). Scoping reviews are applicable when presenting broad overviews of evidence, useful when addressing areas that are emerging, and pertinent in identifying gaps in the evidence base (Arksey & O'Malley, 2005; Munn et al., 2018; Tricco et al., 2016). Overall, they present a rigorous method of mapping and outlining key findings (Arksey & O'Malley, 2005; Munn et al., 2018). The approach is particularly suitable for the nature of the current exploratory research as no distinct

methodological design frameworks were addressed in the inclusion criteria (Arksey & O'Malley, 2005). In line with the aims of this review, the accessible format can assist policy makers and practitioners in making use of the findings (Arksey & O'Malley, 2005). However, Tricco et al. (2016) reported a lack of consistency in how reviews are reported, which can compromise knowledge synthesis and transferability.

To ensure that this scoping review is carried out in a reliable and systematic manner, the search process and reporting of results are carried out in adherence with the Preferred Reporting Items for Systematic Reviews and Meta Analyses extension for scoping reviews (PRISMA-ScR), as outlined by Tricco et al. (2018). This review adopts the framework presented in the checklist and reporting guide for the purposes of clarity and consistency, and to increase the transparency and validity of the reporting process (Tricco et al., 2018).

2.2.3 Objectives

To contribute new knowledge while building on the existing evidence collated in the reviews by Valentine et al. (2016) and Titlestad et al. (2019), this scoping review aims to identify further available evidence exploring grief and bereavement following DRD of a non-familial social contact. As opioid-related deaths are rising on a global scale (EMCDDA, 2020), and these deaths engender uniquely complex bereavement outcomes (Cartwright et al., 2019; Templeton et al., 2016), this review focuses deaths consequential of the intake of opioids or the non-medical use of prescription drugs (Titlestad et al., 2019).

The informed choice to retain this focus is supported by the ongoing necessity to streamline the global understanding of unique and complex bereavement outcomes, with implications for designing appropriately tailored supports. Clinicians require such evidence to make informed decisions regarding how to support the bereaved, and to understand what separates such complicated grief from normative grieving trajectories (Zisook & Shear, 2009). This focus also aligns with, and aims to build on, the growing European effort to understand such complex grief outcomes (Titlestad et al., 2019).

With acknowledgement for the definitional inconsistencies regarding DRD in the literature, however, the term “substance-related death” will be retained in the search strategy to ensure a comprehensive initial scope. As such, the review poses the following questions about an emerging research area:

- Which non-familial social groups have been addressed within the existing evidence base?
- What research exists regarding their grief responses and bereavement experiences?
- What methodologies are employed to engage with participants within these studies?
- What are the key gaps within the literature that serve as points of reference for directing future research?

2.3 Method

In line with the PRISMA-ScR checklist (Tricco et al., 2018), this section will report the decision-making processes and methodological considerations that informed

the current review. The research team engaged in ongoing dialogue and collaboration for each step of the review process.

2.3.1. Eligibility Criteria for Inclusion

For inclusion in this review, eligible papers were required to address the topic of DRDs in line with the definition provided in this paper, with a specified focus on measuring or exploring grief and bereavement outcomes. As there were no restrictions placed on methodological approach, the inclusion criteria accounted for qualitative, quantitative, or mixed methods empirical research studies. Any relevant literature reviews addressing the topic were also eligible. Articles were included in the first search if they were written in English and published between January 1st, 1990-February 29th, 2020. A supplementary search with the same parameters permitted the inclusion of articles published between March 1st, 2020-March 31st, 2021.

2.3.2 Databases

To identify documents and articles that fit the criteria, the following databases were searched: Academic Search Complete, CINAHL Plus with Full Text, MEDLINE, APA PsychArticles, and APA PsychInfo. This search was supported by additional manual searches of reference lists within the chosen papers, and screening of specific journals. These journals included, but were not exclusive to: Death Studies, OMEGA-Journal of Death and Dying, and Addiction Research and Theory. Results of searches were exported to Zotero via BibTex file format.

2.3.3 Search Strategy

The search criteria were broad to initially capture all available evidence surrounding drug-related bereavement, which could then be screened and reduced following informed decisions in line with the inclusion criteria. Search terms were carefully cultivated between the research team in collaboration with a librarian who specialises in supporting reviews of evidence and search protocols. All databases were searched with the same search terms, as follows:

Search of Title, Abstract, and Key Words: "drug related death*" OR "substance related death*" OR "drug-related death*" OR "substance-related death*" OR "drug death" OR "substance death" OR “overdose death” OR “death by overdose” OR “bereaved by substance” OR “bereaved by drug”

AND

Search of Full Text: "grief" OR "loss" OR "bereave*" OR "mourning" OR “mental health” OR “adjustment”

The search strategy involved a three-tier approach to screening items, beginning with the initial search as per the outlined search terms, followed by a review of the titles and abstracts of each resulting item. As a final decision-making process with regards to paper inclusion, the first author examined the remaining full texts.

2.3.3.1 Search 1: 1st January 1990-29th February 2020

A total of 473 items were identified in this initial search, exported to the software Zotero as the citation manager for this review. Once exported, cross-database duplicates were removed, resulting in the retention of 303 items. Upon further

screening, the additional manual removal of several duplicates resulted in the final number of retained items settling at 301. The titles and abstracts of each of these documents were screened, and papers were excluded if they did not address grief and bereavement associated with DRDs. This initial screening resulted in the retention of 15 items that specifically addressed grief following a drug- or substance-related death in any social group. Manual searches of reference lists and journals resulted in the inclusion of an additional seven items. If available, the entire texts for the remaining 22 items were screened, for which the decision process is outlined in section 2.3.4.

2.3.3.2 Search 2: 1st March 2020-31st March 2021

A supplementary search was carried out in April of 2021, spanning the above dates. An additional 121 items were identified, with 71 retained following the removal of duplicates. Six items which directly addressed grief and bereavement were retained for full text screening (Christiansen et al., 2020; Dyregrov et al., 2020; Templeton, 2020; Titlestad et al., 2020, 2021; Urmanche, 2020).

2.3.4 Final Extraction, Charting, and Synthesis

Across both searches, 28 items were retained due to their exploration of bereavement in the context of substance and drug use, consisting of a mix of empirical work, reviews, and doctoral theses. Broadly, four identified works focused on bereaved healthcare professionals (Hartmann, 2018; McAuley & Forsyth, 2011; Urmanche, 2020; Yule & Levin, 2019), and one item investigated the impact of DRDs on peers in active addiction (Wojtkowiak et al., 2019). The remaining 23 items investigated bereavement in various immediate and extended family members. Three studies within this group also investigated bereavement in friends alongside family members (Templeton et al.,

2016, 2017; Walter et al., 2017). Valentine et al. (2018) and Templeton (2020) included service providers interviews but focused on their support of the bereaved.

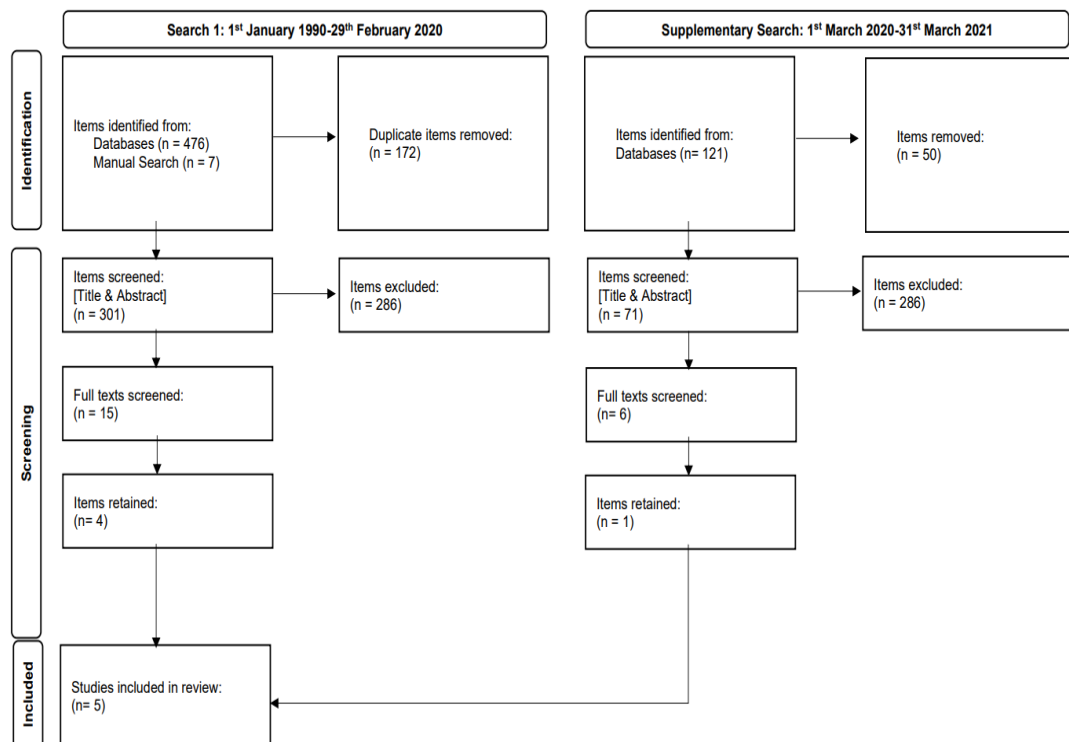
Where possible, each text was screened in full and key details charted by the first author. A doctoral dissertation by Hartmann (2018), a book by Valentine (2017), and a research paper by Valentine (2018) were excluded due to inaccessibility. A decision-making process then occurred regarding which articles to retain. At the first instance, 9 items were removed as they focused solely on alcohol-related deaths (Standing et al., 2019) or accounted for both drug- and alcohol-related deaths in their recruitment, design, or methodology with limited or no clear distinction reported in the findings (Cartwright, 2019; Templeton, 2020; Templeton et al., 2016; Valentine et al., 2018; Valentine & Walter, 2015; Walter et al., 2017). An academic report by Turnbull & Standing (2016), which spoke broadly of people bereaved by both drugs and alcohol, was removed. A scoping review by Valentine et al. (2016) accounted for both alcohol- and drug-related deaths and was subsequently removed from the item list.

The second level of decision-making involved the exclusion of papers that focused exclusively on the bereavement experiences of family members, recently accounted for in a comprehensive systematic review by Titlestad et al. (2019). Screening the population of focus in each remaining study resulted in the removal of 11 items. Seven studies included parents (Christiansen et al., 2020; Feigelman et al., 2011; Feigelman et al., 2020; Guy & Holloway, 2007; Nowak, 2015; Titlestad et al., 2020, 2021), one study included parents and siblings (da Silva et al., 2007), and one involved a grandparent, a sibling, and two parents (Guy, 2004). Additionally, two reviews focusing on family members were excluded (Dyregrov et al., 2020; Titlestad et al., 2019).

The remaining five items were retained, with key details outlined in the review chart (Appendix I). Figure 2.1 displays a sequential flow diagram of the search process adapted from the PRISMA guidelines (Tricco et al., 2018). Overall, in the broader relational context of drug use, three published studies (one empirical, two reviews) centred around bereavement in healthcare professionals (McAuley & Forsyth, 2011; Urmanche, 2020; Yule & Levin, 2019), and one empirical paper addressed bereavement for peers in active addiction (Wojtkowiak et al., 2019). Templeton et al. (2017) investigated overdose deaths among family members and peers, detailing outcomes specific to peers, some of whom were using drugs at the time of death.

Figure 2.1

Flow diagram demonstrating item search and selection process



2.4 Results

This section presents the synthesis of information from the five studies included in this review. Across the literature, two social groups are represented: HCPs bereaved by the DRDs of clients, and peers of the deceased. The peer group is further divided into two subgroups, peers who use drugs and peers who do not. The key details of each of the retained studies are presented in Table 2.1, with further detail provided in the article chart (Appendix 1).

Table 2.1

Characteristics of Studies Included in Review

Author	Item Type	Population Focus	Methods
McAuley & Forsyth (2011)	Empirical Research	HCPs	Survey
Templeton et al. (2017)	Empirical Research	Family & peers	Interview
Wojtkowiak et al. (2019)	Empirical Research	Peers	Interview
Yule & Levin (2019)	Review Article	Clinicians	N/A
Urmanche (2020)	Review Article	Clinicians	N/A

2.4.1 Characteristics of Included Studies

According to the search results, a study by McAuley & Forsyth (2011) is the only empirical research study to directly address staff bereavement following the DRD of a client. This quantitative study included 65 staff members across voluntary sectors, healthcare, and social work who self-reported grief-related reactions on a 22-item questionnaire. Regarding gender distribution, 37 participants identified as female, and

28 as male. The survey was adapted from Rickerson et al. (2005), who examined grief-related reactions in long-term care staff. Participants in the study by McAuley & Forsyth (2011) were asked to answer the survey with reference to a recent, or most impactful, DRD of a client. Items on the survey included “I have been angry,” “I have been sad,” “I have felt that the client is not really dead,” and “I have been unable to accept the death of a client.” Although primarily focused on the prevalence of grief-related reactions in the population, the survey also included a section where participants could mention any specific support services that they would find useful.

Yule & Levin (2019) produced a literature review regarding support for clinicians following the DRD of a client. In their review, the authors acknowledged that this area has not been studied to any great extent, lending to a lack of clear practice guidelines to support staff following such a complex loss (Yule & Levin, 2019). However, to provide recommendations, the authors highlight the link between opioid use and death by suicide, drawing on suicide-related literature to provide guidance towards developing support mechanisms. Similarly, Urmanche (2020) conducted a literature review aiming to provide guidelines for supporting clinicians who work with people who use drugs when a death occurs within their practice. However, given the dearth of literature within this domain, it draws from the family DRD literature and from practitioners who lose clients to a death by suicide.

As part of the comprehensive interview study across England and Scotland that addressed substance-related bereavement in 106 individuals, Templeton et al. (2017) examined a subset of this data accounting for 32 adults who experienced the overdose death of a loved one. The sample consisted of 19 mothers, four fathers, three siblings,

two partners, and four friends, in which there were 23 females and 9 males. Five of the participants, three friends and two partners, were engaged in active drug use at the time of their loved one's death (Templeton et al., 2017). Each of the deaths addressed in interviews were male, apart from one female. Five themes emerged from a thematic analysis of the interviews surrounding drug use, overdose awareness, and prevention (Templeton et al., 2017).

Wojtkowiak et al. (2019) interviewed 10 bereaved individuals who experienced the DRD of a significant other and were currently engaged in active drug use at the time of death. Using grounded theory to understand their grief narratives and meaning making processes in the context of their own drug use, the study highlights the challenges in grieving a stigmatised loss while carrying a societally stigmatised identity as someone who uses drugs (Wojtkowiak et al., 2019). Inclusion criteria for the interviews required participants to currently be engaged in active drug use, and 10 men were interviewed for the purposes of the study. Throughout interviews, several deaths were referenced, by which participants described the deceased as a friend, female friend, acquaintance, fellow drug user, colleague, girlfriend, cousin, and uncle (Wojtkowiak et al., 2019).

2.5 Synthesis & Discussion

From a thorough search of research databases from January 1990-March 2021, this scoping review encapsulates the current evidence base addressing drug-related bereavement beyond the family system. A total of five records were identified, three of which presented original research evidence (McAuley & Forsyth, 2011; Templeton et

al., 2017; Wojtkowiak et al., 2019), and two review studies that reinforce the gap in the literature (Urmanche, 2020; Yule & Levin, 2019). In this section, three themes which were synthesised across each paper, are explored and discussed in relation to existing literature to support the limited available evidence with additional context: (i) Grief Reactions, (ii) Challenges to Support, and (iii) Interrelated Social Context. These themes provide an overview of existing research findings and the implications for communities following a DRD, highlighting the pervasiveness of grief symptoms in additional social contacts of the bereaved that warrant further investigation

2.5.1 Grief Reactions

The most profound and developed theme across the existing evidence relates to the grief reactions of social contacts of the deceased. In their review, Yule & Levin (2019) identified that staff who are bereaved by a client's death by suicide often experience severe stress, grief, and countertransference reactions. Participants in the study by McAuley & Forsyth (2011), who were bereaved by a DRD, reported similarly complex grief reactions such as anxiety, dreams about clients who died, and difficulties with sleeping. Among the most common grief-related reactions in their study were sadness, guilt, anger, and thoughts about their own morbidity. Most crucially, however, grief reactions were present in 90% of the sample, highlighting a requirement to address complex bereavement outcomes in staff who lose a client to drug-related circumstances (McAuley & Forsyth, 2011). Both Urmanche (2020) and Yule & Levin (2019) highlighted the pervasiveness of intrusive thoughts and guilt among staff bereaved by suicide, who often require targeted support to address these emotions. However, no such supports are reported in McAuley & Forsyth's (2011) study.

As McAuley & Forsyth's (2011) study identifies grief reactions in service providers after the DRD of a client, further empirical follow-up is required to discern the complex intricacies associated with this type of death. The impact of client deaths on practitioners in various other healthcare professions has been studied extensively, inclusive of areas such as homelessness (Lakeman, 2011), suicide (Veilleux, 2011, Urmanche, 2020), and terminal illness (Redinbaugh et al., 2001). When deaths are not processed at an individual level, staff are placed at an elevated risk for adverse practice and health outcomes such as compassion fatigue, absenteeism, and burnout (Urmanche, 2020). Furthermore, the concept of the 'wounded healer' emerged in the literature (O'Brien, 2011, as cited in Urmanche, 2020), where unresolved psychological challenges can impede clinical practice. As such, supporting clinicians in the aftermath of a client's DRD is crucial to the maintenance of optimal staff wellbeing and high standards of professional practice.

McAuley & Forsyth (2011) also reported that grief-related reactions were more profound when a staff member had a closer relationship with a client. This is to be expected, as in general bereavement literature, grief reactions are influenced by a complex amalgamation of personal factors such as pre-existing health conditions, capacities for emotional regulation, and the type of relationship (Bonanno et al., 2007; Shear, 2015). Thus, if staff are already experiencing burnout (Urmanche, 2020), they are placed at an increased risk for complex grief outcomes. Comparatively, client deaths by suicide require targeted support pathways to mitigate against the complexity of the professional situational context and complicated bereavements (Murphy et al., 2019), which McAuley & Forsyth (2011) appeal for in their study

While only reported in a single study, the grief reactions reported by HCPs reflect many of the known grief reactions reported by families. DRD bereaved families face profound emotional and social challenges following the death of a loved one, including guilt (Templeton et al., 2016; Valentine & Walter, 2015), shame (Titlestad et al., 2019; Valentine et al., 2018), and self-blame (Carwright, 2019; Valentine et al., 2018). However, as McAuley & Forsyth (2011) utilised a 22-item self-report questionnaire, there is a requirement to develop a more in-depth psychological understanding of how grief-related reactions manifest within the situational context of being a professional. Recent studies investigating family bereavement following the DRD of a loved one have utilised in-depth qualitative interviews, which have resulted in detailed personal narratives that account for the deeply individualised nature of grief (Titlestad et al., 2020, 2021).

The presence of shame, self-blame, and guilt has also been highlighted among peers who use drugs and have experienced the loss of a loved one to a DRD (Templeton et al., 2017; Wojtkowiak et al., 2019). Templeton et al. (2017) presented a synthesis of their findings across both family members and peers of the deceased, and while family members formed much of the sample, the study provides some critical insights into the experiences of bereaved peers, particularly those who also use drugs. One participant, whose peer died from a DRD when both were actively using drugs, had administered the drugs to this friend and was also present at the time of death (Templeton et al., 2017). This death fostered a profound psychological impact compounded by guilt and self-blame, which the participant stated he is still coping with several years later. The concept of grieving a stigmatised loss while engaged in a stigmatised behaviour was

explored further by Wojtkowiak et al. (2019), who acknowledged that DRDs may engender a sense of culpability among other people who use drugs if they were present at the time of death.

While predominantly focusing on meaning making processes in the context of drug use, Wojtkowiak et al. (2019) provides a critical insight into the grief experiences of people who use drugs when they lose a social contact to a DRD. Coinciding with Templeton et al. (2017), participants in this study reported guilt and self-blame which inhibited meaning making processes (Wojtkowiak et al., 2019). However, the authors also refer to the concept of a delayed grief for people who use drugs, as participants acknowledged that drug use often inhibited their emotional reactions. At times when drug use was reduced, participants felt more extreme emotional responses to such losses with sadness, guilt, anger, and profound rumination, often about their own roles in the death (Wojtkowiak et al., 2019). Thoughts about morbidity or accepting death as a possibility following the DRD of a peer emerged as a common grief-related reaction (Wojtkowiak et al., 2019), similar to the staff in the study by McAuley & Forsyth, who reported thoughts about their own death when a client died from a drug-related complication (2011).

These studies have identified complex grief reactions in two social groups; staff who work in healthcare, and social contacts of the deceased who use drugs. However, despite the identification of such reactions, there has been no empirical or practical follow-up to address the risk of adverse health outcomes. Evidently, there is significant overlap in how the stigma associated with DRDs can engender complex grief reactions for different social groups, but each group also carries a different social identity. Grief is

profoundly complex, and can be influenced by relational, contextual, and situational factors (Breen & O'Connor, 2007; Feigelman et al., 2011; Turnbull & Standing, 2016), highlighting the importance of investigating their grief in the context of their social positioning.

2.5.2 Challenges to Support

While Wojtkowiak et al. (2019) do not specifically focus on or measure social support in their study, they acknowledged that bereavement support can be profoundly inhibited for people who use drugs. Their engagement with active drug use acts as a significant compounding factor to the grief process and shifts their social positioning in society, as they carry the identity associated with addiction as opposed to the identity of someone who is grieving (Wojtkowiak et al., 2019).

McAuley & Forsyth (2011) reported a significant lack DRD-specific supports in professional practice, mirrored by the lack of evidence-based approaches to creating supports that target the complexities of drug-related bereavement. Most crucially, 45 of the survey respondents stated that they would attend a DRD-specific support group if it were available, as traditional bereavement supports may not efficiently address drug-related complications (McAuley & Forsyth, 2011). This is particularly the case with deaths perceived as preventable, as internal questions of competence arise when a client dies as staff contemplate whether they, as the professionals, had overlooked important details (McAuley & Forsyth, 2011; Urmanche, 2020; Yule & Levin, 2019).

Death by suicide can engender complex grief reactions in staff, necessitating targeted bereavement responses that acknowledge the compounding factors associated

with these losses (Murphy et al., 2019). For staff in the regional area of Scotland where McAuley & Forsyth (2011) conducted their study, such supports did not exist for DRDs. Bereaved families report a significant lack of social and professional support (Dyregrov et al., 2020; Templeton et al., 2017; Titlestad et al., 2019), and such failures of compassion can exacerbate profound emotional challenges (Valentine et al., 2018), which may extend to the broader context of the bereaved.

Another, perhaps overlooked, aspect of support relates to the administration of education as a preventative measure, supporting people to be prepared to respond to overdose. As the stress of living with active drug use often compounds the bereavement process when a death occurs (da Silva et al., 2007), supporting and educating families and peers on overdose response may be a crucial element to the prevention of more complicated grief outcomes. Strang et al. (2019) acknowledge the importance of community-level administration of naloxone as an overdose reversal agent for emergency responses to overdose. Templeton et al. (2017) also reported many instances where peers made efforts to resuscitate their loved ones, demonstrating that individuals may often be forced to respond to overdoses without the awareness of how to appropriately intervene. Such is also the case for people who use drugs, as people may be present at the time of an overdose (Wojtkowiak et al., 2019).

2.5.3 Interrelated Social Context

Despite the limited evidence, the existing studies highlighted for this review demonstrate the interrelated social context of drug use. In existing literature, when a family member passes away from a DRD, their families are often exposed to an aspect of the deceased's life that they had not previously engaged with. For example,

Templeton et al (2016) reported that family members often met peers of their loved ones for the first time at funerals which, against the backdrop of social condemnation, reinforced the fact that their family member was loved. However, from the perspective of the peers themselves, trepidation around the interaction with other social contacts was identified as a challenge to normative grieving for people who use drugs, as many of the participants in the study by Wojtkowiak et al. (2019) had felt stigmatised at previous funerals and subsequently avoided them. Interactions with family members of the deceased could potentially be uncomfortable (Wojtkowiak et al., 2019), particularly with respect to their own sense of internalised blame for the death. However, this could, at times, be mitigated if there was a pre-existing close relationship with the family (Wojtkowiak et al., 2019). Interacting with bereaved family members was also highlighted as a potential challenge for clinicians who work in suicide prevention, as many clinicians expect anger and criticism from the loved ones of the deceased (Urmanche, 2020; Yule & Levin, 2019). However, this level of interaction was not addressed in the study by McAuley & Forsyth (2011).

Additionally, family members, HCPs, and peers all hold varying relationships with people who use drugs, with a myriad of personal, social, and professional dynamics. Family members reported self-blame when a loved one died (Titlestad et al., 2019), and Templeton et al. (2016) highlights that this can stem from guilt from a perceived failure in one's role as a parent, sibling, or partner. HCPs may face similar complexities, but they are situated in a role where their responsibilities are professionally defined.

The interrelated social context of drug use, which often manifests after the death occurs, highlights the requirement for integrated care models that account for the complex dynamics and perspectives of different community members.

2.6 Recommendations for Research

This review has further reinforced the urgent requirement for more thorough and robust research efforts in drug-related bereavement. The limited number of included studies reflects a broader need for more empirical attention and comprehensive investigations into the impact of DRDs for a diverse range of social groups. This review acts as a point of progression for future research, identifying grief reactions in at least two community subgroups that require additional follow-up.

In McAuley & Forsyth's (2011) study, one of the key limitations emerged from the use of the self-report scale to identify grief-related reactions. Pre-listed items negated the opportunity for a more complex and in-depth analysis of personal experiences, for which the authors recommend further qualitative inquiry. Given the depth of literature that exists in the domain of client death by suicide (Urmanche, 2020; Yule & Levin, 2019), it is imperative that DRD bereaved clinicians are appropriately represented in practice and literature, with findings integrated into organisational structures. Wojtkowiak et al. (2010) contributed valuable knowledge to the concept of grieving a DRD in the context of one's own drug use. However, the sample consisted of 10 men, warranting further investigation with a more gender-diverse sample that may account for differences which can inform targeted bereavement supports. Additional

considerations should be made for the role of active drug use in influencing coping mechanisms.

A comprehensive, inclusive, and community-based approach to addressing drug-related bereavement is crucially important to support families to achieve positive adaptation, to support clinicians to resume optimal personal and occupational functioning, and to support peers when grieving the loss of their friends. Furthermore, this number of groups is not exhaustive, other social groups who have contact with people who use drugs should be identified and considered for support packages.

2.6.1 Considerations & Limitations

The nature of the scoping review was pertinent in addressing the research gap while retaining a broad search lens. Arksey & O'Malley (2005) stated that scoping reviews are useful when examining a complex area or, in this case, one that has yet to be thoroughly reviewed. While this study abided by the PRISMA-ScR checklist (Tricco et al., 2018) to ensure transparency throughout the review process, there are several limitations which must be considered. The generalisability of the synthesised findings is limited due to the small number of studies that exist on the topic of drug-related bereavement. The dearth of evidence is reflected in the two review studies by Urmanche (2020) and Yule & Levin (2019), which primarily drew from other research areas such as death by suicide. However, this lack of evidence simultaneously reinforces the function of the current review as a point of progression for further research.

There was no quality appraisal of the studies included in this review, nor were they assessed for any risk of bias. Given the lack of empirical studies covered within the

review, it was considered important to include them while offering methodological critiques where relevant. Additionally, this review only accounted for studies that were published in English, this may have excluded some research and inhibited the opportunity for cross-cultural comparisons.

2.6.2 Conclusion

Overall, the current review demonstrates a significant gap in the literature surrounding drug-related bereavement. Profoundly complex grief reactions have been reported in DRD bereaved family members (Titlestad et al., 2019), but grief reactions for others within the social context of the deceased have received limited empirical attention. With the identification of grief reactions in the wider relational context of drug use, and the global rise in DRDs (EMCDDA, 2020), this review demonstrates an urgent requirement for comprehensive research and practice initiatives that support the bereaved across a broad social context.

Chapter 3: Methodology

A central design philosophy for the work presented in this thesis, socially engaged research serves as the foundational approach for promoting equity, empowerment, and social value in the research process. This chapter provides an overview of the key methodological, theoretical, and ethical considerations that underpin the work, ensuring that the research promotes the values of psychological justice towards improved outcomes for DRD bereaved populations. While the precise procedural processes involved in each empirical research project are outlined in their respective chapters, the entire research thesis adhered to a set of overarching principles that will be conveyed herein.

3.1 Design Practices in Socially Engaged Research

Socially engaged research, also referred to as community engaged research (Barkin et al., 2013; Han et al., 2021; Wallerstein et al., 2020), involves the meaningful inclusion of community members within the research process (Han et al., 2021). Partnering with community groups to collaboratively address how phenomena impact people who are situated within that community space, the approach is valued in the social sciences for its propensity to mitigate stigmatisation in the research process (Wallerstein et al., 2020). Aligning with the vision for mental health and human rights by the World Health Organisation and United Nations (2023), which encourages collaborative partnerships with those who have lived experience, studies that adopt this social framework have reported outcomes such as community empowerment, reduced inequalities, and policy changes (Meadow & Owen, 2021; Wallerstein et al., 2020).

In studying public health issues in a real-world context alongside those who have lived experience or a developed understanding of these issues (Barkin et al., 2013), socially engaged approaches are effective at facilitating the transition of research findings into policy and practice (Meadow & Owen, 2021). As an inclusive process, it often provides agency to those who have been excluded from research and policy decision processes (David-Chavez & Gavin, 2018, as cited in Meadow & Owen, 2021). In terms of design, Han et al. (2021) proposed that community engagement is suitable for any stage of the research process, including study design, recruitment, data collection, and dissemination.

For the current research, which aims to amplify marginalised voices and produce research for impact that operates at the confluence of policy and practice, developing a socially engaged approach was a methodological priority. To ensure the research is suitable to the context in which it aims to be applied, I sought to develop a research framework that gave communities and populations agency over their input and role in each project. For the purposes of sensitivity, I also aimed to communicate with partners about their guidance on best practice approaches when engaging with bereaved populations for qualitative research. Thus, to ensure participants were safeguarded for each empirical study, I identified key stakeholders in the discipline of addiction support and recovery who were then involved in design and recruitment processes.

3.1.1 Engaged Research with DRD Bereaved Families (Chapter 4)

In working with secondary data for this paper, the design and recruitment process was previously established with a community collaborator for the original study by Lambert et al. (2021). The study was conducted in partnership with the National

Family Support Network (NFSN) who, although now inoperative, played a crucial national role in supporting families impacted by substance use and dependency. After initial meetings to conceptualise the recruitment process and the design of the study, the NFSN facilitated engagement with families through their nationwide family support groups. In collaborating with the NFSN, it ensured that the findings were directly transferrable to their support frameworks while concurrently building a broader knowledge base around drug-related bereavement.

Collaborators in the NFSN circulated the information within their family networks to ensure that all bereaved family members were provided with equal opportunity to participate if they wished to do so. Family members who fit the inclusion criteria and expressed interest in participation were subsequently sent information packs outlining the nature of the study prior to providing informed consent. Recruitment in this manner ensured that bereaved families were informed of the study by a familiar and trusted agency they were linked with, and they were fully aware of the voluntary nature of the study. Collaborating with the NFSN also ensured that families were provided with follow-up support post-interview if required.

3.1.2 Engaged Research with HCPs (Chapters 6 & 8)

This project was the result of a collaborative effort with multiple agencies across addiction, medicine, homelessness, and social work. As the research process began, and continued, throughout the COVID-19 pandemic, the uncertainties of healthcare were creating unpredictable and stressful working environments. As such, I was cautious about creating additional work for HCPs during such unprecedented times. An initial meeting with a healthcare professional in my existing collaborative research network

opened a preliminary discussion about the project, and they circulated the information for study recruitment through their professional networks. This initial discussion centred around sensitivities towards staff working in healthcare, how to ensure staff are supported in the process of participation, and the identification of various professions that work with clients who use drugs.

Despite the chaotic nature of healthcare during the pandemic, I received significant interest through snowball sampling as the concept of drug-related client loss was pertinent to so many HCPs. Furthermore, the project involved collaborations with community-based organisations such as Cork Simon to source participants working in these areas. In terms of participant safeguarding, each participant was employed in an organisation where employee assistance programme supports was readily available in the event of distress. As participants referenced experiences that occurred within their workplace, the findings could then be circulated back to the organisations to improve support frameworks within their organisational structure.

3.1.3 Engaged Research with People in Recovery (Chapter 9)

The primary collaborator for this project was the Recovery Academy, an organisation that provides support for people in recovery and their families by raising awareness, facilitating recovery activities and training, and conducting research to advocate for policy reform. In conceptualising this project, I met with a representative from the Recovery Academy and an associated individual with lived experience in addiction to delineate the ethical procedures and best practice protocols for interviews. With sensitivity to participants as an utmost priority, I aimed to ensure participants were protected in the process of bravely sharing such difficult experiences. Upon finalising

the research design, the Recovery Academy facilitated the recruitment process by circulating information to clients where participants could self-select to contact myself as the researcher.

The initial criteria for inclusion stated that participants were required to be in recovery for at least two years; in my efforts to ensure sensitivity, I hoped this timeframe would create a safe psychological distance between participants and their experiences. However, this duration proved to be too restrictive and exclusionary for people who self-determined their capacity to participate. In the pilot phases of recruitment, potential participants who reached out to share their stories would not have been permitted to participate under such guidelines. At the request of bereaved peers and in the interest of creating a more inclusive socially engaged research design, additional consultations with practice experts in addiction support and recovery clarified that recovery is self-defined. Thus, once participants had completed treatment and were linked in with the Recovery Academy (or another suitable support organisation), they were eligible to participate.

From a personal standpoint, this experience reinforced the importance of socially engaged research; had this research not been co-designed with community partners, the design may have been exclusionary to a population whose voices are under-represented in the literature and in policy decisions. The setting of a two-year period denied participants agency and enforced an arbitrary timeframe that assumed participants had less capacity to self-select. The feedback from peers was a learning moment regarding the exclusion of voices from research processes. When conducting interviews, meeting times were organised for days where participants also had meetings with their key

workers from the Recovery Academy, ensuring that additional debriefing and follow-up support were available.

3.2 Principal Ethical Practices

The work presented in this thesis adhered to a shared set of ethical principles that underscored the approach to engaging with participants and discussing sensitive experiences. Firstly, all individual research projects received ethical approval by the departmental ethics committee in the School of Applied Psychology, or the university-level Social Research Ethics Committee (SREC). The frameworks for safeguarding participants through community partnerships were conceptualised at this stage of the research design. When working with participants' data, all associated files were anonymised, stored safely in a digital repository, and encrypted. If requested, participants were granted access to their interview transcripts to ensure accuracy of representation.

A primary ethical consideration for all empirical work involved in this doctorate was to create a psychologically safe and compassionate participation experience for all who generously took part. Each participant who shared their voice for this project was linked in with an organisation where support was readily available in the event of distress when discussing topics such as death, bereavement, and loss. Ensuring psychological safety was the main priority, but it was also recognised that while discussing grief can foster feelings of sadness for participants, this is a normal reaction to bereavement and the research process can be part of the healing journey. In the study by Lambert et al. (2021), the same family units represented in Chapter 4 of this thesis,

most family members who participated in the study reported feeling very positive about their participation. No participants described the process as negative, and the majority stated they ‘felt better’ in the days after the interview. Research participation can facilitate meaning making and addresses a desire to help others through the telling of their own story.

Interviews were organised based on each participants situation and individual preference, and while HCP interviews took place online, participants who were in recovery opted to participate in an in-person meeting at a co-agreed suitable location. Collaboration with external agencies also ensured that utmost care was taken with regards to emotional and cultural sensitivity. As I had not yet worked directly with people who have lived experience in addiction, I wanted to ensure the research process was fulfilling and mutually beneficial in a way that recognised participants’ essential contributions to this work. Thus, conversations around the design of the research with research partners were profoundly informative and crucial to the cultivation of a psychologically safe environment. In line with this sensitivity, I maintained a process of ongoing consent throughout interviews.

3.2.1 Considerations for Analysing Secondary Data

The empirical work in Chapter 4 consists of a secondary qualitative data analysis of interviews with bereaved families, originally collected by my PhD supervisor for a study titled ‘Special Death: Living with Bereavement by Drug-Related Death in Ireland’ (Lambert et al., 2021). Before the onset of pandemic-related restrictions related to socially engaged research, I was creating the ethical paradigm for Chapter 4 in which I would recruit families bereaved by a DRD to participate in interviews. However, with

the prolonged lockdown period creating barriers to research practices, I pivoted to the empirical work presented in Chapter 6, engaging in online interviews with HCPs.

As pandemic-related uncertainties continued to generate pervasive research barriers, questions arose as to how I would ethically engage with families while ensuring psychological and public health safeguarding measures. Considering the depth of the experientially rich qualitative data collected for the study by Lambert et al. (2021), a secondary data analysis presented an opportunity to contribute progressive scientific knowledge while expanding the utility of the data (Tate & Happ, 2018). A secondary data analysis, at its core, involves the further analysis of existing data to develop new interpretations and knowledge separate from the original exploration (Hakim, 1982, as cited in Grinyer, 2009; Irwin, 2013). However, such an approach engenders its own epistemological challenges and considerations.

As the data was collected by another researcher, a potential risk was the omission of essential contextual or relational understandings regarding family dynamics and bereavement constructed in the field. However, these concepts are generally not possible to reconstruct with secondary analysis (Tate & Happ, 2018), but the new researcher can interpret the transcripts in their purest form. Tate & Happ (2018) illustrate that access to the original researcher is crucial regarding clarification in this instance, and for this project, my PhD supervisor acted as an adviser and co-author. This connection also facilitated critical and ongoing reflexive processes for my research position, an essential facet of secondary data analysis (Grinyer, 2009).

When investigating life experiences, such as the loss of a child to a DRD, I was deeply conscious that the relationships in qualitative research between interviewers and

participants carry a significant degree of trust (Irwin, 2013). Thus, as the primary researcher on this secondary analysis, I viewed it as an academic necessity and personal responsibility to maintain the integrity of the dataset and ensure the new output would accurately represent participants' stories of grief. Regarding consent, all family members in the original study kindly permitted future academic use of the anonymised transcripts. Transcripts were anonymised by the original researcher, considered to be best practice for the potential further use of data (Tripathy, 2013). Initially, I considered regaining consent from the family members, but as illustrated by Grinyer (2009), in the event consent is already obtained, it is ethically sensitive to avoid placing further demands on participants who recalled painful life experiences for research. We were also aware that one participant was since deceased and that another of the families had lost a second member of their immediate family to a DRD.

While I provided co-authorship on the study by Lambert et al. (2021), I had not viewed the dataset in its entirety nor engaged with it in any analytical capacity. Thus, my familiarity with the original research context, objectives, and methods informed my approach. As such, all analytical and ethical judgements and procedures were carried out with respect to the original research context.

3.3 Theoretical Framework

Grief, as a phenomenon, has been subject to multiple frameworks and theoretical constructs across social science, medicine, and other disciplines, often within sequential stage models that address the progression from initial grief to healing (Fiore, 2021). When determining a suitable theoretical framework to inform the conceptualisation of

this research, initial considerations pointed to one of the most prominent stage models in grief, the five stages of grief model, which has made historically significant practice contributions in the bereavement space (Kübler-Ross, 1969; Kübler-Ross & Kessler, 2005). In this framework, the grieving process moves sequentially through denial, anger, bargaining, depression, and acceptance (Kübler-Ross & Kessler, 2005).

However, DRD literature demonstrates that the associated grief is characteristically unpredictable and non-uniform (Lambert et al., 2021; Titlestad et al., 2019; Dyregrov et al., 2020). In support of this rationalisation, Corr (2019) argued that while the stage model has informed much of contemporary practice, it may yield inaccuracies or damaging effects if misapplied, with consideration for the unpredictable nature of grief. Thus, upon further consideration, it became evident that drug-related bereavement necessitates the integration of a model that accounted for the fluctuating essence of such grief.

Accordingly, this thesis grounds its empirical work within a theoretical framework developed by Stroebe & Schut (1999, 2010) known as the dual process model of coping with bereavement (DPM). The DPM acknowledges grief as a complex process and is a non-linear and dynamic framework that aims to conceptualise how bereaved persons come to terms with loss (Stroebe et al., 2010; Stroebe & Schut, 1999, 2010). Reinforcing the selection of this framework, the model has been effectively utilised with consideration for drug-related bereavement in families by Titlestad et al. (2020), and subsequent research efforts by other authors (Lambert et al., 2021; Selseng et al., 2023). The model considers two forms of coping, loss-oriented and restoration-oriented, and suggests that a confrontation-avoidance process of regulatory oscillation

occurs between both coping strategies (Stroebe et al., 2010). As a key term, coping refers to the manner in which the bereaved manage their circumstances and the context in which they are situated (Stroebe & Schut, 2010).

Loss-oriented coping is associated directly with the loss of the deceased (Stroebe et al., 2010), which can involve facing the reality of loss and relocating the deceased emotionally (Fiore, 2021). It may also include engagement with traditional grief work, coping with intrusive emotions associated with the loss, or rumination on events related to the death, or life before the death (Fiore, 2021; Stroebe et al., 2010; Stroebe & Schut, 2010). Restoration-oriented coping addresses secondary stressors consequential of the loss. These coping strategies can include role and identity changes (Fiore, 2021), reorientating oneself into the world without the deceased (Stroebe et al., 2010), or engagement in distraction-based tasks separate from the loss (Stroebe & Schut, 2015). Oscillation, then, acknowledges that the bereaved will confront aspects of the loss at one stage and may avoid these aspects at another (Stroebe & Schut, 2010).

The authors suggest a balanced oscillation between loss-oriented and restoration-oriented processes can facilitate the most optimal adaptation (Stroebe & Schut, 2010). However, those experiencing drug-related bereavement may find difficulty oscillating between the two (Dyregrov et al., 2020; Titlestad et al., 2020), instead focusing on a single extreme (Stroebe & Schut, 2010). This model provides a framework for complicated bereavements and accommodates the fluctuating nature of grief in the context of drug-related bereavement (Stroebe & Schut, 2010). As such, the theory will act as a foundational theoretical basis for the work presented herein.

3.4 Positive Ethics Statement

In adopting a socially engaged research approach with the values of psychological justice underpinning the work, it was fundamentally important to me that these concepts did not function solely as theoretical constructs within this thesis. Throughout this research endeavour, 38 people, who tragically lost a loved one to an untimely death, bravely gave their voices and shared their stories of grief. As the researcher who collated these stories, which are unheard in society and underserved in policy, I take it as an onus and a responsibility to utilise my platform as an academic to ensure that their voices are heard and represented.

In my efforts to make a real-world difference with this work, I have disseminated the findings in a variety of accessible ways. Thus, non-traditional outputs are of significant value when working towards the improvement of outcomes for marginalised groups. I have written an article for online news site RTE Brainstorm to share the experiences of DRD bereaved families with the broader public. I have also communicated this work to policy and practice audiences, upon the publication of each paper I have sent them to the relevant government Ministers. I also ensure to participate in a range of conferences to a wide variety of audiences during each academic year

My work in Chapter 9 has informed training for peer-to-peer naloxone support, and I have presented this work at training days for this initiative. Each year, for overdose awareness day, I aim to disseminate my work in various ways to humanise the experiences of the bereaved. In 2023, I was deeply privileged to share my work directly to the populations represented in my PhD, presenting my findings at a community event

to families, peers who use drugs, and HCPs who have been impacted by overdose deaths, showing that they are not alone. In 2024, I will use this work to create a quotation-based art piece that will be projected on to walls in cities as a visibility-enhancing initiative for the experiences of the bereaved. Throughout this entire research process, I have developed and held dear the values of mutual respect, collaboration, and equity. Below, I provide examples of additional outputs as outlined above.

3.4.1 Additional Outputs

- O’Callaghan (2023, May). Exploring grief-related reactions in people who were in active addiction at the time of a peer’s drug-related death. Psychological Society of Ireland (PSI) All-Ireland Student Congress. Dublin. [Awarded Best Postgraduate Presentation resulting in my selection as an invited speaker at the subsequent PSI Conference in November].
- O’Callaghan (2023, Nov). Exploring how peers are affected by overdose death. Launch of Circle: Peer to Peer Overdose Prevention Programme training day for staff facilitators.
- O’Callaghan (2022). RTE Brainstorm Article: “Supports needed for Irish Families Mourning Drug-Related Deaths. Available at: <https://www.rte.ie/brainstorm/2022/0511/1297376-ireland-drug-deaths-families-grief-health-problems/>
- O’Callaghan (2021, Sept) The impact of bereavement on staff who experience drug-related deaths within their caseload. AFINet Conference. Bath, England.

Chapter 4: Posttraumatic Growth Following a Drug-Related Death: A Family Perspective

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4.1 Abstract

This paper explores the experience of posttraumatic growth in families who have lost a family member to a drug-related death. Seven family units (17 participants) were interviewed, and interviews were analysed using reflexive thematic analysis. Analyses revealed themes that reflected positive adaptation and growth, including (a) reframing the loss, (b) open dialogue and social support, and (c) reclamation of purpose. Themes are presented in this paper for their pertinence in understanding how best to negotiate adaptation through complicated grief. The paper concludes that posttraumatic growth can occur once families begin a process of acceptance and receive support through the journey.

4.2 Introduction

Positive adaptation following the loss of a loved one is a deeply personal journey influenced by diverse personal characteristics and environmental factors (Jordan & Litz, 2014). The grieving experience is inherently complicated, and healing trajectories can be shaped by an individual's existing or underlying vulnerabilities, relationship to the deceased, gender, age, social supports, spirituality, and the cultural script that guides their society (Kaltman & Bonanno, 2003; Tedeschi & Calhoun, 2004). Research suggests that “normative” grieving patterns begin with intense emotional reactions that begin to reduce after six months (Zisook et al., 2010), but the circumstances surrounding death play a significant role in determining the trajectory of the healing process and, consequently, adaptation strategies.

As the nature of a death can influence adaptation following a loss, traumatic deaths may lead to an increased risk of complicated grief. Traumatic deaths refer to deaths that occur with a degree of suddenness or violence (Feigelman et al., 2012) and may be perceived as preventable (Tay et al., 2016), where the untimely or violent nature of the death may leave the bereaved paralysed by grief, anxiety, or intrusive flashbacks (Bonanno et al., 2008; Neimeyer, 2006). Such complicated grief does not typically remit over time, preventing a person from accommodating their bereavement (Lambert et al., 2021; Tobin et al., 2020) and placing them at risk for prolonged grief outcomes such as depression, anxiety, and post-traumatic stress (Bonanno et al., 2008; Tedeschi & Calhoun, 2004). Within traumatic death literature, a systematic review by Titlestad et al. (2019) identified families bereaved by a drug-related death as a critically understudied group who are at a considerable risk for complicated grief. Furthermore, this population

also reported more severe mental health difficulties than those bereaved by accident or natural deaths.

DRDs (Drug-Related Deaths) are deaths that occur due to the intake of narcotics, or a result of violence, suicide, or infectious disease (Titlestad et al., 2019). These losses are often very abrupt, and the positioning of drug dependence as a criminal activity within many sociocultural contexts can result in a disenfranchised grief that is not socially sanctioned, openly acknowledged, or met with social sympathy (Doka, 1999; Feigelman et al., 2020). Many families struggle to find meaning in such losses as outcomes including stigmatisation, guilt, self-blame, and a lack of support from family and peers compound their sense of disenfranchisement (da Silva et al., 2007; Lambert et al., 2021; Neimeyer, 2006). Furthermore, Christiansen et al. (2020) reported that parents bereaved by DRDs have a higher natural cause mortality rate than those bereaved by other causes of death and face an increased risk of death by suicide and substance dependence during the most intense stages of grief. Additionally, Lambert et al. (2021) found that families attributed physical illness outcomes to the combined stress of living with active drug use and navigating the emotional complexities of the loss.

While there is limited literature to date, two studies have engaged with family members bereaved by DRDs to understand their pathways to healing and adjustment. In Norway, a study by Titlestad et al. (2020) examined how parents bereaved by DRDs advanced emotionally following the death of their child. The authors interviewed 14 parents bereaved by DRDs and used reflexive thematic analysis to explore their coping experiences. Participants stated that going back to work, ceasing to blame others, and permitting themselves to grieve facilitated overall positive adaptation. Participants also

stated that recognising and avoiding some triggers (places and things associated with the deceased) was an adaptive coping strategy. Similarly, Feigelman et al. (2020) interviewed 11 family members bereaved by DRDs in the United States where posttraumatic growth occurred following acceptance and open disclosure of the nature of the death to others. However, those who had experienced healing were only able to do so after many years as the complex outcomes associated with DRD bereavement can impede coping strategies.

Recent research efforts exploring bereaved parents who use meaning making as a process to cope with traumatic child loss from chronic illness have shown that meaning reconstruction can facilitate posttraumatic growth (Dutta et al., 2020). Meaning making typically involves understanding the value of one's life after death, making sense of the loss, and finding purpose (Martela & Steger, 2016). In the context of DRDs, both Titlestad et al. (2020) and Feigelman et al. (2020) identified meaning making as a positive process of adaptive rumination, which assists families in understanding complex emotional reactions. These studies highlight the early intense grief stages as a critical period for intervention, which supports findings by Christiansen et al. (2020) who identified an increased risk of external mortality for families bereaved by DRDs during this period. Social support can buffer against the pathogenic effects of distress, grief, and isolation by promoting feelings of safety, connectedness, and intimacy (Cohen & Wills, 1985; Doka, 2002). In contrast, family members bereaved by DRDs often feel isolated, misunderstood, and disconnected from their community and their family (Lambert et al., 2021; Titlestad et al., 2019).

The findings from Titlestad et al. (2020) in Norway and Feigelman et al. (2020) in the United States have provided an in-depth understanding of the healing trajectories of families bereaved by DRDs with international implications. In 2021, Lambert et al. conducted a study examining DRD bereavement in an Irish context. The study explored the impact of complicated grief on the family system and intra-family dynamics following the DRD of a family member. The authors interviewed multiple members of each family together, and highlighted outcomes such as familial relationship breakdown, the renegotiation of relationships, family shame, and isolation from their community. On an individual level, the study reflected international findings that highlight stigma, helplessness, internalised feelings of shame, guilt, and physical health difficulties as outcomes (Lambert et al., 2021; Titlestad et al., 2019). However, while the Irish study demonstrated the negative social and health implications of a DRD, it did not highlight potential healing trajectories for these families.

The current study aims to examine how the families interviewed by Lambert et al. (2021) engaged in positive adaptation and experienced posttraumatic growth following the DRD of a family member. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2021, p. 17), an expert-led network which collects data and analyses information to provide an evidence-based overview of European drug trends, total DRDs in Ireland are now twice above the European average. Research has highlighted that these families require more robust policies to challenge stigma and provide early intervention for their unique grief (Lambert et al., 2021). Understanding the key facilitators to positive adaptation for families following the loss of a loved one in an Irish context will help inform appropriately targeted family-based

interventions and individual supports concerning Irish policy and best practice, while also aiming to inform interventions on an international level.

4.3 Materials and Methods

4.3.1 Approach

The current research is part of a study by Lambert et al. (2021) which examined the impact of drug-related bereavement on families in Ireland. In this paper, we investigated how the families recruited and interviewed by Lambert et al. (2021) experienced posttraumatic growth following a DRD, aiming to provide a phenomenological understanding of potential healing trajectories. In identifying an appropriate qualitative framework, we wanted to ensure that the family unit, at the centre of the phenomenon, was the primary focus. Furthermore, we wished to consider the personal nature of bereavement and the individualised impact of disenfranchised grief. As such, reflexive thematic analysis emerged as a tool to explore common patterns and experiences across the data, while also allowing the authors to account for potential biases throughout the process (Braun & Clarke, 2019)

4.3.2 Participants & Sampling

As per Lambert et al.' (2021) recruitment, this study included 17 family members bereaved by DRDs representing seven families across seven interviews (Table 4.1). As a method of purposive sampling and to ensure transferability of the findings, contact with an independent organisation, which supports families affected by drug dependence, facilitated the recruitment process. Staff within the organisation approached family members with information leaflets including details of the study's

aims and the professional qualifications of the interviewer. Family members subsequently self-selected to contact the research team by phone, by email, or allowing a staff member to contact the team on their behalf. Those who expressed such interest received a detailed information pack inviting them to participate. These packs outlined the study parameters, potential uses of their anonymised data, the role of the research team in working with the data, and information about their role in the interview process. All who received this information pack decided to participate and invited members of their own family to be involved in a focus group interview. There were no incidents where participants sought to withdraw from the study at any point.

As primary inclusion criteria, participants had to be active members of a family support organisation, and to have experienced the DRD of a family member. In line with the requirements of the ethics committee at the researchers' home institution, persons who were under 18, recently bereaved (under twelve months), and those who disclosed an active addiction or mental health issue were excluded from the recruitment process. Follow-up support services from the support organisation were available to any participants who wished it after taking part in the research.

Participants included four males and thirteen females, (six mothers, three fathers, one brother, five sisters and two nieces). The study investigated the deaths of seven men (two of whom were brothers) and one woman, between the ages of 19 and 46. Four deaths occurred by accidental overdose involving opiates and benzodiazepines and three were suicide by hanging. At the time of interview, time since death ranged from one year to 27 years. One family was from the south of Ireland, two from the southeast, and four from the east.

Table 4.1

Demographic and essential participants' details

	Participant	Time (years) since bereavement	Relationship to the deceased
Interview 1	1	1	Mother
	2	1	Brother
Interview 2	3	9	Sister
	4	9	Father
Interview 3	5	27	Father
	6	27	Mother
	7	27	Sister
Interview 4	8	13 and 5	Father
	9	13 and 5	Mother
Interview 5	10	21	Mother
	11	21	Sister
	12	21	Niece
Interview 6	13	9	Mother
Interview 7	14	3	Mother
	15	3	Niece
	16	3	Sister
	17	3	Sister

4.3.3 Data Collection

As per the methodology of Lambert et al. (2021), a semi-structured interview schedule guided six focus group interviews alongside one in-depth individual interview with a mother parenting alone. Six interviews took place in the family home, and one occurred in the office of the support network. The semi-structured nature of the interview allowed for the exploration of unanticipated topics while ensuring thematic consistency across cases. The interview schedule contained five open-ended core questions that were supported by general interview protocol such as paraphrasing, follow-up questions, and prompts: (1) “Can you tell me a little about yourselves?,” (2) “What do you think are the impacts on your family of experiencing a drug-related death?,” (3) “Do you think your experiences are the same or different to those who lose a family member in other ways?,” (4) “Have you any recommendations for what is needed to support families who have experienced this loss?” and (5) “On a scale of 1–10, how difficult was this interview for you?.”

Adopting this flexible interview format allowed participants to provide a continuous narrative about their experiences at a comfortable pace. Overall, the interviews provided information about the impact of experiencing a DRD, challenges, supports, and future recommendations. However, a recurring, yet unanticipated, concept that emerged throughout the data was the journey of healing which highlighted how families had adapted in the time since death. Interview lengths ranged from 1 hour and 11 minutes to 2 hours and 40 minutes. The second author conducted all interviews and used a recording device

4.3.4 Data Analysis

The analysis followed Braun and Clarke's (2019) framework for reflexive thematic analysis with findings presented in adherence to O'Brien et al. (2014) standards for reporting qualitative research. All authors have experience in working with marginalised populations and we considered this methodology as the most systematic, yet flexible, tool to bring our skills and values in research to the data. The authors followed six steps as recommended by Braun & Clarke's protocol: (1) familiarisation with the data, (2) coding the transcripts, (3) generating initial themes, (4) reviewing emergent themes, (5) defining the themes, and (6) writing up the findings. At times, there was back-and-forth movement between phases when discussions encouraged revisions of certain emerging concepts. To ensure credibility, transferability, confirmability, and dependability of the results, we followed recommendations cited in the four-dimension criteria for assessing rigor in qualitative research outlined by Forero et al. (2018).

All authors familiarised themselves with the data by reading and re-reading the anonymised transcripts. The first and third author coded the transcripts utilising NVivo qualitative analysis software and adopted a-priori approach to deconstruct the data and develop non-hierarchical codes, followed by a second round of coding. To ensure dependability and inter-coder reliability, this process was followed by open discussions between the first, second, and third authors about the coding, potential discrepancies, and how to synthesise the codes across the entire data set. As new codes began to decrease in frequency over time, all authors made an informed decision that data saturation had been achieved. The authors moved to initial theme generation with

specific focus on any required changes, additions, or biases. Through rigorous reorganisation, initial codes from all transcripts transitioned into preliminary themes. All authors reviewed and named the themes, and the first author drafted the report with input and feedback from each coauthor.

4.3.5 Roles & Reflexivity

In line with Dodgson's (2019) recommendations for qualitative research, we adopted a reflexive approach to the analysis to ensure that the process was confirmable, clear, and methodical. Prior to coding the data, all authors met to discuss and reflect on the anonymised transcripts. This discussion encouraged an open dialogue about how our experiences may influence our thoughts, pre-formulated assumptions, and ideas about the content. To reinforce the credibility of the analysis, the authors who coded the data wrote reflective memos and journals to keep a record of emerging thought processes. Each coauthor brought individual experiences to the research team, and to account for potential influences in interpretations, we engaged in reflective practice to minimise the risk of biased analysis.

As drug use is a sensitive topic often associated with criminality, we ensured that the terminology used in the coding and write up was sensitive, appropriate, and non-stigmatising. The second author conducted all interviews, as they have professional experience working therapeutically with families through addiction services. To augment the credibility of the research process, this individual was considered the most suitable to conduct sensitive interviews while being cognisant of their own prior assumptions. This researcher was the only person present alongside the participants during interviews, and peer debriefing occurred during initial discussions about the data.

To understand bereaved families' experiences with participating in engaged research, and to continue to develop suitable practices, participants were given an opportunity to provide feedback on the research process. The feedback was exclusively positive as participants spoke appreciatively of the therapeutic value of the interviews: "It was most positive for me as I bottled a lot of anger and resentment over the death of my son, and this was the first time that I ever spoke about his death openly," and about the opportunity to potentially help other families through their own experience: "The most positive aspect for me was the knowledge that recounting my son's life and death might in some way help in the future."

4.3.6 Ethical Considerations

The departmental ethics committee within the authors' home institution granted ethical approval for this research. All components of the research process adhered to the guidelines within the Code of Ethics of the Psychological Society of Ireland (PSI). All participants in this study were briefed, informed how their data would be used, provided informed consent, and offered follow up support the support network. Participation in this study was voluntary, confidential, and family members could withdraw from the study up to 6 weeks post-interview. Once the final report emerged, withdrawal from participation was no longer viable. Data for this research was stored in an encrypted data repository provided by the university.

4.4. Results

The analysis revealed varying degrees of individuals' posttraumatic growth in the aftermath of a DRD and identified three core themes: (a) Reframing the Loss, (b)

Dialogue and Social Support, and (c) Reclamation of Purpose. The findings suggest that each of the participants experienced a profound sense of loss and pain following the death of their loved one, but most reported a sense of personal growth and healing. By making sense of the death through various active engagements, bereaved family members expressed that they were able to come to terms with the loss.

4.4.1 Reframing the Loss

The period of active addiction before death was tumultuous for families. Years of uncertainty, stigma, and hopelessness permeated throughout the family system and left heavy emotional scarring as they lived in constant fear for the safety of their loved one, and sometimes for themselves. Following the death, this fear alleviated as the unpredictability surrounding the location of loved ones, issues with police, looming threats, and death began to fade. Participant 6 described finding comfort in knowing her son was now safer than he once was:

He could have ended up getting killed on the streets and he didn't suffer, so I am happy with that...I wouldn't have liked to have seen him found dead outside somewhere or over a lot of drugs or one thing or another.

Although she initially felt guilty about experiencing relief, all this mother truly wanted for her son was peace. She understood his life in addiction was painful for him and would not provide such comfort. As a mother, she experienced a prevailing sense of helplessness in this role that transformed to solace post-death in knowing her son was no longer suffering:

I am happy with where he is “cos, you know,” if he was here and going on with heroin and the life that he was leading, I’d say he was going to end up in really bad crime and drugs and that. So, if he is where he is and in no pain and happy, sure that’s all a mother wants for their kids.

In the data, there was a distinguishable difference between living one’s life and simply trying to survive chaotic circumstances. Positioning loved ones in “a better place” and references to “God’s will” was commonplace as family members drew on their faith to bring peace to their loved one, make sense of the death, and reach acceptance. Finding meaning in the loss in the context of fate also provided some solace for her husband (Participant 5). They had lost their son 27 years prior, and although the memory of the death remained, he was eventually able to reframe the loss in such a way that helped him transcend the grief:

I have come to accept (son’s) death but maybe it was something that was meant to happen. His life wasn’t going to change, you know? And I think he was happy to go ... It was meant to happen. His life wasn’t going to change, you know? And I think he was happy to go...It was meant to happen or something, that’s what I keep saying to myself.

This family’s experience echoed many of the other participants’ struggles with their loved one’s active addiction. Families spoke about harrowing emotional experiences following the death, but they did find peace in knowing that their loved one’s hardship, and the uncertainty about their health, had ceased. Participant 1’s comments mirrored these sentiments: “I know he didn’t want to die. But to me, I think he’d be happier up there because he wasn’t going to have a good ending.”

One father (Participant 4) only permitted himself to begin healing after a prolonged period of self-blame for his son's DRD. In holding himself accountable for the loss of his son, this father's guilt negotiated his healing trajectory, as he did not consider himself within his own right to grieve. Nine years on, he eventually came to understand that his son's behaviour was beyond his direct control. Over time and with the support of his daughter (Participant 3), a greater awareness unfolded that his son's death ended the associated hardships. This realisation facilitated the eventual relief of his guilt and felt that even in his last moments; their son was trying to protect them: "Personally, I think that my son had an insight into where his life was going, and he didn't want to bring that to us. So, we lost him to the street, there's no two ways about that." As an overall family unit, they experienced posttraumatic growth by supporting each other, but the journey to self-acceptance was very much individualised even within the family structure.

Despite the emotional trauma associated with his son's addiction, Participant 4 managed to absolve himself of guilt and remembered his son with fondness. Such memory reconstruction was challenging for others as some participants struggled with identity fluidity. Conflicting memories of loved ones from life before addiction and the suffering experienced during addiction generated confusion when trying to reframe the loss. Efforts to align these versions of their loved one proved difficult for some, such as Participant 16: "You have to go back and pick out the bits you loved about him and knock out the other bits, that was very confusing." Emerging from this conflict was the concept of a double loss, where families felt they lost their loved ones to addiction and, consequently, experienced an exacerbated grief following their death. Participant 2

stated: “We always talk about this, she didn’t just grieve for [our brother] when he died, she grieved for [our brother] when he went on drugs.”

4.4.2 Dialogue and Social Support

Bereavement support groups, where the unique grief associated with a DRD was recognised, offered an empathic space where families could unburden their sense of shame and helplessness. Many found comfort through interaction with others who had experienced this unique loss and sense of seclusion. For Participants 8 and 9, parents who had lost two sons to DRDs, the support groups fostered a deep sense of resiliency, self-preservation, and vitality. This mother (Participant 9) demonstrated that as parents, they moved from prolonged self-blame toward healing after engaging in support groups:

We blamed ourselves for years but then through the family support we got a little bit of learning that it wasn’t our fault at all...And I always say we are the lucky ones, because God knows where we would be today without the support we have gotten from the groups. You know people that have encouraged us to look at things differently, with a different view, and that’s what we do.

Reframing the loss helped the family move toward positive adaptation, but family support groups mediated this journey. Both family members spoke at length about how the clarity and guidance they received helped them to navigate the painful journey of loss: “Dialogue, to us, is the most important thing.” A key outcome of this engagement was that the parents found greater self-compassion, and Participant 8 reflected on recognising the importance of their own wellbeing: “I am no good to anyone if I am not well. I can’t do anything for myself if I’m not well, so our whole

objective now is to keep ourselves as well as possible, so we keep going to our meetings.” Opening a dialogue with other families created a space of deep reflection where different perspectives, sensitivity, and a culture of mutual understanding fostered posttraumatic growth.

Upon reflection, Participant 14 came to understand that constructing her entire world around intense support provision consumed her quality of life: “If you focus on your children all the time when they are in addiction, you are never going to get well yourself.” However, the parental instinct to care for one’s child took precedence, and many parents experienced a sense of failure, questioning their parental self-efficacy when their loved one passed. As acute stress had already compromised the health of many family members prior to the death, learning the value of prioritising one’s own health was instrumental to recovery. Engagement with support groups guided families through the process of rebuilding their sense of self-worth and strengthening familial bonds. Open dialogue and reflection facilitated the development of emotional practices to build resilience and maintain wellbeing during daily functioning. In gaining a new perspective and renegotiating their sense of self-worth, families were able to pass on the value of their reflections to others, as shown by Participant 3:

It brings great peace into your life. We often speak to people. We have had a bereavement group here for the last 4 years. We often say to people, when they realise that their children are not able to stay in this world anymore it is better for everybody, you know it’s hard to come to that you know, to that realisation but we have come to it. That they are not meant to be there, their time to go you know and prolonging it doesn’t really help.

Speaking to others in the groups who are all at various stages of their recovery cultivated a community of learning where people with similarly complex experiences could establish supportive relationships, validate their grief, and share coping mechanisms. Participant 17, who had lost her older sister three years earlier, described how she found “reassurance from hearing other people’s stories.” Participant 10, whose son passed away 21 years prior to the time of interview, showed considerable posttraumatic growth following engagement with bereavement services and reflected on the value these groups would have had at an early stage: “One good thing is all the work I’ve done on myself through the family support. I probably should have got that done 20 years ago.” This mother still had unprocessed trauma even 20 years post-death and demonstrates that there are benefits to social support that cannot be offered solely by the passing of time.

Although group-based social therapy fostered posttraumatic growth for most families who were in a position to access it, the individualised nature of grief demonstrates that this solution may not work for everyone. Participant 6 expressed her personal discomfort with support groups:

I went but I didn’t like it, for the simple reason I don’t think [group member] should’ve ever mentioned her son’s name. She should have never been telling us stories about her son. But yeah, that kind of group was all about that. When I found I was passing that same person on the street I’d say, “Jesus I know all their business.”

Her desire to keep details about the death confidential may reflect the stigma and shame that families burdened by their loved one’s addiction must live with. For those

who had not previously engaged with a bereavement group, the thought of having to speak openly about their anguish tempered their orientation toward counselling.

Participant 6 mentioned that dealing with the grief was something done internally: “It’s a struggle that a family has to work through themselves, there’s no outsider can help you.” Speaking about her distress magnified her sense of vulnerability and unease, particularly with respect to engaging in open dialogue about personal issues with strangers from the locality. Evident from her concerns, understanding how participants define their own parameters of anonymity is a crucial component of developing individualised support packages for individualised grief processes.

4.4.3 Reclamation of Purpose

During their loved one’s active addiction, one constant for family members among the uncertainty was their role as a parent, caregiver, or sibling. Fathers, mothers, and other family members found their identities and roles fractured by a loss that trapped them in cycles of guilt, but many participants demonstrated how they reclaimed and continued these roles in diverse ways. Through self-determination to maintain their identities post-death, many achieved a constructive reorientation of their grief experience to make sense of the loss and find a new purpose in life. Participant 1 spoke about how she continued her role as a mother, taking care of her son even after he had passed away: “I would drive out to the grave, it was like I was making his bed, I would pat the whole thing down and fix it and everything.” As she continued to care for her son while conducting tactile actions to maintain her sense of maternal identity, this role constancy helped her to contend with grief.

While some conducted personal rituals in memory of their loved one, others channelled their energies into loss-inspired activism. Participants 10 and 11 (mother and daughter) cultivated a sense of purpose through advocacy work and drug awareness campaigns, where their new roles as activists served the dual purpose of honouring their loved one while also supporting them to find meaning in the loss. Participant 10 and her daughter reconstructed their lives by becoming proactive in their community, supporting others in similar circumstances, and creating a legacy in honour of their loved one:

I felt that I was doing something, for [my son]. Yeah, I just poured all my life into it...I was doing voluntary work up there for a year, family support up there for a year. I then got the job as [houseworker], and then they got funding for a family support worker, so I was doing that as well.

Over time, participants who attended group support services transitioned their roles and purpose within that framework from solely seeking support to concurrently providing support to others. Participant 8 reflected on how they used their stories and coping efforts as opportunities to support fellow attendees the way others had supported them in the past, developing a communal environment among people who felt isolated from their respective communities:

It reminds us of how important it is to stay well and maybe our story might help people and we might be able to encourage people, but we know ourselves [it's difficult] when somebody comes in and they are only starting off on their journey.

At the time of the interview, Participant 7 had not engaged in any advocacy work but spoke at length about her experience with her own addiction years prior. She stated that the death of her brother acted as a catalyst for her desire to use her first-hand experience of the different social supports to guide and mentor others through recovery:

I'd like to do that, to let people know that social workers are not there to hurt or harm them. I've been through a process. So, if an individual comes in now that's new, I can sit down and I can guide them the best I can and say try it this way. There is good information coming back from my mouth to them.

Forging a new identity by taking up new active engagements nurtured posttraumatic growth. Participant 5 spoke about the benefits of “breaking the cycle,” where falling into inactivity and languishing made it difficult for him to transcend the loss and overcome his grief. He described intense mental anguish in the early years following his child's death: “I didn't handle it very well...I started drinking, not every day drinking that's not the way it was, but I was drinking more than I was, I felt I couldn't grieve the way I wanted to.”

His family (Participants 6 and 7) emphasised the importance of participating in activities as it alleviated their own sense of helplessness and gave their life a sense of order. This value was pertinent in the case of Participant 6, as while she did not feel comfortable in family therapy, focusing on extracurricular activities provided her with a sense of purpose: “I'll tell you what I excelled with over the death as well—with crochet, because my whole focus is gone into it.” She encouraged her husband to engage in similar activities, demonstrating an intra-family support network that was vital to recovery. This family experienced posttraumatic growth in diverse ways and at a

different pace, but as a family unit they all engaged in other activities that they were passionate about, as Participant 5 highlights:

I nearly used to fish every day [before son's death]. I got to a stage one time it was like déjà vu. Every day was the same, day in day out, and I was getting depressed about [son's death], so I got my fishing rod and just threw it in ... I did that for a few days to break up the monotony of every day being the same because I was doing everything the exact same every morning.

DRDs can result in the breakdown of family dynamics, but some of the participants in this study spoke about the strengthening of intra-family social bonds. With less emotional distance among family members and a willingness to communicate openly, Participant 3 strengthened her bonds with her parents: "There are a lot of positives that came out of it. Like, I'm very, very close to mom and dad because of (brother's) passing as well." When speaking to her father in the interview she noted that he is more empathetic and emotionally available: "I think that a positive thing with you Dad is that you have softened, you are easier to talk to."

4.5 Discussion

The process of experiencing positive psychological change following the DRD of a loved one is multifaceted. Healing trajectories are impacted by unique compounding variables such as stigma, the cultural perception of drug use, and the preventable nature of the death (Lambert et al., 2021; Titlestad et al., 2019) and, as research suggests, for every DRD, there are at least ten people directly affected (Dyregrov et al., 2020). As total DRDs in Ireland are now twice the European average

(EMCDDA, 2021), the current study provided a crucial insight into the healing trajectories of families and aims to inform services about how to support this population at an early intervention stage. The most common tools that facilitated posttraumatic growth, as shown by the thematic analysis, included reframing the loss, opening a dialogue among social supports, and finding purpose following the death.

The amalgamation of acute stress from providing support during life and processing the death yields significant implications for how families cope in the initial grief stages, which Christiansen et al. (2020) identified as a critical period due to a substantial risk of negative health outcomes and increased mortality rates for the bereaved. Services should endeavour to assist families in making sense of the complex and unfamiliar emotional outcomes associated with DRDs. For example, families reported experiencing a sense of relief when their loved one passed, but this relief was initially enveloped in guilt and exacerbated by a sense of remorse for feeling this way. These findings coincide with previous research that reported some families experienced a similar sense of ambivalence in the aftermath of a DRD (da Silva et al., 2007). In struggling to understand and accept the complexities of their own emotions, family members were trapped in cycles of shame. More specifically, in the absence of support to provide guidance and clarity, it was unclear to them at first that this relief was stemming from having their loved one's peace at heart.

Finding peace for their loved ones was a priority for families. Death offered a stillness from the tumultuous nature of addiction, but families could not begin to process their own grief until they psychologically separated their loved one from chaotic circumstances. Many participants reframed their loss in the context of fate, with spiritual

references to God and “a better place.” While their personal sadness did not remit and remained intense, drawing on their faith to position their loved one in a happier place provided a sense of solace with their loved one’s best interests at heart. For those who did not reference religion or spirituality, the fact that their loved one was at peace acted as a form of comfort. Using the various spiritual and emotional tools at their disposal was an essential component of posttraumatic growth and services should aim to support families in drawing from these. Closing this chapter acted as a catalyst for families to finally transition their priorities from their loved ones to themselves. This research was conducted in a predominantly Christian country and future research could examine how spirituality and religion within various cultures may facilitate positive adaptation with reference to how drug use is culturally perceived.

Social support has long been understood to be a protective factor against the negative health outcomes associated with complicated grief (Cohen & Wills, 1985; Doka, 2002), and Feigelman et al. (2020) found evidence of posttraumatic growth following open disclosure about the nature of the death to other people. The current study supports these findings as many families spoke approvingly about the incomparable value of social support. Opening a dialogue amongst other individuals and families bereaved by DRDs cultivated a judgment-free culture of understanding, empathy, and compassion. As family members bereaved by DRDs often feel isolated and disconnected from their community (Lambert et al., 2021; Titlestad et al., 2019), these support groups helped to legitimise their experience and foster a newfound sense of community. As documented by Lambert et al. (2021), some family members in Ireland, who were already experiencing isolation, were met with stigmatisation when

seeking social and professional support for a DRD. Therefore, it is of pivotal importance that the individual at the first point of contact within a service is cognisant of bereaved families' emotional complexities, and meets them with compassion, direction, and empathy

Support between members of the same family proved valuable for participants, but family members within the same unit often grieve in different ways. Lambert et al. (2021) reported that some families experienced a breakdown of relationships following the death. Intra-family support that addresses complex needs and emotions in socially excluded populations should aim to be trauma informed with professionals educated in how to navigate the intricacies of family dynamics, assisting them in developing emotional tools to support one another during daily functioning. Within the development of targeted support frameworks, it is important to consider individualised response plans alongside familial projects as some participants felt uncomfortable about disclosing information in a group setting. All families in this study were registered with a family support network at the time of interview, but not at the time of death. National support efforts should consider how to bring practice-based frameworks to those who require it, especially considering some families in the current study reflected on how the knowledge of available supports and their value would have been beneficial to them many years ago.

The current study has also yielded similar findings to recent literature exploring the lived experience of bereaved parents who lost children to chronic illness (Dutta et al., 2020), where parents developed new meaning structures by positively reappraising their trauma through rituals and fostering a new outlook on life. Many of the successful

coping strategies in the current study involved reclaiming a sense of what was lost after the death, such as parental/sibling identity, community participation, or emotional connection to the deceased. Reestablishing their identity was vital to positive adaptation, and family members maintained their bonds with their children through religion and physical actions such as candle lighting and grave maintenance. Others engaged in advocacy work to keep their loved one's memory alive. The value of rituals to empower one's sense of identity and purpose was a key finding of the current study and coincides with literature from other traumatic deaths (Dutta et al., 2020). Wheeler (2001) found that parents coped with the loss of their child to suicide by preserving memories, conducting rituals, and engaging in reflective processes to maintain bonds with their children.

For DRD bereavement, Titlestad et al. (2020) and Feigelman et al. (2020) specified meaning making as a tool for making sense of the loss. Martela and Steger (2016) suggest that people achieve meaning making when understanding that an individual's life matters, it has value, and that it has a broader purpose in life. By becoming active members in their own community, engaging in new hobbies, or focusing on their own wellbeing, the pain of bereavement shifted from paralysing to transformative as family members in the current study established a newfound sense of purpose. Some family members found their roles within support groups transitioning from simply being supported to providing support and guidance to more recently bereaved families. This new role helped them find meaning and purpose in the loss where they once felt disenfranchised.

Recent meaning focused narrative interventions have shown promise in supporting families living with a child with chronic illness (Dutta et al., 2022). While their research deals with pre-loss interventions for anticipatory grief, the framework has success in implementing a narrative e-writing tool through a therapist facilitated smartphone app to assist meaning-making processes for families. In improving psychological and spiritual wellbeing for families, the tool resulted in increased hopefulness for their own future and the quality of social support available to them. Given some of the similarities between positive adaptation strategies for DRDs and other traumatic deaths, future research could seek to conceptualise a similar support tool for families bereaved by a DRD that incorporates meaning making as a supportive intervention.

Overall, the families in this study found their identities and sense of community shattered by DRDs, and experienced posttraumatic growth through various active engagements that helped them to find purpose and meaning in the loss. Services should aim to support the strengthening of intra-family bonds where possible, while also assisting family members to make sense of unfamiliar and complex grief reactions. Some coping strategies associated with other traumatic deaths are similar, and the development of DRD supports could employ transferable elements of existing frameworks. Furthermore, support efforts must assist the bereaved in reconnecting with themselves and their communities while keeping themselves actively involved in fulfilling engagements. Policy and practice should consider these families in the specialised responses to complicated grief associated with other special deaths. For

example, specific services in Ireland support suicide bereavement, but there are currently no extensive formal networks that specifically address DRD bereavement.

4.5.1 Strengths and Limitations

A strength of this study lies in its in-depth methodology and approach that allowed participants to voice their experiences, which are seldom heard voices in empirical research. In analysing the experiences of families of which the members were interviewed together, the analysis allowed for a comprehensive overview of how these participants experienced posttraumatic growth, both individually and as a family unit.

This study included a purposive sample, and all participants were white Irish in a similar urban socioeconomic position. Future directions for this research may benefit from a more culturally diverse sample to address any potential differences that were not identified. Future studies could also look to explore intersectionality of experiences with addiction while experiencing social exclusion, considering groups such as the traveller community and other ethnic minority groups. This study included DRDs due to accidental overdose and death by suicide. Researchers should consider the possibility of comparing bereavement experiences and healing trajectories among those who are bereaved from accidental overdose death, intentional overdose death, and other drug-related causes of death, and whether grief and health outcomes differ in a considerable manner. Finally, future research could investigate individuals' and families' experiences of posttraumatic growth in more discrete—and narrower—post-death time intervals, as the participants in this study represented a broad range of years since the death of their loved one.

There is a need for targeted supports to help those bereaved by DRDs, not only in the immediate aftermath of the death but as an ongoing support structure to facilitate adjustment. Services could implement bereavement screening to ascertain the specific psychosocial needs of families grieving DRDs. These could be coupled with information sessions where participants are provided with an opportunity to understand the nature of group support and how the sessions are facilitated. Specialised interventions are warranted to help those dealing with complex, disenfranchised grief reactions.

Chapter 5: Additional Theoretical Considerations for Families Bereaved by a Drug-Related Death

5.1 Chapter Overview

In chapter 4 (henceforth: O’Callaghan et al., 2022), exploring the journeys of posttraumatic growth for DRD bereaved families provided unique insights into the collective and individual healing processes within family structures. Alongside Lambert and colleagues’ (2021) comprehensive exploration of the overall impact of these deaths, both studies present a distinct overview of how each family unit adapted over time. Conversely, the work also highlights the barriers and challenges to adaptation that trapped families in cycles of rumination and anguish for prolonged periods without support.

In this chapter, the findings from Chapter 4 are theoretically grounded in the dual process model of coping with bereavement (Stroebe & Schut, 1999, 2010), exploring the processes of adaptation with respect to the oscillation between loss-oriented and restoration-oriented processes. Furthermore, this chapter will underscore how drug-related complex grief reactions inhibited the regulatory process of adjustment. With additional considerations for the dual process model-revised (Stroebe & Schut, 2015), which explores adaptation when considering relational dynamics in family structures, this chapter generates recommendations for how service provision can support and expedite the process of achieving positive adaptation.

5.2 The Dual Process Model-Revised (DPM-R)

Since its inception, the dual process model of coping with bereavement has been subject to several empirical developments and distinct variations (Stroebe & Schut, 1999, 2010). In recognising the synchronous interplay of both individual and relational factors when coping with grief, Stroebe & Schut (2015) produced an additional framework known as the dual process model revised (DPM-R). Adopting the same structure of the original DPM, the revised model integrates loss-oriented and restoration-oriented concepts across inter- and intra-personal factors that occur at both the individual level and family level (Stroebe & Schut, 2015). As people often do not grieve alone (Fiore, 2021), the integration of family factors acts as a crucial theoretical consideration for posttraumatic growth in families bereaved by a DRD. Reported by O’Callaghan et al., 2022 and the family study by Lambert et al. (2021), family dynamics can influence both individual and group adjustment (Stroebe & Schut, 2015).

Within the revised model, family processes carry similarities to the previously established individual regulatory tasks but are differentiated by how they manifest collectively within a family system. Correspondingly, the extension integrates individual grieving tasks within family dynamics, acknowledging how families work through stressors together as a unit (Stroebe & Schut, 2015). In this instance, loss-oriented family processes involve coming to terms with the loss (Stroebe & Schut, 2010). Relationally, these tasks include family acceptance of the loss, sharing the pain of grief with family members, and psychologically relocating their loved one within a family context (Fiore, 2021; Stroebe & Schut, 2015, p. 875). For restoration-oriented coping, associated with changes in the surrounding world, these processes include familial

distractions, changes in family life and relationships, and progressing with reoriented roles within the family structure (Fiore, 2021; Stroebe & Schut, 2015, p. 875)

5.2.1 Continuing Bonds

A prominent concept across bereavement literature, the notion of continuing bonds with the deceased (Klass, 2006) challenges the conceptualisation of bereavement as a psychological parting with the person who has died (Neimeyer et al., 2006; Stroebe et al., 2010). Principally defined as the maintenance of an ongoing inner relationship with the person who has passed away (Goodall et al., 2022), continuing bonds can be an adaptive or maladaptive process when coping with bereavement (Field & Filanosky, 2009). A diverse individual construct that is theoretically integrated as a potential loss-oriented factor within the DPM (Stroebe et al., 2010), emotionally relocating the deceased or continuing bonds with them emerged as a prominent theme in the grief journeys of DRD bereaved families (O’Callaghan et al, 2022).

This construct is pertinent to DRD bereaved individuals due to the social and cultural components that influence the process of continuing bonds (Klass, 2006; Klass et al., 2014). With drug-related stigmas a unique compounding factor, difficulties with psychological integration of the loss and continuing bonds with their loved one may emerge due to disconnects between inner beliefs and social reality (Klass, 2006). Stroebe et al. (2010) propose that continuing bonds may be necessary to relocate the deceased person in the lives of the bereaved, while other situations may cause for a psychological distancing. As such, the concept of continuing bonds is also considered within this chapter as it relates to families bereaved by a DRD.

5.3 DPM-R and Family Adaptation

Throughout the narratives provided by families in the study by O’Callaghan et al. (2022), clear evidence emerged of the parallel, and often intersectional, occurrence of both individual level and group level coping tasks. The DPM-R generates a critical opportunity to theoretically contextualise, frame, and understand the convergence of these processes, whereby the specific challenges to positive adaptation can be a source of focus within therapeutic intervention. Overall, the healing trajectories of DRD bereaved families are influenced by a deeply complex exchange between drug-related stigmas, individual grief correlates, group processes, and the social context in which this interactivity is situated. Drawing from the findings of O’Callaghan et al. (2022) and Lambert et al. (2021), which analysed the narratives of the same family units, this section presents how the outcomes of these complexities can be contextualised within the DPM-R.

As a loss-oriented mechanism, accepting the reality of, and confronting, the loss is an important component of achieving positive adaptation (Stroebe & Schut, 1999, 2010). Inherently challenging as an individual process, discordance among family members can impact family cohesion and further inhibit grief processes (Stroebe & Schut, 2015). As explored in Lambert et al. (2021), family members grieving at different paces can generate psychological difficulties in the process of adaptation. One mother, who retained contact with her son’s partner after he died, noted his partner had become very distant from the family. This distance was especially prevalent around occasions that act as reminders of his passing, such as anniversaries. In this mother’s attempts to accept the loss, honour her son, and remain connected to his partner, the incongruence

between the confrontation-avoidance strategies adopted by both family members has negatively impacted the family structure, straining the relationship (Stroebe & Schut, 2015). From a restoration-oriented standpoint, this mother had difficulty oscillating to an acceptance of the changed world, as her son's partner had become an integral part of the family structure. The presence of blame and shame within the family, consequent of the drug-related circumstances of the death, acted as a further inhibitor to adaptation.

Conversely, individual coping processes can also be mutually reinforcing for others within the family, as well as the overall adaptation for the family system. In her efforts to achieve positive adaptation, one mother engaged in restoration-oriented distraction and non-grief-related activities by starting crochet projects (O'Callaghan et al., 2022; Stroebe & Schut, 2015). In highlighting her oscillation between loss-oriented and restoration-oriented processes, she demonstrated her journey to posttraumatic growth. Her husband, however, was trapped in loss-oriented cycles of rumination, falling into inactivity and increasing his use of alcohol to cope (O'Callaghan et al., 2022). Blaming himself for the DRD of his child, his internalised self-concept was deeply affected by the loss. Through the support of his wife, however, he began to engage in restoration-oriented processes and reignited his love for fishing. Intra-family dynamics may, in this case, be particularly crucial in the case of DRDs.

This narrative example supports the importance of Stroebe & Schut's (2015) conceptualisation of distraction-based tasks while grieving. This husband found difficulty in taking time away from the loss at an individual level, but familial level support fostered his individual oscillation. Thus, while both husband and wife engaged in different types of distraction-based tasks, it demonstrated an intra-familial acceptance

of individual grieving processes within the family structure. Overall, this family's efforts to move forward highlights the very prevalent interaction between familial and individual processes, and how unidirectional acceptance is crucial in this context. Additionally, the intrapersonal dynamics between members of the same family acted as a supportive mechanism which countered the intrusion of external stigma. In focusing on themselves as a family unit, and acknowledging the individual characteristics they both carried, this family was able to positively adapt to the loss.

Across each family, there were numerous inter-group differences in achieving posttraumatic growth. Individual level self-compassion acted as a crucial facilitator to healing, which then supported the adaptation at a family level. Self-compassion was profoundly inhibited by the contextual nature of drug-related bereavement, with a pervasive sense of guilt permeating many family systems (Lambert et al., 2021; O'Callaghan et al., 2022). One father ruminated over the loss for many years, trapped in cycles of guilt. Over time, however, his daughter had developed a strong sense of self-compassion and supported her father in achieving the same (O'Callaghan et al., 2022). Through reciprocal and synergistic healing, this support also enhanced the quality of their relationship. For policy and practice initiatives, this example illustrates the importance of supporting the individual as a mechanism for mutual reinforcement of the family unit, acknowledging that each member moves at a different pace.

However, the findings in the studies by Lambert et al. (2021) and O'Callaghan et al. (2022) demonstrate the bidirectional nature of family level adaptation, where individual healing can also inhibit family healing and disrupt the social dynamics within. A mother in one family began to engage in individual grief work and sought

counselling to move on from the loss, which was misconstrued by other family members as not caring for her son who passed away (Lambert et al., 2021). This mother initiated a process of balanced oscillation by working on different stressors, but the equilibrium was disrupted as her family members remained focused on the loss. As such, in the same way individual healing supports the adaptation of other group members, adverse interactions and divergent psychological approaches can inhibit individual healing. Theoretically, family members focusing on one extreme, loss-oriented stressors in this case, demonstrates the difficulties those bereaved by a DRD can encounter when grieving a stigmatised loss (Dyregrov et al., 2020; Stroebe & Schut, 2010; Titlestad et al., 2020).

Thus, the differential paces at which people grieve individually can negatively impact the family system, highlighting how individual paths to healing can influence the family structure in the absence of communication. Such complex and group-specific dynamics demonstrate the importance of support protocols that target both individual and family level stressors, supporting families to achieve coherence, develop an understanding of individual grieving processes, and facilitate growth. For example, one mother and daughter found new purpose in conducting advocacy work (O’Callaghan et al., 2022), by which individual and family decision making processes to move forward and adopt new roles is classified as an adaptive restoration-oriented stressor (Stroebe & Schut, 2010; 2015). Reorienting to life without the deceased and carrying a new purpose post-loss can serve as a facilitator to finding meaning in the death, which is crucial to positive adaptation (Neimeyer, 2019; Stroebe et al., 2006). As those bereaved by a DRD can find difficulty attributing meaning to the loss of their loved ones (Selseng et al.,

2024; Stout & Fleury-Steiner, 2023), care practices should cultivate a theoretical and practical understanding of meaning making processes, and how stigmatised perceptions of the loss that are incongruent to the love carried by the bereaved can inhibit how they make sense of the loss.

In relation to continuing bonds (Klass, 2006) and DRDs, against the cultural backdrop that stigmatises their grief (Guy, 2004), the process of maintaining bonds with loved ones proved to be an adaptive coping mechanism. Reconstructing the memory of their loved one was crucial to the maintenance of bonds post death (Lambert et al., 2021), but this process was often shrouded by drug-related stigmas, sociocultural perceptions of the death, and the trauma of living with active addiction before the death. One mother recounted the difficulty in “picking out the good bits” when remembering her son and struggled with the perceived loss of her identity as a mother (O’Callaghan et al., 2022). When achieved, family members engaged in processes that honoured the life of their loved one separate from their addiction. One mother spoke about maintaining her son’s grave in the same way she would maintain his bed (O’Callaghan et al., 2022), and grief-inspired activism functioned as a mechanism to continue the legacy of their loved one for others (Lambert et al., 2021; O’Callaghan et al., 2022). Ritualistic mechanisms also played a role in the maintenance of bonds, empowering their sense of identity and keeping their loved one’s memory alive alongside them.

Evidently, the DPM-R acts as a crucial mechanism by which family adaptation processes can be theoretically understood, with clear implications for practice as clinicians can utilise these findings to develop strategies around meaning making, memory reconstruction, and family coping practices.

5.4 Discussion Within the Broader Research Context

Upon completion of this doctoral thesis, there has been a marginal increase in the number of research publications addressing posttraumatic growth in DRD bereaved families. Titlestad et al. (2022a) explored posttraumatic growth in a sample of DRD bereaved parents in Norway through a mixed methods study with 89 survey respondents and 14 interviews. Their findings outlined that self-efficacy and social support have statistically significant associations with posttraumatic growth, measured through the Post-Traumatic Growth Inventory. These findings corroborate with the qualitative findings of O’Callaghan et al. (2022), which show that greater self-compassion can support individual healing, but also synchronously support the healing of other family members.

Additionally, social support emerged as a central catalyst for posttraumatic growth for families in both studies (O’Callaghan et al., 2022; Titlestad et al. (2022a), as well as in an interview study with bereaved parents by Feigelman et al. (2020). For families in O’Callaghan et al. (2022), engaging in peer support with other bereaved family members who share their experiences acted as a strong predictor of positive adaptation, a finding echoed by Cartwright (2019). However, it is important to acknowledge that in the instance of DRDs, stigma-related barriers to social support and help-seeking behaviours remain prevalent (O’Callaghan & Lambert, 2023; Reime et al., 2024a; Titlestad et al., 2019), accentuating the need for accessible and visible services alongside awareness-raising and stigma-reduction campaigns. Hill & O’Brien (2023), who investigated how disenfranchised grief, social support, and coping predict grief

outcomes in 159 people bereaved by a DRD, found that non-stigmatising social support can contribute to posttraumatic growth.

Sperandio et al. (2021) examined the constructs of hope and self-compassion and their association with posttraumatic growth for 292 people who lost a loved one to a DRD. The authors found that self-compassion acts as a predictor for posttraumatic growth (Sperandio et al., 2021), which may counteract the high levels of guilt experienced by family members. An example of this was seen within family systems as reported by O’Callaghan et al. (2022), where individual self-compassion facilitated the cultivation of more self-compassion in other family members. Evidently, self-compassion is hugely important for posttraumatic growth, and perhaps necessary to boost family level processes (O’Callaghan et al., 2022). Both Titlestad et al. (2022a) and Sperandio et al. (2021) reported an association between lower levels of self-compassion and lower levels of posttraumatic growth and more complex symptoms of grief.

With the theoretical integration of the findings by O’Callaghan et al. (2022) alongside the recent findings by Titlestad et al. (2022a), Sperandio et al. (2021), and Hill & O’Brien (2023), a greater understanding of posttraumatic growth following a DRD for individuals and families now exists across the evidence base. Services should endeavour to integrate bereavement support policies that address both individual- and family-level stressors and needs, supporting them to achieve posttraumatic growth in a strengths-based blend of self-compassion building, peer support, and meaning making. Furthermore, as reported by Reime et al. (2024a), DRD bereaved parents often have limited contact with other people who share their experiences, identifying a significant gap in policy when considering the importance of peer support for families in the study

by O’Callaghan et al. (2022), and that Titlestad et al. (2022a) found a strong association between social support and posttraumatic growth. DRD bereavement is inherently complex, especially when considering group processes, so this chapter and the associated works act as a significant contribution to understanding the key psychological constructs which bereavement supports should aim to address.

Chapter 6: The Experience of Drug-Related Client Loss for Healthcare Professionals Who Support People in Addiction

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(Appendix VI)

6.1 Abstract

Introduction: Addiction support and recovery is a multifaceted support context in which practitioners work with clients who present with increased mortality risks. Drug-related deaths are understood to be a risk factor for complicated grief-reactions but, to date, research has neglected to explore the intricacies of drug-related client loss for practitioners who work with clients experiencing addiction. Due to wider expectations of professional endurance and the demanding nature of healthcare, grief-related reactions associated with the loss of a client may go unprocessed and, therefore, result in long-term health implications.

Method: Fifteen healthcare professionals took part in individual semi-structured interviews, which were analysed using reflexive thematic analysis. Participants represented various disciplines in addiction support and recovery, including homelessness, inclusion health, addiction, and emergency medicine.

Results: Three core themes emerged encapsulating the experience of drug-related bereavement for HCPs who support people experiencing addiction, as follows: (i) Grief Beneath the Surface, (ii) The Cost of Caring, and (iii) Finding Closure. The findings identified acute grief-related reactions in HCPs such as self-blame and shame, alongside fears of litigation and questions of clinical competency. Participants' accounts of drug-related client loss emphasised a deep professional connection with those that they work with, with grief-responses akin to the loss of peers, family members, and other close connections. The bereavement experience was complicated by unique compounding variables associated with drug-related deaths, but also by incongruity between their emotional responses to death and their professional responsibilities.

Conclusions: This article highlights the complex nature of drug-related client loss, and despite their social positioning as experts in their field, HCPs' reactions to client deaths were predominantly human responses to loss. The article identified a need for targeted postvention protocols that address complicated grief while also allowing staff to resume occupational functioning in a measured manner.

6.2 Introduction

Exposure to death in the workplace has well-documented health and practice implications for healthcare professionals (HCPs). Research in areas such as homelessness (Lakeman, 2011), suicide (Veilleux, 2011), and long-term care of patients near the end of life (Rickerson et al., 2005) identifies HCPs as an at-risk group for negative health outcomes following a client's death. Bereavement experiences can be influenced by individual factors, existing support structures, the nature of the death, and closeness to the deceased (Stroebe & Schut, 2010), and considerable variance in grief-related reactions across professions exists within HCP literature. For example, death by natural causes for elderly patients typically follows a normative grieving cycle (Da Silva et al., 2007), but a death by suicide, which is sudden and traumatic, can result in a complicated grief that requires specific postvention protocols (Morrissey & Higgins, 2021; Murphy et al., 2022).

A recent focus in the social sciences has seen increased inquiry into the implications of drug-related bereavement for affected individuals, who are an underrepresented social group within traumatic death literature. Drug-related deaths refer to deaths due to overdose, but the cause of death may also be violence, suicide, or infectious disease consequential of opioid intake (Health Research Board, 2019; Titlestad et al., 2019). To date, the research has focused on drug death bereaved families, identifying unique and complex grief reactions such as shame, guilt, and isolation, with long-term health outcomes such as anxiety, depression, and an increased risk of physical illness and natural cause mortality (Christiansen et al., 2020; Lambert et al., 2021; Titlestad et al., 2019). The cultural perception of drug deaths as 'bad deaths' is

not conducive to the fact that the bereaved require specialised support to facilitate positive adaptation after a loss (Feigelman et al., 2020; O'Callaghan et al., 2022; Titlestad et al., 2020).

Almost all individuals who use drugs exist within a social context in which they interact with family members, HCPs, and peers, and research suggests that for every drug-related death at least 10 bereaved individuals may be connected (Dyregrov et al., 2020). Yet research efforts have neglected to investigate the direct impact of client drug deaths on HCPs who support people experiencing addiction. Practitioners in areas such as homelessness, addiction, social care, and emergency medicine play crucial roles in addiction support and recovery, and clients will navigate a range of health, social and justice systems. At each of these touchpoints, people using drugs connect with general practitioners, key workers, and other HCPs, often forming various levels of sustained professional relationships. Branson (2019) reported that HCPs who engage in empathic relationships with clients are at increased risk for vicarious trauma, which can result in accumulative changes emerging in one's personal or professional life. The emotional impact of exposure to clients' traumatic experiences can lead to outcomes such as intrusive imagery, loss of clinical motivation, and stress-induced health conditions (Branson, 2019).

An empirical study by McAuley and Forsyth (2011) examined the impact of drug-related deaths on staff that experience death within their caseload in Scotland. Utilising a self-report grief questionnaire adapted from a study by Rickerson et al. (2005), the authors investigated the emotional responses to a client's drug death in 65 HCPs in health, social, and voluntary care sectors. Participants identified grief-related

reactions from a list of 22 set items and provided a brief description of their grieving process. Although no significant differences existed among staff of different professions, grief-related reactions were present in 90 % of the sample, and staff exhibited similar reactions to drug death bereaved families (Lambert et al., 2021) with self-blame, helplessness, anger, and thoughts about their own morbidity being among the most common outcomes (McAuley & Forsyth, 2011). However, one of the identified limitations of this study is that participant responses were limited to set items, potentially increasing the risk of participant response bias. To truly discern the experience of HCPs who are bereaved due to a client's drug death, the authors recommended further qualitative inquiry.

More recently, Yule and Levin (2019) & Urmanche (2020) conducted literature reviews investigating grief outcomes in HCPs after the overdose death of a client. Given the current lack of HCP drug death-specific research, both reviews draw from existing family drug death bereavement literature and HCP research in other areas, primarily exploring client death by suicide. For practitioners, such grief is often disenfranchised, as Morrissey and Higgins (2021) identified intense grief responses to client suicide including isolation, guilt, and questions of professional competency. Veilleux (2011) reported that HCP reactions are often categorised into two distinct pathways; while HCPs commit to professional response requirements while on duty, they must also contend with personal responses that are akin to other forms of loss, such as grieving for peers (Morrissey & Higgins, 2021; Veilleux, 2011).

Due to the countertransference reactions evident in HCPs with other traumatic deaths, and the complicated grief outcomes associated with drug deaths, HCPs should be

supported with peer supervision that specifically encompasses the complexities of drug-related client loss (Urmanche, 2020; Yule & Levin, 2019). In McAuley and Forsyth (2011)'s study, most participants said they would avail themselves of such a service if it existed. However, to inform the development of such targeted support packages for HCPs, it is crucial to understand their needs, outcomes, and experiences with this specific form of grief.

An interview study in Norway (Løseth et al., 2022) examining HCP's first-hand experiences supporting drug death bereaved persons reported that first responders and other municipal HCPs encountered resentment from family members who were critical of the care system's ability to help their loved one during life. A key finding of the study highlighted how organisational structures and personal attitudes towards drug use can contribute to how HCPs relate to drug death bereaved persons, and an Irish study echoed these concerns as Lambert et al. (2021) reported that some families were met with prejudice and unfavourable reactions from professionals. On the other hand, such encounters with families can lead to reduced self-esteem and doubts about one's occupational competency. Løseth et al. (2022) examined how HCPs relate to drug death bereaved persons with the aim of informing best practice for support provision, and the authors suggested that practitioners should be trained in how to respond to such complicated grief.

While not directly exploring the grief experience of HCPs, the Norwegian study by Løseth et al. (2022) provided a crucial insight into the intricacies of providing an appropriate response to drug death bereaved individuals, and the complexities involved in providing diverse assistance in a multifaceted support context. However, the current

study argues that to truly provide context-sensitive support, we must also understand the emotional intricacies and trauma responses for HCPs themselves. O'Brien (2011), as cited by Urmanche (2020) spoke about the 'wounded healer', where although our experience and personal histories can help us relate to clients, unresolved or neglected wounds can inhibit our ability to deliver effective therapeutic practice. Continuing to work under elevated levels of stress is an often-accepted aspect of the occupational culture in healthcare, but exposure to traumatic deaths has clear implications for HCP wellbeing (Murphy et al., 2022) and occupational functioning, as vicarious trauma is associated with poor clinical decision making (Branson, 2019). In this paper, we argue that HCPs should also be considered as an at-risk group worthy of targeted support following the drug death of a client.

The current study intends to fill a gap in the literature by examining the impact of client drug deaths on HCPs in a range of professions in Ireland. In an Irish context, Lakeman (2011) conducted a thorough grounded theory study of how homeless sector workers experience the death of a client. However, the 2011 study addressed deaths of significant variety, inclusive of death by suicide, shooting, and overdose. Annual drug deaths in Ireland are now twice the European average (EMCDDA, 2021), and the country recorded its highest number of overdose cases since 2008 in 2018. In interviewing service providers specifically about their experience with drug-related client loss, this study also presents international implications as drug-related deaths are increasing in both Europe (EMCDDA, 2021) and North America (CDC, 2022 as cited by Reime et al., 2022). Understanding the nature of bereavement for HCPs in this context has implications for best practice and can identify opportunities for supporting

and protecting the wellbeing of professionals, who are often overlooked in the support process, and ensure they can sustain optimal levels of occupational functioning when working with drug death bereaved individuals and families.

6.3 Methods

The current study adopts a phenomenological approach to understanding the impact of client drug deaths on HCPs who support people experiencing addiction. It covers a wide range of professional roles where exposure to drug-related deaths is an acute risk within client caseloads. The first author conducted 15 in-depth interviews with HCPs who support people in active addiction. Participants represented a range of disciplines in healthcare such as homelessness, emergency medicine, addiction, and social work. In a sub-study of the current paper, the authors previously examined a subset of the data with respect to the specifics of supporting people experiencing addiction during the COVID-19 pandemic (O’Callaghan & Lambert, 2022).

6.3.1 Participants and Sampling

This study includes 15 participants (8 women and 7 men) working as HCPs in addiction, homelessness, emergency medicine, social care, and public health. Using convenience sampling, the authors sent emails containing information sheets to organisations where HCPs support clients experiencing addiction. Information provided to potential participants at this point included details of both authors, the objectives of the study, and the ethical framework for participation. Departmental leads within these organisations circulated the information sheet to relevant staff, and those who expressed interest in taking part contacted the first author directly. Table 6.1 lists the current

occupation of each participant (at time of interview). However, participants also spoke retrospectively of previous relevant roles they had worked in.

Table 6.1

Profile of Participants

Participant	Role
Participant 1	General Practitioner
Participant 2	Inclusion Health Social Worker
Participant 3	Homelessness Project Manager
Participant 4	General Practitioner
Participant 5	Addiction Project Manager
Participant 6	Clinical Nurse Manager
Participant 7	Researcher in Social Services
Participant 8	Paramedic
Participant 9	Community Detox
Participant 10	Addiction Counsellor
Participant 11	Emergency Medicine Consultant
Participant 12	Community Drug-Alcohol Worker
Participant 13	Housing Support/Addiction After-Care
Participant 14	Addiction Counsellor
Participant 15	General Practitioner

For inclusion eligibility, participants had to be over 18, employed in professional support roles working directly with service users experiencing addiction, and had experienced the drug-related death of a client during their time of employment. The study had no sex or gender restrictions but made efforts to include a balanced sample. All participants who expressed interest in the study committed to participation, and none sought to withdraw from the study post-interview.

Participants were based throughout the Republic of Ireland, and the geographical spread covers staff based in the South, Southeast, Mid-West, West, and East of the country. Specific locations of each participant have been withheld for the purpose of anonymity.

6.3.2 Data Collection

To collect data, the first author conducted 15 one-to-one semi-structured interviews between October 2020–January 2021. Two interviews occurred by telephone, and 13 took place online via the Microsoft Teams video call function. The duration of interviews ranged from 30 min to 57 min, with the average duration being 44 min. To maintain anonymity, the first author recorded the interviews using an external audio recorder and transcribed each interview verbatim while ensuring to remove any information that would be considered identifiable.

Interviews followed a list of seven open-ended questions about drug-related client loss to ensure a level of topic constancy across cases: (1) “Can you speak about your role?,” (2) “Can you tell me about the nature of staff-client engagement in your work?,” (3) “Can you tell me about your experience with drug-related deaths in your

practice?,” (4) “How have such losses had an impact on you personally or your occupational functioning?,” (5) “On a personal level, and given the demands of healthcare, do you find space to process such losses if required?,” (6) “Are you aware of current protocols and supports available to you as a front-line worker in the event of drug-related client loss?,” (7) “Reflecting on your experience with drug-related client loss, are there any supports you feel would have been beneficial that were not available at the time?”

The flexible nature of the semi-structured interview and the use of prompts allowed for the exploration of unanticipated topics while participants spoke at their own pace. Participants spoke compassionately about the impact of client drug deaths on their own wellbeing. At the beginning of each interview, staff again briefed participants on the study's aims and methods and informed them of their right to pass on questions or end the interview at any time. At the conclusion of each interview, we debriefed participants and reminded them of relevant support services if required.

6.3.3 Data Analysis

Data analyses utilised Braun and Clarke (2019)'s reflexive thematic analysis framework, and we subsequently outlined findings in accordance with the standards for reporting qualitative research as presented by O'Brien et al. (2014). Both authors are experienced qualitative researchers who work with socially excluded populations, and we considered reflexive thematic analysis to be the most appropriate methodology for presenting the experiences of drug death bereaved HCPs. More specifically, reflexive thematic analysis acted as a systematic methodology where we could draw from our research values, skills, and training to synthesised theories and concepts when engaging

with, and attaching meaning to, the data (Braun & Clarke, 2021). The stages in Braun and Clarke (2019, 2021)'s are sequential, but fluid movement between phases allows for the necessary rigor involved in deconstructing the data and presenting it through synthesised patterns of latent meaning.

The stages of analysis conducted in this study were as follows: (i) familiarisation with the data, (ii) coding the transcripts, (iii) generating initial themes, (iv) reviewing emergent themes, (v) defining the themes, and (vi) writing up the findings.

Each author familiarised themselves with the anonymised data transcripts, and the first author carried out inductive coding using NVivo qualitative analysis software (released in March 2020), adopting a ground-up approach and creating non-hierarchical codes through direct examination of the data. Upon completion of the initial coding, both authors engaged in continuous dialogue regarding the nuances of the codes and the generation of initial themes. The authors carried out this process through rigorous reorganisation of the non-hierarchical codes from individual transcripts into more refined coding patterns across the entire data set. Back-and-forth movement between phases was common at this stage of the analysis when new codes and concepts emerged from conversations related to the data. Using our own knowledge and experience, we reviewed and defined emergent themes through arbitrary decisions about how to reconstruct and contextualise the data within HCPs' experience with drug-related deaths and bereavement.

6.3.4 Reflexivity

Due to the inherently subjective nature of the coding process, the authors aimed to ensure that the analytical strategy was transparent and systematic. The authors engaged in reflective journaling and used reflective memos to build a history of thought progression from the beginning of the analysis. These memos involved written reflections about how the first author's experience around drug-related bereavement may have fostered pre-existing assumptions and biases. Through journaling and ongoing conversations between both authors, we aimed to address researcher bias by demonstrating rigor and approaching the data in a most inductive manner. The first author has prior experience in working with socially excluded populations in addiction services through research-based practice, and the second author has both practitioner and research experience in addiction services. The first author was the sole interviewer, but after each interview the authors met to debrief and discuss the data. Our use of reflective practice ensured our efforts to address the risk of bias and deductive coding were extensive and coincided with our responsibilities as qualitative researchers (Dodgson, 2019).

6.3.5 Ethical Considerations

The current study received ethical approval from the departmental ethics committee at the University where both authors are employed. The information sheet provided to participants outlined the voluntary nature of the study, the potential uses of their data, and ensured that all information would be confidential with anonymised identities. All consent forms were electronically signed and returned to the first author prior to the corresponding participant's interview. Upon completion of the anonymised

transcripts, the original interview recording was deleted, and the collected data was stored in written format (Microsoft Word document) on an encrypted Microsoft OneDrive provided by the authors' home institution.

6.4 Results

Exploring the emotional intricacies of drug-related client loss unveiled diverse grief-related reactions for HCPs which were compounded by the unique stigma associated with drug dependence. Three core themes that illustrate the experience of drug-related client loss emerged from the data, (i) Grief Beneath the Surface, (ii) The Cost of Caring, and (iii) Finding Closure. Each core theme includes associated subthemes.

6.4.1 Grief Beneath the Surface

Due to the nature of healthcare, the emotions of grieving staff members are often masked by professional composure as they deliver a service in times of difficulty, stress, and trauma. This professional resilience can result in a belief system that HCPs are expected to work with a detached emotional competence, a perception which some staff internalised as an accepted component of their role: "It's not the most straightforward thing. It's not like the sudden death of a 60-year-old that dies of a heart attack either. Like, when you're trying to explain to somebody else, you have the whole stigma around drug use." Due to the way patients lived their lives, practitioners felt that this grief had to remain beneath the surface. However, despite these expectations of professional endurance, when sharing stories of clients who passed away due to drug-related complications, all participants addressed complex psychological outcomes that

centred around their roles as decision makers, self-blame, and vivid recollections of a death's details.

6.4.1.1 Intrusive Flashbacks

Participant 14 highlighted that it is important not to neglect the reality that HCPs are exposed to primary trauma despite their tendency to carry on with work: "A lot of it is primary trauma in terms of witnessing, finding bodies, or identifying bodies. Or going to the inquests or getting assaulted or getting threatened." Many participants detailed hostile encounters stemming from high tension in emergency situations. Participant 8 mentioned having paramedics "assaulted in the past" and Participant 11, also working in emergency medicine, spoke of an encounter with a grieving father:

I have been attacked by a father...The son was in his late teens, early 20s, and died from an overdose. And, I mean, I never saw a human being froth at the mouth the way this dad came at me because I had stopped resuscitating. There was nothing we could do he, he...

Such tense and aggressive energies were consequential of traumatic situations, for which participants empathised, but being a tenured professional did not always negate the long-term cumulative impacts of traumatic events. Evocative recollections of these encounters rekindled emotions of fear and panic and, similarly, many participants spoke of haunting imagery that stayed with them after the harrowing experience of finding a client's body. Discoveries of this proportion can lead to such sensory overload that not only do HCPs carry the emotional weight of the moment, but the visual experience becomes ingrained in their mind, as illustrated Participant 7:

I heard a thud from [client's] room, and I thought "oh she must be moving furniture around...I'll pop up and check she's alright in a minute or if she needs a hand". And I remember sitting there and this was ten years ago, and I can still feel it, I can still see it. So, if I can connect that deeply with the visual and the emotional experience it means I probably haven't integrated it, you know? I can see her face, I can see the mucus, I can hear the sound of her falling.

The multisensory integration of this experience left a lasting impression on Participant 7, who visualised scarring imagery to a thoroughly vivid extent. In the absence of targeted professional support to address and recognise the trauma, the experience was concealed by the demands of professional responsibility. In the same way participants carry positive facets of their connections with clients for many years, so, too, can adverse experiences linger, and with damaging effects. Such animated recollections were commonplace, as Participant 14 elaborated on how such experiences can have a profound impact on daily functioning:

I knew from the stench and the smell what I would face when I opened the bedroom door. He was gone and he was rigor mortis, he was pooling. It would have been physically not a very attractive sight...I had to ring my staff member maybe 48 hours later and I said, "How are you?" and he said he wasn't sleeping, I said "neither am I". Couldn't get the smell out of my nostrils... I couldn't eat after that... You get a vision of the person lying on his bed, with the stench and the smell, and the contents that were coming from his air passages, just make you gag.

Practitioners are primed to respond professionally in the moment, but such events impacting HCPs' wellbeing, appetite, and sleep highlight the very real physiological aftermath of drug-related client loss. Occupational functioning, as crucial as it is to healthcare, can mask the implications of drug-related bereavement that exist beneath the surface. Timely and targeted support to address trauma in this context is pivotal as experiences may be repressed to ensure one's capacity to meet professional demands. As shown with Participant 14, neglecting to address trauma can have long-term health implications that even practitioners may not recognise within themselves:

Without a doubt it had a massive impact on me. I didn't realise it at the time. I had partners and they may have been able to see it but, definitely you know I... I had a panic attack once when I was managing [service], maybe six months after the incident, right? I had one, and I didn't know what it was at the time, it was horrific.

6.4.1.2 The Clinical Carer's Burden

The coalescence of a HCP's duty of care and the potentially preventable nature of the death often engendered feelings of culpability surrounding a client's drug death. Participants ruminated on alternative outcomes as they cross-examined their decisions: "It's an awful knee jerk reaction but first thing, did I miss something? Did I give the wrong dose? Did I, should I have asked different questions?" In this quote, Participant 4 highlighted the emergent process of self-questioning that stemmed from his position as the advocate within the staff-client relationship. Similarly, Participant 6, a clinical nurse manager, captured how the emergence of self-blame often compelled staff to retrospectively assess the accuracy of their own case management:

There's always this anxiety...Were they on high-risk checks? Were there signs? Did they have a support plan around their overdose risk? From a mental health point of view, were there any previous overdoses, did we do everything we needed to do? So, it's almost like it's somebody's fault.

Engagement in contemplative processes is documented as a valuable loss-oriented mechanism for making sense of loss, but the traumatic nature of a drug death can shroud these processes in guilt, self-questioning, and blame. In the absence of appropriate external support that recognises these emotional responses, Participant 3 explicated that grief can further manifest into feelings of futility, hopelessness, failure, and decreased occupational self-efficacy: "It was impacting on us. It was making us really angry and sad. What's the point of doing this? They're dying. No matter what we do they're all dying. And they were dying so young."

Self-blame resulted in even the most experienced staff questioning the efficacy of their decision making, as uncertainty surrounding procedural correctness became a primary initial concern. A key function of their role in this healthcare context is to mitigate the risk of a drug-related death, and an embodied sense of responsibility for the outcome can yield implications for HCPs' trust in their own clinical competence. Through the process of self-blame, internalised fears were compounded by external factors such as legal disputes and fears of litigation, as voiced by Participant 4: "I know my colleagues have ended up in court over the years. Because someone has died, and the family has taken it further."

Amidst such inner conflict, participants spoke of needing to "box off" adverse experiences to meet the urgency at which healthcare demands their services.

Correspondingly, many participants, such as Participant 3, recognised during the interviews that although they returned to higher levels of occupational functioning, they still had unprocessed emotions from client drug deaths: “I think for me in this conversation what struck me is that I’m still really angry and sad about the lads that died last year.” The demands of healthcare may lead practitioners to prioritise their work and create a silent, unprocessed, and unrecognised grief that, as professionals, is their own burden to bear.

6.4.2 The Cost of Caring

The duty of care to others is a key competency of a HCP’s job description, but an emotional investment in their clients’ recovery complemented participants’ occupational responsibilities. Participants spoke of clients with compassion, fondness, and privilege, ensuring to humanise them in a manner that far exceeded the simplicity of the term ‘service user’. HCPs frequently developed empathic connections with their clients that transcended surface level interactions one would expect to occur between them as “part of the job”. Participant 9, a community detox manager, eloquently shared how a staff/client dynamic becomes a deep and authentic human connection within the boundaries of professional conduct:

Sometimes you see more of the clients you work with than you do of your own family members. Sometimes you know this person so well you have more of an understanding of where their trauma is. More of an understanding as to why this is the road they’re on in life...Sometimes the long-term staff member is on the journey with that person.

However, this deep emotional investment often came at a cost as it also compounded their distress when a client passed away, and grief-related reactions were further exacerbated by unique complexities associated with drug-related client loss. Participant 8 showed that the possibility of death by overdose can cast a shadow over these interactions: “It does have a burden, but maybe it’s, maybe there is a sense of inevitability about it.”

6.4.2.1 Occupation and Vocation

HCPs emphasised staff/client connections as a facet of healthcare that should be professionally and socially acknowledged. Paramedics, addiction counsellors, and general practitioners engaged with clients at different stages of their journey, but the relationships progressed beyond familiarity and into authenticity by virtue of proximity, frequency of interaction, and rapport. Due to their clinical knowledge of addiction, however, HCPs considered an intrinsic preparation for the possibility of client death to be a key professional requisite. Yet, as detailed by Participant 2, understanding the nature of the work does not diminish the psychological impact of the loss of a client’s life:

The nature of the work we do and the clients we work with, you are going to have drug-related deaths. It would be very naïve of us to think that we’re not going to experience death...But obviously, you build a particular relationship or a bond. Then when [clients] pass, particularly if it’s sudden or violent, you would really grieve.

Evidently, there is an internal dissonance between maintaining a pragmatic perspective on client outcomes and coping with the emotional sadness of loss.

Responding to death is a professional demand, but participants stressed that the response to losing a client was not simply procedural in nature. As they connect to the humanity of their work, Participant 12 demonstrated that there exists a strong emotional connection that merits recognition:

I worked with her for so long. It's fascinating to me to think that, gosh, she died a number of years ago and I would still think of her often, and that I would feel so emotional just talking about her. It's not fair to underestimate. It's a work situation but people working in services, you build up a connection with people. It can still make a massive impact.

For HCPs, this stigmatised and disenfranchised grief is complicated by societal and organisational expectations of professional endurance which, at times, resulted in self-stigma that can have implications for help-seeking behaviour, as illustrated by Participant 1: "Maybe you do internalise that a bit and think, can I really go and tell somebody I'm sad that someone who was injecting heroin for 20 years has died suddenly?" Endeavouring to rationalise their emotions, participants struggled to align their professional persona, crafted by external social and organisational norms, with their internal personal sense of grief. However, Participant 9 underlined that drug-related client loss is as devastating and valid as any other, and despite being a trained professional, human loss of any kind invokes a human reaction: "There was an awful lot of emotion that came up for me in that death, that type of emotion that you'd think you would only identify with if it was somebody of your own family."

6.4.2.2 *Mutual Learning & Lost Potential*

Beyond the transactional nature of service provision, participants emphasised the importance of cultivating trust with clients. In exploring the more in-depth aspects of these exchanges, HCPs revealed a reciprocal facet to their interactions that often go unnoticed in the wider sphere of healthcare, particularly given their positioning as the ‘provider’ in the dynamic. As HCPs shared heartening anecdotes of clients who had passed on, many participants, such as Participant 9, treated these relationships as connections of mutual learning:

This lady was really unique. I’ve never met anyone like her in life before, I’d imagine I never will again. And I was very, very lucky to be her person. It was a very privileged position, and I think it is that privilege that has brought me to where I am today in my career.

Crediting clients for shaping their professional practice highlighted how such dynamics can foster a meaningful space of shared personal growth. Many participants carried these lessons forward to improve their practice but also to honour their client, holding memories dear to their heart and showing that death is not where these relationships end. Arising from this affinity, Participant 9 stated that the abrupt and traumatic end to this potential from an untimely and preventable death was one of the most difficult aspects of drug-related client loss to contend with: “It’s not just that person is gone, it’s the loss of potential. It’s the fact that they never got to resolve some of the things that brought them to this life in the first place.”

In mourning their clients, HCPs could imagine the future potential for an individual’s life beyond addiction. Thus, accepting the finality of death was difficult and

the loss of potential engendered feelings of frustration and discouragement. Exploring this frustration, Participant 2 acknowledged that the stigma surrounding drug use often leads society to condemn people in active addiction and subsequently disregard their death, rather than recognising their potential for life: “In the drug related side of things, there’s all this stigma around ‘oh, he was using.’ I don’t care that he was using, he was a person. With the drug side of things, it’s like ‘oh they chose that’.” Participant 7 stressed the importance of shifting this condemnation into a social acknowledgement of the significance of each loss, both within services and the community:

It definitely felt like it was more of the expected part of the job, and you just got on with things...But are we saying it’s an acceptable part of life and we don’t even notice it? And if not then what’s that doing to us, to our hearts, to our respect for life, or our compassion for people, or our hope for their potential?

6.4.2.3 Shock to the System

HCPs are acutely aware of the increased mortality risks associated with addiction and specified an underlying preparation for the possibility of client loss. However, clinical knowledge does not grant immunity from traumatic shock, as anticipatory grief can be inhibited within certain contexts and leaves HCPs emotionally vulnerable to unexpected deaths. While there was a veiled preparation for many deaths, there are a sub-group where death is less anticipated depending on the timing of the death and what stage the client was at in their recovery. In some cases, deaths occurred when clients were perceived to be on a positive trajectory towards recovery, as illustrated by Participant 6:

With this recent gentleman, he was doing so well. He was overdosing quite regularly, and then he had a period of doing so well, and then [he died]. And I guess, you're expecting it when they're going over all the time and you're not expecting it as much when they're doing well. It's very difficult for the staff who are supporting people to stabilise.

Times of prosperity during a client's journey to recovery may be associated with less professional proximity to services and losses during this time can be harrowing for HCPs. For Participant 6, the loss of a client in this manner generated a range of complex emotions. The perilous nature of addiction yet unexpected nature of the death created an incongruity between the characteristics of the work and the emotional impact of the loss. Such complex emotional dissension can inhibit one's capacity to grieve, as efforts to make sense of the loss are obstructed by wider misconceptions of how professional expertise should function as a coping mechanism.

In other circumstances, participants experienced traumatic shock when a client passed away during an ongoing dialogue and planning process about their future. When a death occurred during this apex of hope and ambition, anticipatory grief was diminished and resulted in traumatic shock, as shared in this anecdote by Participant 10:

I had real traumatic shock where I needed the support of my colleagues. One client went to residential treatment, lasted 3 weeks, and rang me to say he wasn't staying there after I worked 9 or 10 months to get him in. And then, he said 'I promise you I'll come in and see you next week'. All the promises. You are invested in their recovery. And then I got a call on Monday to say that he had overdosed. On heroin, which was not his drug of choice.

Participant 10 mourned the loss of life, but also struggled with an unfamiliar sense of incongruence as she found herself predominantly experiencing anger and frustration towards her client, alongside the sadness for his loss:

I found myself being pissed off. Pissed off with him for all the promises. And then I thought he was trying to not let me down, trying to make me proud by staying off the benzos. He probably went off to try and get painkillers and then someone offered him heroin.

Participant 10 struggled to make sense of her emotions and felt guilty for harbouring anger towards her client. However, she also recognised the respect she had earned from a client who sought not to disappoint her. While this accentuated her sense of guilt, earning that esteem was not something she took for granted and highlights the degree of mutual respect that can develop in healthcare contexts. Participant 10 truly mourned the loss of potential for this young man and the working relationship she had developed with him. Such anecdotes highlight the complexity of drug-related client loss, demonstrating that the anticipatory knowledge that HCPs carry does not always mitigate the emotional impact.

6.4.3 Finding Closure

Achieving emotional closure was sentimentally important to HCPs and considered to be an entirely separate journey of personal healing to professionally closing a client's engagement with a service. Fulfilling these professional commitments did contribute to the process of healing, as shown by Participant 10:

The policy did provide me with support, I suppose it gave me a practical lens because from an emotional standpoint I was really angry...The policy was a good way to keep my rational mind. I needed to ensure my files were up to date.

A key aspect of this quotation that applied to all participants was the identification of an emotional facet of finding closure. Honouring their client was a very personal matter and closing the relationship with them on their own terms, independent of professional responsibility, was pertinent for participants. However, at times it was difficult to separate professional and personal closure, as Participant 2 spoke of the process of retaining mementos for clients:

In my office at the moment, there's four- or five-people's belongings, the belongings of people that have died recently, that I'm trying to get back to their families. So, it's nearly like a little shrine in here sometimes. But I have artwork and stuff that people who have passed away and left me things as well, which is nicer to have than their belongings.

Due to the complexities associated with drug-related client loss, closing relationships post-death was often a journey of trepidation, balance, and uncertainty.

6.4.3.1 Trepid Last Respects

Attending client funerals was considered standard practice in some healthcare frameworks, but situational context played an important role. Specifically, due to the shame and stigma surrounding drug-related deaths, Participant 7 showed that the process of attending funerals became shrouded in uncertainty: "Is it appropriate for us to go to his funeral? We've been working with him for a long time but, his family may not want

that part of his life represented at a funeral.” All participants sought to be considerate of families’ wishes but upholding this respect sometimes inhibited HCPs’ own opportunities to grieve. Funerals are an integral component of emotional closure in many cultures, and marking the death in this capacity was an important value that HCPs wished to uphold. Participant 9 demonstrated the significance of attending funerals as it pertains to achieving closure: “If I don’t go, I always expect them to come back. Closure. It’s me closing that relationship with them.” As Participant 9 elaborated, this desire was not solely for their own emotional closure, but also out of respect for their client: “You didn’t know whether you were leaving the person down, even though they were gone, by the fact you didn’t attend their funeral.”

When clients passed away, a previously estranged part of their lives then emerged, and HCPs often had not previously engaged with parents and other family members grieving this person. Entering this new dynamic was a source of trepidation for practitioners who often dealt with an internalised sense of culpability for the death, with Participant 10 showing she was conflicted about respecting her client but also respecting those who were left behind: “I didn’t know how they were going to respond to me, react or what way it was going to go. I do remember driving to the funeral home, you don’t know if it’s the right thing to do or not.” Evidently, the stigma and shame surrounding drug-related deaths added an extra layer of complication to the process of achieving closure.

In some cases, fulfilling communication occurred with families where HCPs were welcomed to funerals, mitigating their feelings of apprehension. Participant 10 highlighted how such transparency allowed her to bypass some emotional complications

at another funeral: “No blame...Didn’t have the fear someone was going to blame me, and I could concentrate on myself then.” In other cases, funeral details were withheld or modified to mask the shame and stigma associated with the use of drug-related services. Participant 14 showed that, sometimes, tensions can exist between a family and a service post-death: “I suppose it was the impact for me. It was that the family went through a coroner. I met the family afterwards; they were very bitter towards the service.” Participants compassionately accepted families’ decisions, but stigma and shame often created a barrier to achieving closure in the traditional sense as participants grieved for their client, and Participant 9 also lamented over the community they belonged to:

It’s not that you want to be acknowledged or thanked or whatever. But I think the acknowledgment needs to be that this person was part of a very important community in our society that’s always overlooked.

6.4.3.2 Balancing Act

Due to the level of vicarious trauma and grief that HCPs are exposed to throughout their professional tenure, Participant 7 highlighted that finding the delicate balance between grieving and moving on was identified as a critical professional skill:

I think anyone working in crisis type services has to disconnect from the emotional impact. Like, if every time something happens you allow yourself to feel the full force of the emotional impact as if it was the first time, then you would probably be quite unwell, you know? I don’t think you’d be able to do your job and I think there’s a required amount of it in order to enable you to act and do your job and continue to be there.

As professional longevity emerged as a protective factor, Participant 6 stated that she developed undefined coping strategies for dealing with vicarious trauma but reinforced that she preserved her compassion: “Personally, I don’t like to use the word desensitised, because I’m not desensitised to it. They’re actual people... Whatever I’ve developed, I’ve developed to continue to do this work.” Participant 9, then, spoke of how she drives forward to remain at a functioning level: “It’s skimming over, it’s driving on, it’s getting on with it. Because if I stop, I’m going to be flattened by all the loss I’ve experienced.”

Tenured professionals developed their own mechanisms for coping with occupational hazards, but these techniques are not universal. Many participants, such as Participant 3, admittedly struggled with finding this balance or had suppressed emotions stemming from previous traumatic experiences: “I don’t know how to meet that need fully. Because I’m conscious that working in this area, I’m going to come across [drug-related deaths] every year.” Developing these coping mechanisms without appropriate guidance, however, presents a high risk for negative health outcomes, and Participant 7 highlighted the importance of proper support infrastructures where practitioners can feel safe in their help-seeking behaviours:

I think without proper structures in place to allow you to recognise that, to say ‘I am disconnecting from this in order to sustain my capacity to work with people who are at such crisis all the time’, if that’s not done in a planned measured way then people do it in a negative, unplanned way which turns into burnout and turns into disconnection and turns into compassion fatigue.

Participants wished to validate the loss of human life to an extent that reflects and recognises the depth of connection they shared with their clients, while also allowing them to continue their work. Across the different professions represented in this paper, there were numerous support packages available for HCPs such as employee assistance programs, internal supervision, and peer support. However, all participants identified a gap in the support process as it pertained to drug-related client loss beyond debriefing, where the availability of a structured, external support program that tackles complicated loss would be of significant benefit to achieving this balance, as Participant 4, a general practitioner stated:

You try and box it, and park it off, Unconsciously, in your own head and so there's that. And then *functionally*, the service isn't doing anything about it...I feel very strongly about it, I have been trying to ask people for the last two years that we as doctors, and nurses within the service, get supervision the same as our comrades do.

When mentioning “comrades”, the participant was referring to those who work in other disciplines that support people experiencing addiction such as therapists, homelessness project workers, and social care workers. For those staff, however, while some organisation-specific supports had been developed in relation to supervision, the concept of external supervision was highlighted as important to provide an impartial space, as was peer support.

The importance of carrying on with your job was explicated throughout interviews, but not at the cost of staying connected to the humanity of the work. Participant 7 spoke of achieving this balance: “Recognition processes, symbolic things.

If there were discussions after you lose someone. That we don't allow our desensitisation, that we build as professionals to cope, to go over into our capacity to actually grieve and mourn." Balancing the two unique constructs, the requirements of work and humanity, was a difficult one to strike. Crucially, participants spoke about how it is important that organisations do not overestimate the capacity of staff or underestimate the impact of a death.

6.5 Discussion

The current study explored the experience of drug-related client loss for HCPs who support people experiencing addiction. The findings identified acute grief-related reactions in HCPs akin to the loss of peers, family members, and other close connections. The bereavement experience was complicated by unique compounding variables associated with drug-related deaths, but also by incongruity between their emotional responses to death and their professional responsibilities. Despite their social positioning as tenured practitioners, HCPs' reactions to client deaths were predominantly human responses to loss, for which participants wished for wider societal acknowledgement. As the key finding in this paper, HCPs experience a profound grief from drug-related client loss that requires further targeted professional intervention and wider social acknowledgement.

Research on drug death bereaved family members has consistently identified complicated grief reactions inclusive of shame, self-blame, frustration, rumination, and a fractured sense of purpose (O'Callaghan & Lambert, 2022; Titlestad et al., 2020). Similar reactions emerged in drug death bereaved HCPs (McAuley & Forsyth, 2011), as

practitioners in the 2011 study reported self-blame, shame, and anger. In its exploratory approach, the current paper coincides with these studies, and provides a critical insight into emotional processing difficulties consequential of drug-related client loss. In a similar manner to how drug death bereaved parents relayed feelings of self-blame for the loss of their loved one due to their role as a primary carer, HCPs reported self-blame stemming from their position as an advocate in the staff/client dynamic. HCPs, however, are societally situated as experts, where the function of their role to mitigate such outcomes is publicly defined. As participants internalised these external professional expectations, and the preventable nature of drug-related deaths, grief-reactions manifested into a sense of failure, culpability, and self-questions of clinical competence.

Participant reactions to client drug deaths were two-pronged, often involving a bilateral relationship between distinct professional responsibilities and personal responses. Previous literature conveyed the divergence of grief reactions in this manner (Lakeman, 2011, Morrissey & Higgins, 2021; Veilleux 2011), where rituals and behaviours linked to death response were categorised based on their association with organisational necessity or individualised emotional processing. Similar to the current findings, Lakeman (2011) demonstrated that homelessness sector practitioners fulfilled procedural death response protocols but required another outlet for their personal grief, resulting in both formal and personal methods of marking deaths. In the case of drug-related client loss, however, this study found that many personal coping methods, such as attending client funerals or openly grieving the death, were inhibited, undermined, or socially unsanctioned due to drug-related stigmas.

Despite their occupational necessity, in a comparable finding to Lakeman (2011), participants reported some professional mechanisms to be beneficial, such as documenting a client's closed engagement with a service or tending to other clients in the aftermath. However, while these processes were considered important for the purposes of pragmatism, the emotional weight of drug-related client loss was profound, and the personal impact transcended what could be managed in a purely procedural capacity. Throughout interviews, participants emphasised the depth of connection they shared with their clients, and while this presented itself differently across professions, such rapport with a client intensified traumatic grief reactions. Yet, participants sometimes felt the need to censor their emotions, an experience mirrored in literature addressing other traumatic deaths such as death by suicide (Morrissey & Higgins, 2021). In the wider healthcare context, help-seeking behaviours among HCPs are impeded by the prevalence of self-stigma emerging from projections of professional fortitude (Ellis & Korman, 2022). However, for those who experience drug-related client loss, the amalgamation of self-stigma and the broader societal stigma surrounding drug use generates a disenfranchised and complicated grief.

Peer support has been identified in the literature as a significant facilitator of positive organisational attitudes to help seeking (Urmanche, 2020; Yule & Levin, 2019), particularly through the lens of creating a shared sense of understanding about the emotional and physical taxes of the job. It has also been identified as a protective factor against vicarious trauma. Targeted organisational supports that recognise the emergence of blame or claims of incompetence that exist in healthcare roles is important, as practitioners have an extent of individual responsibility over client welfare during life

and may experience the heavy burden of death in silence. Positionality played a key role in the experience of drug-related client loss, both from HCPs' position as clinical specialists, and the social positioning of clients shaping them as autonomous active agents in their death due to perceived choices to engage in risky behaviour. Participants expressed frustration at the current social belief system that constructs addiction in neglect of a trauma-informed understanding, with implications for how HCPs internally validate their own grief.

Anticipatory grief can be considered a functional aspect of coping with loss and similar to research on Irish families (Lambert et al., 2021), but this did not always protect HCPs from traumatic shock. Clients sometimes passed away while they were perceived to be on a positive trajectory, with aspirations for their potential abruptly shattered. Participants spoke about the mutual respect between them and their clients, evident from dialogue related to not wanting to let each other down. Contending with sudden loss against a backdrop of anticipatory grief inhibited efforts to make sense of the loss, and participants explicated that the traumatic shock from such events is profound. Furthermore, HCPs often have to contend with visceral experience of finding client bodies, and the generation of intrusive recollections (Lakeman, 2011). Evidently, strong postvention protocols are required to mitigate posttraumatic stress responses.

HCPs who support people experiencing addiction require targeted support to mitigate the unique and complex grief-related reactions consequential of drug-related client loss. These findings suggest that a balance between both personal and professional processes is important, but participants openly acknowledged difficulties in achieving this. The process of internally validating their own grief was punctuated by self-stigma

and a lack of external social acknowledgement on a broader societal level. Through relational based models of care, frameworks should aim to separate, recognise, and normalise grief-related emotional responses to client drug deaths. Normalising such grief experiences at a broader societal level would assist in the internal validation of their grief and mitigate against experiences of disenfranchisement. Lead staff and healthcare professionals need to be accountable for making sure people do this in an effective way to avoid burnout and compassion fatigue, with targeted bereavement programs that understand that staff do not work with a detached emotional proficiency, that normalise grief-related reactions, and that support HCPs to re-enter work at a functional level; these policies should be an organisational priority.

6.5.1 Strengths, Limitations, and Directions for Future Research

The development of a conceptual framework and targeted support should aim to support HCPs in harmonising their professional and personal equilibrium. However, in order to achieve this, the emotional facets of drug-related client loss cannot be neglected within organisational support structures. The concept of a dual process model to coping with grief was developed by Stroebe & Schut (1999, 2010) and recently applied to drug-related bereavement in families (Dyregrov et al., 2020). Subsequent findings by Dyregrov et al. (2020) posit that a healthy balance between loss-oriented and restoration-oriented processes is an important mechanism for reorientation following drug-related bereavement. HCPs certainly oscillated between two distinct processes when coping with drug-related client loss, but the true application of this model in a professional context requires further study. The demarcation between what functions as loss-oriented or restoration-oriented in this instance is undefined, particularly because

many professional responses are borne out of organisational necessity, and personal responses are inhibited by internalised expectations of standardised professional conduct.

As McAuley & Forsyth (2011) noted in their study, there were no significant differences between grief-related reactions in staff of different disciplines. The current study explored this in further depth, and although no clear anecdotal differences emerged between staff of different professions, HCPs engage with clients in different capacities and further exploration of the intricacies of these dynamics in specific contexts is recommended. The experience of witnessing and encountering death can vary from profession to profession, and anticipating or responding to overdose can generate feelings of stress, fear and anger depending on the quality of training received or its recognition as a psychological trauma (Wagner et al., 2014). Therefore, as this study succeeded in identifying a range of professions where targeted support options are required for drug-related client loss, future research should aim to focus on specific disciplines to account for differences in engagement and support access.

Given that those with a dual diagnosis (i.e., substance use disorders comorbid with a mental health diagnosis) struggle with service access (Karapareddy, 2019), services often run in parallel instead of integrated care. In these instances, people can fall between the cracks, leaving HCPS struggling to signpost their client to an appropriate recovery pathway. Future research should seek to investigate if this compounds workers' experiences of grief reactions.

Although not addressed in the current paper as an aspect of HCPs' grief experiences, throughout interviews, participants referred to their services as a

community inclusive of the clients they work with. As a result, staff expressed concern for the clients who lose peers to drug-related deaths and raised questions about how this may affect the wellbeing of clients and bring their own morbidity to the forefront of their emotional regulation. Exploring the bereavement experience of people who use drug and related services when a peer dies by overdose is important to understand to improve services for those who avail of them. Future research should also aim to examine the potential impact of alcohol-related deaths within such communities and services.

Overall, HCPs who support people experiencing addiction can exhibit profound grief reactions that are often masked by their professionalism. As O'Brien (2011, as cited by Urmanche, 2020) identified the concept of the 'wounded healer' having significant implications for best practice, it is of crucial importance that HCPs are supported and protected in their venture to support clients in their recovery. Ensuring their wellbeing will, then, ensure that practitioners are also positioned to support drug death bereaved persons as highlighted by Løseth et al. (2022), whether that be family members, other practitioners, or other clients. In conclusion, as evidenced by the manner in which some participants maintained continued relational bonds with their clients post-death, the grief associated with drug-related client loss has a clear impact on practitioners who support people experiencing addiction.

Chapter 7: A Critical Reflection on Conducting Empirical Research During the COVID-19 Pandemic

7.1 Chapter Summary

This chapter presents a critical reflection on conducting a portion of this doctoral thesis within the restrictions of the COVID-19 pandemic. As an early career researcher, this period generated countless uncertainties about safe and ethical research practice, which raised significant concerns regarding research that could potentially be distressing for participants. In overcoming these challenges to produce meaningful work, the experience acted as a formative period in terms of the development of adaptive research skills. Following the reflection, this chapter presents an evidence-informed overview of some of the challenges faced by staff in the addiction support and recovery sector during the pandemic. To conclude, the chapter provides a rationale for the empirical work presented in Chapter 8, exploring the experiences of healthcare professionals who supported people in active addiction during this time.

7.2 Reflection

When I began this PhD journey, I did not envisage the term ‘uncertainty’ to be the dominant thematic concept of the first couple of years. Reaching this milestone in my professional life was something I was, and still am, inherently proud of. For 18 months prior to my enrolment as a PhD student, I had worked in several cross-

disciplinary research roles, carefully cultivating a skillset that I was keen to apply to a research area I was deeply passionate about. Ready as I was to begin, the transferability of these skills was promptly called into question mere months after my enrolment. With the onset of the COVID-19 pandemic, everything I knew about socially engaged research was suddenly considered unsafe in the new public health emergency.

Conducting a PhD is a challenging process under normal circumstances but attempting to navigate the early and formative stages of my doctorate during a global pandemic generated profound difficulties. My research, at the core of its values, requires careful consideration of ethical practices. Following numerous delays due to prolonged lockdown periods and several attempts to develop ethical measures to engage with DRD bereaved families, I had decided with my supervisor that it would be best to forego that research strand. I recognise the importance of cultivating a psychologically safe and compassionate environment for participants, and I would never wish to compound existing pandemic-related circumstances by placing requests for research participation. After consulting with some of the community partners, it was then decided that I conduct online interviews with healthcare staff, who could avail of on-site support if they became distressed during interviews.

At first, conducting interviews online directly challenged my values as a researcher and as a person. My primary concern in all instances is to protect the participant in the process of engaging with my research. Particularly when talking about death, bereavement and client loss – such sensitive topics should be discussed in psychologically warm places. To me, the ability to engage in in-person interviews helps to build rapport and foster trust. The transition to online interviews was difficult; I was

concerned about the authenticity of these virtual interactions, especially when considering sensitive topics. There was the potential for difficulties with establishing rapport, concerns around confidentiality, and, fundamentally, the dynamics of communication would be shifted. It did feel a bit impersonal. Would this affect the quality of my data?

My most profound internal struggle related to the PhD emerged from how I internalised the broader expectation that while the rest of the world slowed their pace, the pandemic was an optimal opportunity to resume writing and continue the doctorate unabated. I felt, at times, that the motivational and psychological health challenges of the lockdown were not considered for some of us who could work from home. During my consultations with community partners, however, I found myself struck by the discussions surrounding the increased pace of work and overwhelming challenges faced by healthcare professionals and marginalised groups while much of the rest of the world had slowed down.

The stories of occupational disempowerment, fear for the safety of their clients, and the abolishment of the low threshold service opened my eyes to the severity of the circumstances that were unfolding as many of us were primarily restricted to our households. Despite the restrictions imposed on socially engaged research, I was in a privileged position where I was fortunate enough to be able to continue my work. In taking on this doctorate, I hoped to make change for people whose experiences were rarely reflected in research and in practice. Thus, alongside the commencement of my research investigating bereavement experiences in healthcare professionals, I was equally motivated to utilise the time and opportunity in front of me to investigate their

experiences during a time where they were bravely putting other's needs before their own. As an active researcher, this experience taught me the importance of adaptability, empathy, and flexibility in research; skills I will carry with me as I grow professionally. In terms of practicality, this period also developed my proficiency in working with digital media, a skill that will, no doubt, be useful in an evolving academic landscape. Above all, this experience reminded that a core principle of meaningful research relates to how we utilise our skills to investigate matters of urgency psychology, social and public health, and other domains.

7.3 Challenges in Addiction-Related Services

As a response to the outbreak of the SARS-CoV2 virus and its classification as a pandemic in March 2020, services and businesses worldwide were forced to cease operations as a preventative safety measure. However, in the context of healthcare, the lockdown measures yielded the opposite effect, compounding many existing difficulties and creating new challenges surrounding the protection of clients. Empirical research that took place during the pandemic has highlighted that, with the additional pressures placed on them, HCPs experienced a significant increase in stress (Jerg-Bretzke et al., 2021), with pandemic-related stressors exacerbating the already demanding nature of healthcare (Awan et al., 2022). Within the evidence base, HCPs reported insomnia, anxiety, depression, and an increased risk of suicidal ideation or death by suicide (Awan et al., 2022; Jerg-Bretzke et al., 2021).

COVID-19-related health issues and addiction operate as two distinct societal wellbeing challenges (Edinoff et al., 2022), but they are strongly interrelated and

simultaneously posed a major public health challenge during the pandemic (Dubey et al., 2020; Edinoff et al., 2022). People in active addiction were identified as one of the most high-risk populations for adverse health outcomes and increased mortality during the lockdown periods (Dubey et al., 2020; Perry et al., 2020; Vallecillo et al., 2021). They suffered disproportionately during the pandemic, as restrictions and barriers to healthcare aggravated already complex social and economic circumstances for people who use drugs (Edinoff et al., 2022; Vallecillo et al., 2021). Lockdown regulations that were designed as public safety measures inadvertently marginalised these groups even further, increasing their isolation and inhibiting their already reduced access to services (Edinoff et al., 2022; O’Callaghan & Lambert, 2022).

The reported outcomes of increased marginalisation included an increase in drug use or the use of substitute substances that may be more dangerous (Chiappini et al., 2020), increased susceptibility to comorbid health issues such as HIV and viral hepatitis (Chiappini et al., 2020; Dubey et al., 2020; Perri et al., 2020), and an elevated risk of homelessness (Chiappini et al., 2020; Dubey et al., 2020). With significant disruptions in the continuity of care for clients, such profound challenges to their resilience placed increased demands on HCPs to support their clients in staying alive (Chiappini et al., 2020; Columb et al., 2020).

With significant implications for practice and support provision, HCPs experienced intense emotional and occupational challenges, such as a reduction in human resources and increased durations of shift work (Chiappini et al., 2020). Some of the largest concerns reported in the literature centred around infecting loved ones, stress from changes in professional duties, the lack of standard treatment protocols to address

evolving health concerns, and psychological and physical exhaustion (Awan et al., 2022; Jerg-Bretzke et al., 2021).

7.4 Study Rationale

When designing the empirical study presented in Chapter 6 within the restrictions imposed on socially engaged research, I also reflected heavily on the values of psychological justice. In line with the idea of ensuring people are supported with enough psychological resources, it is important to meet each challenge as it arises. As an active researcher with the opportunity to conduct novel research, I felt there was an onus on me to utilise the circumstances I was working within to facilitate and create change. Thus, I ensured to include service provision during COVID-19 as a key aspect of the study design. Additionally, anecdotal evidence from service providers suggested that deaths of people in active addiction and homelessness were rising which could potentially bring complex grief reactions for the service providers within the context of the pandemic. This notion is reinforced by Chiappini et al. (2020), who stated that some of the biggest stressors for HCPs in the addiction sector were the high mortality rates and grieving the loss of patients and colleagues.

Chapter 8: The Impact of COVID-19 on Healthcare Professionals Who Are Exposed to Drug-Related Deaths While Supporting Clients Experiencing Addiction

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8.1 Abstract

Introduction: This paper explores the impact of the COVID-19 pandemic on healthcare professionals who support clients experiencing addiction. During the pandemic, addiction support became more challenging, as existing healthcare models had changed or been completely abolished. Clients continued to engage with social, justice, and health services in limited capacities, connecting with general practitioners, key workers, homelessness support workers, and other service providers. This marginalised population was among the most high-risk groups for adverse health

outcomes during the pandemic and understanding the associated implications for practitioner wellbeing is crucial.

Methods: Fifteen healthcare professionals who work with active addiction in homelessness, public health, addiction, emergency medicine, and other areas participated in individual semi-structured interviews. Data analyses utilised reflexive thematic analysis.

Results: Four core themes emerged from the analysis: (i) Shift in Priority, (ii) Being Left Behind, (iii) Managing a Death, and (iv) Anxious Environment. Within each core theme, associated subthemes provide further context. The COVID-19 pandemic had a significant impact on the wellbeing of clinicians who work with people who use drugs, fostering a more anxious environment and compounding what can already be a high-stress occupation. Participants exhibited high levels of concern for the wellbeing of clients, and uncertainty permeated throughout conversations. Furthermore, staff expressed concern for their own wellbeing in the long term due to the inability to process adverse events, such as a service user's death, due to the chaotic nature of the pandemic.

Conclusions: This paper highlights some areas of concern to address for future service delivery and presents opportunities to future-proof services as the world moves toward hybrid models of working. The inflexibility of service provision during the pandemic and the digital divide due to public health measures pushed marginalised groups further into the margins, with significant implications for practitioner occupational wellbeing due to feelings of anxiety, powerlessness, and concern for mortality of clients. This

study collects a broad scope of experiences across disciplines in healthcare and demonstrates how professionals navigated unprecedented circumstances.

8.2 Introduction

The declaration of the SARS-CoV2 virus outbreak as a pandemic in March 2020 created unprecedented challenges for healthcare professionals worldwide. For example, routine healthcare demands were exacerbated by the need for strict screening processes and social distancing requirements (Gavin et al., 2020). Turnover rates worldwide during the pandemic were at comparatively high levels (McConnell, 2020), leaving many healthcare settings substantially understaffed during a time in which services in the mental health sector were at an increased demand (Xiang et al., 2020). Global research efforts have documented how the pandemic affected staff in many front-line disciplines, such as nursing (Labrague & de Los Santos, 2020), fire departments (Prezant et al., 2020), and emergency medicine (Gavin et al., 2020). To date, literature is lacking that specifically addresses how the pandemic affected the wellbeing of healthcare professionals working in the addiction field.

One of the most high-risk groups for adverse health outcomes during the COVID-19 pandemic was individuals experiencing addiction (Dubey et al., 2020). Due to a high prevalence of medical comorbidities and environmental factors, many drug-dependent individuals navigate a range of health, social, and justice services. At each touchpoint, they connect with general practitioners, key workers, homelessness support workers, and other service providers (Perri et al., 2020). Addiction support and recovery became a significant challenge during the pandemic, as existing healthcare models

changed or were completely abolished. The associated implications of these changes for practitioners have yet to be investigated.

The COVID-19 pandemic was not conducive to addiction recovery, and the implications for drug-related mortality were significant. Social support is a well-documented protective factor against relapse (Nikmanesh et al., 2017), and addiction recovery services often rely on group-based therapies (Columb et al., 2020; Liese & Monley, 2021). Evidently, social distancing requirements limited peer support options. Shared living spaces placed individuals at risk for coronavirus transmission and, to mitigate against the spread of the disease, residential services operated at largely reduced capacities (Perri et al., 2020). Marginalised groups experienced further social isolation, increasing the risk of overdoses occurring without observers who could provide medical intervention to counteract adverse drug reactions, e.g., naloxone (Volkow, 2020). Physiologically, comorbid cardiovascular and respiratory challenges are highly prevalent among drug-dependent individuals (Columb et al., 2020), which places them at higher risk for adverse COVID-19-related health outcomes with significant implications for mortality.

Current bereavement literature has identified grief-related and countertransference reactions in clinicians following the death of a client (Lakeman, 2011; McAuley & Forsyth, 2011; Yule & Levin, 2019). These studies highlight service providers as a vulnerable group in the aftermath of a service user death, calling for targeted support to address a high risk of complicated grief. The deaths of elderly patients often have generally normative healing trajectories, but a death by suicide, which is sudden and traumatic, may require targeted bereavement support (Murphy et

al., 2019). Predictors for complicated grief, as such, include the nature of the death and closeness to the deceased. Recent literature has identified intense and complicated grief reactions associated with drug-related deaths, where deaths occur due to substances, but the cause of death may also be violence, accidental overdose, infectious disease, or suicide (Lambert et al., 2021; Titlestad et al., 2019).

Given that global drug-related deaths are increasing in prevalence (European Monitoring Centre for Drugs and Drug Addiction, 2020), and COVID-19 inhibited available supports while indirectly increasing mortality risks, considering the wellbeing of professionals who are exposed to drug-related deaths while supporting clients is important. These deaths can be socially stigmatising, and associated bereavement outcomes include guilt, self-blame, anxiety, and, conversely, relief (Titlestad et al., 2019). Research to date has primarily focused on families, but a study by McAuley and Forsyth (2011) in Scotland examined grief-related reactions in service providers who experience drug-related deaths as part of their caseload. The authors examined emotional responses to a client's drug death using a self-report questionnaire with 76 caretakers across social, health, and voluntary care sectors. The key finding of this research was that grief-related reactions were present in 90% of the sample, with the most common grief-related reactions including self-blame, helplessness, anger, and thoughts about their morbidity. No statistically significant difference occurred in mean grief reaction scores between staff of different disciplines. Yule and Levin (2019) more recently addressed the identification of grief-related reactions in service providers specific to drug deaths in a literature review. The authors drew on literature from other stigmatising deaths such as suicide and suggested that clinicians who experience the

death of a patient by drug-related outcomes are at increased risk for higher stress levels and grief-related reactions.

The responsibility to provide a high standard of care during the pandemic was challenging for service providers, especially while maintaining their occupational health. Clients of professionals providing addiction services face further risks to their mortality compared to other healthcare settings. The complicated nature of drug-related bereavement has significant implications for providers, who are placed at increased risk for prolonged grief outcomes such as self-blame, depression, and anxiety (McAuley & Forsyth, 2011; Titlestad et al., 2019). Furthermore, a decreased sense of job control and increased demands both in and out of work can lead to a rise in occupational stress (Jetha et al., 2017), which may be exacerbated by unprecedented circumstances. As such, the aim of this study is to examine how COVID-19 impacted the wellbeing of healthcare professionals who are exposed to drug-related deaths while supporting clients experiencing addiction. The paper examines this impact within a range of different healthcare professions, with considerations for future practice and evolving opportunities to support staff in the future.

8.3 Methods

The current study is explorative and takes a phenomenological approach to understanding how the COVID-19 pandemic impacted the wellbeing of Irish healthcare professionals who support clients experiencing addiction. The first author conducted 15 individual semi-structured interviews, employing reflexive thematic analysis (Braun & Clark, 2019) as a framework to interpret the transcripts in a hermeneutic manner.

8.3.1 Participants and Sampling

This study includes 15 participants, seven men and eight women, all classified as healthcare professionals working in areas such as homelessness, addiction, public health, and emergency medicine. Initial recruitment occurred through purposive sampling by emailing departmental leads of various organisations. The email contained an information sheet for circulation in the service if appropriate. Further recruitment transpired through a snowball effect.

This research took place as part of a larger qualitative study examining drug-related bereavement in Irish healthcare professionals (O’Callaghan & Lambert, 2023). However, as data collection commenced, staff had been working under pandemic-related conditions for several months. Therefore, capturing their experience during these times was of significant importance. To reflect the objectives of this research, the inclusion criteria were as follows: participants were required to be over 18, in direct contact with clients who are actively using drugs and to have experienced the drug-related death of a service user during their time of employment. As an additional inclusion criterion, all staff were required to be in active healthcare roles throughout the pandemic, a requirement fulfilled by all participants. There were no sex or gender restrictions. The recruitment process excluded recently bereaved staff (within the last three months) with consideration for their psychological state.

Table 8.1 lists the current roles of participants, but participants also spoke retrospectively of previous relevant occupations.

Table 8.1

Profile of Participants

Participant	Role
Participant 1	General Practitioner
Participant 2	Inclusion Health Social Worker
Participant 3	Homelessness Project Manager
Participant 4	General Practitioner
Participant 5	Addiction Project Manager
Participant 6	Clinical Nurse Manager
Participant 7	Researcher in Social Services
Participant 8	Paramedic
Participant 9	Community Detox
Participant 10	Addiction Counsellor
Participant 11	Emergency Medicine Consultant
Participant 12	Community Drug-Alcohol Worker
Participant 13	Housing Support/Addiction After-Care
Participant 14	Addiction Counsellor
Participant 15	General Practitioner

Participants worked throughout the Republic of Ireland, with staff based in the South, Southeast, Mid-West, West, and East of the country. This study has a wide geographical spread, but each participant's specific location remains anonymised.

8.3.2 Data Collection

The first author collected data through 15 in-depth individual semi-structured interviews. Thirteen interviews took place online via Microsoft Teams and two by telephone. An external audio device recorded the interviews, which were then transcribed verbatim. The data collection process took place from October 2020-December 2020. Interviews ranged from 30 minutes to 57 minutes in duration, and the average duration was 44 minutes.

The semi-structured interview schedule guided the interview process; the schedule contained a list of seven open-ended questions asked across all interviews to ensure consistency and to allow the exploration of unanticipated topics. Participants spoke about drug-related bereavement and any implications COVID-19 had on supporting people throughout their addiction and recovery. COVID-19 was a recurring and unprompted topic throughout interviews, but the interviewer also dedicated specific questions to understanding how COVID-19 affected participants. The interviewer encouraged participants to speak at their own pace, but in adherence to general interview protocol for qualitative research, interviewer prompts and relevant questions facilitated further conversation. A briefing process occurred at the beginning of each call, informing participants of the sensitive nature of the study and of their right to pass on questions or end the interview at any time. However, none of the participants chose to do so. Debriefing conversations occurred at the end of each interview, including a reminder of relevant support services available if required.

8.3.3 Data Analysis

Data analyses utilised Braun and Clarke's (2019) updated reflexive thematic analysis framework for conducting thorough exploration and interpretation of data transcripts, with findings reported in adherence to the standards for reporting qualitative research outlined by O'Brien et al. (2014). Both authors are experienced researchers who work with marginalised populations and consider reflexive thematic analysis to be the most appropriate analytical framework for bringing their research values, skills, and training to the data as they generate patterns of latent meaning (Braun & Clarke, 2021). The stages in Braun and Clarke's process are sequential but allow for fluid movement between phases. The stages are as follows: (i) familiarisation with the data, (ii) coding the transcripts, (iii) generating initial themes, (iv) reviewing emergent themes, (v) defining the themes, and (vi) writing up the findings.

Each author familiarised themselves with the data, and the first author carried out inductive coding using NVivo qualitative analysis software (QSR International Pty Ltd., 2020), adopting a ground-up approach and creating codes through direct examination of the data. Upon generation of the initial codes, the authors engaged in continuous dialogue about theme generation. Back-and-forth movement between phases was common when new codes and concepts emerged from conversations related to the data. Given the inherently subjective nature of the coding process, the first author engaged in reflective journaling at the start of the coding process, adhering to the updated reflexive thematic analysis framework by Braun and Clarke (2019). This journaling facilitated written reflections about how the first author's experience in the area and how preexisting assumptions may have influenced any potential biases

emerging during the coding process. The journaling process, supported by ongoing conversations between both authors, ensured that the researchers approached the data in the most inductive manner possible.

8.3.4 Reflexivity

When utilising reflexive thematic analysis, researchers must address how their experience and preexisting assumptions may influence interpretations of the findings. The first author has prior experience working with socially excluded populations in addiction services through research-based practice. The second author has both practitioner and research experience in addiction services. The first author was the sole interviewer, but the authors met to debrief and discuss the data after each interview. In our efforts to ensure an inductive approach to analysis, sometimes evidence of deductive thematic analysis emerged in the data, bringing assumptions into our interpretation. However, our use of reflective practice ensured our efforts to address this were comprehensive and congruent with our responsibilities as qualitative researchers (Dodgson, 2019).

8.3.5 Ethical Considerations

The departmental ethics committee at the authors' university granted ethical approval for this research. Furthermore, the research protocol followed the Code of Ethics outlined by the Psychological Society of Ireland. Recruitment emails contained a briefing sheet and consent form outlining the voluntary nature of the study, ensuring that information remained confidential with identities anonymised. Prior to interviews, the participants returned electronically signed consent forms to the first author. For data

management and protection purposes, the authors stored the interview recordings on an encrypted laptop with a password-protected Microsoft OneDrive provided by the University. Data will be stored for a minimum of 10 years in the university data repository. Upon completion of a transcript, both authors discussed any further identifying information requiring removal from the data.

8.4 Results

Four core themes emerged from the analysis: (i) Shift in Priority, (ii) Being Left Behind, (iii) Managing a Death, (iv) Anxious Environment. Core themes are supported by sub-themes to provide further information and context.

8.4.1 Shift in Priority

The participants in this study acknowledged that despite their wealth of professional experience, they were not fully prepared for the unprecedented challenges that the pandemic created. Staff members experienced widespread anxiety and increased occupational stress in the workplace, and evidence existed of confusion among staff as sudden changes emerged in their roles. Safeguarding against the spread of COVID-19 took priority in environments that typically prioritise the service user. Themes of internal conflict surfaced as participants addressed how their new priorities challenged their values as healthcare workers: “In addition you’ve got to be flexible. Especially with COVID, it can’t just be about the client now. I have to consider all the people in the building, my colleagues, my staff. Myself, even my own family.” The shift in prioritisation that Participant 10 described represents cognitive dissonance as contradictions arise between duty to clients and duty to oneself and others. Many project

workers who have dedicated their professional lives to improving education, training, and support outcomes for marginalised populations witnessed their work come to a halt due to new priorities, such as Participant 3: “For me [COVID] has changed literally everything. The project I’ve spent years building has been suspended and I’m redeployed.” The repercussions of this change are two-fold; these changes have mental health implications associated with increased job stress and a reduction of training and support opportunities for marginalised groups.

Participants acknowledged the timely importance of investing resources into pandemic-related research and protocols but feared that this prioritisation retracted from some basic harm reduction techniques utilised in addiction. Participant 4 outlined the shift in priority within the healthcare system:

Basic harm reduction, naloxone, needle exchange. Even just hepatitis C treatment, it has stopped you know, and it was just about to get going. In the last six months, I don’t know if I’ve had one patient who was treated. It just gives you an example that the focus and the funding is on COVID, and yes it has distracted from some of the basics.

Staff expressed concerns that the fundamentals keeping many people alive did not have the same reach during the pandemic, even though addiction remained a prevalent issue. Drug-dependent individuals were at a significantly higher risk of overdose without any observers present to provide pharmacological support such as naloxone.

8.4.1.1 High Threshold

The reprioritisation of organisational components within addiction support and recovery also affected service delivery, reducing ease of access for service users. The pandemic necessitated the introduction of new administrative protocols and abolished the low threshold environment, which participants feared might result in fewer clients following through with service engagement. Contact tracing individuals with chaotic lives is difficult, and Participant 1 explained that the pandemic circumstances were not conducive to ideal operations. In fact, COVID-19 protocols contradicted the very foundation on which addiction support is built:

The ideal is to have specialist low threshold services, no appointments, the least amount of administrative barriers. And all of that is the total opposite of what we're told to do as a service provider to keep the service safe now [during the COVID-19 pandemic].

Numerous once-accessible services ceased operations with implications for social work, homelessness, and other residential services. Participant 3 demonstrated the impact of this new “high threshold”: “I can’t bring someone from the streets or another project in because then it creates more potential exposure to COVID.” Concern for people who rough sleep permeated throughout the theme of reprioritisation, where integrating new people into services and existing projects was almost an impossibility. The closure of drop-in services also had a significant impact on recovery progression, and for the participants in this study, the loss of control over critical responsibilities was extremely stressful. Participant 2 highlighted some of the emotions associated with this loss of control:

I'm qualified around 10 years now and it's more so just a feeling of sadness and frustration where I could either scream at someone or cry my eyes out...Whereas before COVID, you could discharge someone from a hospital, get them two weeks in a B&B with a guaranteed detox bed at the other end. That's not the case now. I can barely get a key worker to ring them once a week to see if they're alright.

8.4.2 Being Left Behind

Amidst the changes influenced by the pandemic, addiction continued to exist as a public health concern. Participants emphasised the importance of recognising that people experiencing addiction were significantly more vulnerable than they were before the pandemic. As described by Participant 1: "Addiction doesn't go away, and the lockdown has pushed more people to risky behaviours...I feel [the pandemic] is going to leave more people behind than were being left behind before." Healthcare professionals take pride in their responsibilities, as summarised by Participant 15, a health professional working with active addiction, "what you're trying to do is hopefully keep people alive long enough for them to get enough chances to get better." A prevailing sense of uncertainty existed among staff about the effectiveness of support efforts in achieving this goal during the pandemic, and some participants, such as Participant 6, reflected on the loss of control:

That is my biggest fear right now. Mental health difficulties go unrecognised in the monotony of this. Outside of COVID, it's really hard to be in hostels for years. My biggest concern, those guys that are chronically homeless and taking tablets are such high risk and I don't feel empowered. I don't feel I can do

anything for them right now, even as somebody with a lot of experience. I feel a little bit helpless in this situation.

Participants expressed deep concerns about how service engagement became more challenging for an already marginalised population. In the extract above, the participant exhibited a sense of helplessness in being unable to draw on their experience to reach those who had become further marginalised. With drug-related deaths continuing to be a major public health concern, participants feared that more clients would experience adverse health outcomes while being left behind due to the reduced reach of support services.

8.4.2.1 Lost in Transition

Participants identified the transitional stage between phases of recovery as a critical period, and as clients experienced significant delays in their recovery, service providers had an increased responsibility to watch over, maintain contact with, and keep clients on course. There was a prevailing sense of insecurity due to prolonged wait times increasing the risk of service users experiencing “slips” in their recovery, dropping out of contact, and getting lost in the transition. Participant 3 illustrated her concerns when reflecting on the noticeable changes in service users’ recovery since the onset of the pandemic:

The amount of people who have had serious slips in their recovery whether it be mental health, starting to self-harm, engaging in crime, the lack of routine and structure, increases in domestic violence, tenancies being lost. If you’re in recovery and you were struggling beforehand, you know it’s too much to handle for people on their own.

The lack of outreach and residential treatment options heavily impacted stabilisation programs, and extended waiting lists needed to be considered within care plans. Participant 2 stated that COVID-19 made procedures more strenuous with the closure of so many services, concurrently affecting morale as staff scrambled to ensure their clients maintained their course. She solemnly described the demoralising effect that COVID-19 had on her as a professional:

It's great when you see people want to change their behaviour, but now I have nowhere to get for them. You are trying so hard to stay in contact with people who have chaotic lifestyles over the phone to maybe keep them going with a little bit of motivation along the way just to keep them alive. Until something might come up, but you don't know when that's going to come up. I can't do that for six months...It's really disheartening as a worker to know that a service might not be available for someone, when you know they're ready now.

8.4.2.2 Digital Divide

The shift to virtual communication was a prevalent topic of discussion, and participants reported varying experiences with its implementation. Participant 1 demonstrated that marginalised populations were at risk of being further divided with the move to virtual communication for professional support: “The front doors of services were shut, and not all my patients and clients have smartphones and can't do video counselling. There is a digital divide”. Other participants, such as Participant 6, echoed these concerns: “I don't think for this population that virtual consultations work very well. Personally, I find it difficult, but that might just be because the infrastructure wasn't set up.” The mention of “infrastructure” acknowledges the potential for

successful integration of virtual support. However, such support required heavy facilitation that was not always available due to prioritisation changes and staff redeployments.

The difficulties with virtual consultations were rooted in their limited reach. Participants spoke of clients with intellectual disabilities, language barriers, or a lack of technological understanding who struggled to engage. However, participants openly acknowledged that even well facilitated virtual consultation systems had some insurmountable barriers. The pandemic exacerbated the challenge of keeping in touch with clients with chaotic lives, as stated by Participant 10: “I have so many clients where having the internet, having smartphones or even having the same phone number is a challenge.” These difficulties resulted in valuable time lost with clients and, in other cases, service users were not comfortable discussing their lives online or over the phone. Participants prided themselves in creating a safe space for clients within their practice, and feelings of frustration and helplessness permeated throughout interviews as COVID-19 abolished the sense of safety and security staff had fostered over their years of experience:

A lot of people we work with are very self-conscious about asking for help. Some don't like speaking over the phone, because they might have a mental health fixation on the fact that someone is going to hear something about their business. On the phone, how are you supposed to make someone feel safe?

However, it should also be acknowledged that participants reported positive experiences with virtual communication, especially when communicating with other professionals and when considering implications for future practice. Participant 14

outlined his experience of working with fellow support workers. This counsellor acknowledged similar difficulties but demonstrated how, with the correct infrastructure, professionals could learn from the pandemic circumstances to develop efficient virtual practice alongside in-person support

We were brought together in this virtual team and we had a task to ensure that any social inclusion clients presenting with symptoms or were close contacts, we were able to configure self-isolation accommodation for them...I've actually learned to make the most of the functionality. I've been able to do workshops and use breakout rooms and other facilities to make the work very engaging. That's one positive thing we can bring into the future.

8.4.2.3 New Relationship Dynamics

All participants spoke compassionately about the relationships they had developed with their clients. In detailing these impressions and connections, staff recalled pleasant and positive memories while becoming invested in their recovery. Service users being left behind during the pandemic was a significant source of anxiety for workers, not only from a professional standpoint but also from an emotional one. Staff emphasised the deep personal fulfilment in maintaining these relationships, but the pandemic strained some of these connections. Some clients began to take the safety protocols personally and felt threatened by them. Participant 10 provided an example as to how she mediated this:

I was very cautious about a mask not meaning 'you're dirty and I'm wearing a mask in case you have the disease'. I was clear that I was wearing a mask

because I was instructed. I don't have a choice – it's my responsibility to keep them safe.

Relationship-building plays a crucial role in keeping clients engaged with services. In recognising the value of positive relationships with clients, staff acknowledged that new protocols, alongside the digital divide, added a further layer of complexity to the navigation and maintenance of these relationships. Participants were concerned that the sudden shift away from in-person contact and reduced proximity would offset these often-delicate relationships. They also considered how this change might influence a client's service engagement and wellbeing. Many participants, such as Participant 4, expressed concerns that some of their clients felt left behind or abandoned due to their new responsibilities, especially in residential settings:

It has a huge impact on staff wellbeing. When we are in complete lockdown, you can't meet people. We have such an amazing relationship with the participants over the years and they've built such trusting professional relationships that you become a huge support person for them. But all our service users may not understand the fact that I've been redeployed and I'm unavailable. In lockdown, you can't even meet up for a coffee.

8.4.3 Managing a Death

The strong emotional investment staff have in their clients' recovery means that, in the event of a death, the death must often be marked emotionally alongside the procedural requirements associated with being a HCP. Managing a death in this manner was difficult due to the lack of "downtime" during the pandemic. The overwhelming

consensus among participants was that when a death is associated with addiction, enmeshed feelings of self-questioning, blame, and guilt occur. Participant 15 detailed the range of emotions she experiences when a service user dies by overdose or other drug-related complications: “There’s an unbelievable guilt. I always feel it’s my fault if one of my patients dies, as you always feel it’s such a shame and so unnecessary and unfair and potentially preventable.” Describing the deaths as preventable implies a degree of responsibility or control over the circumstances.

The pandemic hindered efforts to keep people alive and when participants solemnly reflected on deaths that had occurred since March 2020, the increased loss of control and anxiety generated from working during this time exacerbated bereavement outcomes. Alongside increased guilt, self-questioning was also prevalent in this theme, as participants questioned if the deceased would still be alive under pre-pandemic circumstances. When speaking about a drug-related death that occurred during the pandemic, one participant stated: “I’ve always found that bringing services to people where they are is much better and without the ability to do that you need a lot more coordination on site and I just find that I wasn’t really there.”

The personal investment staff have in the wellbeing of their clients further illustrates the devastating impact COVID-19 had on addiction support. In the event of a service user’s death during the pandemic, the strain and changes in proximity in some of these relationships made the grief process more complicated. Pre-pandemic, processing grief was difficult due to these well-built and trusting relationships. During the pandemic, it became even more difficult due to how fast service provision was required to move forward. Furthermore, funerals were difficult to attend due to public health

restrictions. Participant 9 highlighted the importance of funerals for service users and staff:

Their peers have literally been their own family unit for years. And they're left with nowhere to process that emotion, or that grief. They can't attend the funeral. Now, in the pandemic it's easy for families to say [it's closed] due to COVID restrictions. The lads then struggle to emotionally regulate around this person's death. If I don't go to funerals, I always expect them to come back. It's me closing that relationship with them. And it's also an acknowledgement of the fact that they were part of the community we belong to.

HCPs played a crucial role in supporting marginalised groups but simultaneously placed themselves and their close contacts at risk for disease transmission when on site. Balancing the duty to protect themselves while maintaining a stable and healthy environment in the workplace and at home became a significant challenge. With little time to process adverse experiences, particularly after the death of a service user, Participant 4 pondered the long-term implications for his and his colleagues' mental health:

I'm conscious that COVID has brought this in, we are now fitting in more stuff into our days. So, they're a little bit more frantic, and that background noise number one. And [contracting COVID-19], number two. It impacts on how all of it affects us from... First of all, the background noise in one way doesn't allow us to stop and think about [service user deaths] as much as we might have and I suppose the background stress, the impact of this actually makes the stress worse.

8.4.3.1 Loosening of the Guidelines

The sudden onset of the pandemic necessitated immediate regulatory changes within services. The creation of quick solutions to unique challenges resulted in abolishing existing operating procedures and altering others to cater to the emerging needs of service users. The supply of methadone was a recurring topic during interviews, especially among general practitioners. Participant 4 provided context to this:

There was a set of guidelines that you had to go by pre-COVID, but they actually were loosened because of COVID. We needed to see more people, so instead of seeing someone that we might have seen every two weeks you might now see them every three weeks. You might give them a little bit more takeaways so that they don't have to go to the chemist every day to get their methadone. Those sort of loosening of the guidelines means that everyone is a little bit more exposed.

This data emerged within a conversation about service provider protection following the drug-related death of a service user. Participant 4 mentioned colleagues that experienced legal issues while managing a drug death in a service, and the loosening of the guidelines created further anxiety surrounding decision-making processes and legal outcomes for professionals. COVID-19 guidelines also had implications for the homelessness sector. This reduction in beds and living spaces led to frustration among service providers who, again, questioned how events might have played out in other circumstances:

Our rooms in the shelter were shared rooms, and that would be strategic, because when people were intravenous drug using, we tried to create a culture of a buddy

system. So, if we had two intravenous drug users, they'd share a room so that if one got into difficulty the other could raise the alarm. With COVID that system has been abolished. We've had 15-bed shelters reduced to 8, shelters with 70 beds reduced to around 44.

8.4.4 Anxious Environment

The overarching theme of anxiety was prevalent throughout interviews and, as it permeated throughout conversations, evidence suggests that COVID-19 fostered a more anxious environment within the context of service provision. Many service users live with comorbid health difficulties that placed them at high risk for adverse health outcomes during the pandemic, and the fear of outbreak within residential services was a perpetual concern for both staff and service users. Participants spoke about how fortunate they were not having experienced this in their own workplace but acknowledged other services where a single COVID-19 case had crippling effects on service provision. Participant 3 detailed the anxiety and constant monitoring that occurred within a shelter for people experiencing homelessness:

The anxiety of some of the residents and staff with regards to COVID like...We are doing temp checks twice a day, assessments every time someone comes and goes. Even with that, the masks obviously in place, social distancing in place, reducing numbers in and out of kitchens. You can still see how much people are nervous and anxious about it.

The anxiety surrounding the knock-on implications of their profession extended across all disciplines represented in this study. During interviews, participants

questioned the quality of their own mental health, given the increased level of consideration they needed to maintain for others. For Participant 8, a paramedic, house calls could have had significant implications if not carried out with due care: *“There’s a bit of a suspicion or fear there within paramedics as well for [our safety], like ‘Does this person have COVID?’”* The increased health risks, demands, and anxiety surrounding the consequences of their work for their loved ones contributed to a concurrent rise in occupational stress. Participant 3, who worked in homelessness shelters throughout the pandemic, spoke about the difficulty in separating oneself from the anxiety: *“It is so impactful at all levels...Never, ever, ever have I found it so difficult to separate work from home.”* Navigating the working day while considering the welfare of their colleagues and family added an extra layer of complexity to the work-life balance, which was typically crucial to maintaining positive mental health routines.

8.5 Discussion

The current study examined how COVID-19 impacted the wellbeing of healthcare professionals who are exposed to drug-related deaths while supporting clients experiencing addiction. The findings identified many obstacles unique to the pandemic and highlighted how lockdown restrictions compounded existing challenges in service provision. Staff experienced increased anxiety and occupational stress due to the chaotic nature of operating during these circumstances. With little opportunity to address this, concerns about the long-term impact of the pandemic were prevalent, particularly in relation to service users being left behind by new protocols and the subsequent impact on mortality rates in addiction. Participants reflected on potential long-term effects on

their wellbeing as they worked at a frantic pace with little time to process adverse events.

Sudden role changes and the reprioritisation of responsibilities prompted internal conflict within staff who have adhered to personal and professional values throughout their careers. Staff with over 20 years of experience in addiction support expressed feelings of increased occupational stress due to unfamiliar barriers and the inflexibility of the “high threshold.” Jetha et al. (2017) developed a system dynamics model of workplace stress among nurses and acknowledged that workplace stress is constantly evolving. The key findings of the study stated that job control, social support, workplace safety, and demands outside of work are strong predictors of poor mental health outcomes in healthcare professionals (Jetha et al., 2017). Similarly, as the pandemic evolved, key occupational stressors included increased out-of-work demands when trying to keep their loved ones safe, a loss of control over their core responsibilities to keep clients alive, and decreased workplace safety due to the fear of disease transmission. A continuous cycle of exacerbated stressors resulted in intensified feelings of frustration, fear, and helplessness. In moving to a new model of service provision following the re-opening of services, much can be learned from service provider experience during this pandemic in terms of how they adapted both professionally and emotionally. Furthermore, we can identify their needs in the face of intensified stress. Organisations can examine these experiences retrospectively to inform policies to optimise their staff’s occupational health in times of unprecedented distress while also optimising support provision to marginalised groups.

The direct health implications of COVID-19 for people experiencing addiction are widely understood within the literature (Dubey et al., 2020), but participants urged healthcare systems to recognise the indirect effects of the pandemic on marginalised populations. Staff highlighted that some clients were being left behind and experiencing ‘slips’ in their recovery due to delays, issues with virtual support, and increased social isolation. As a result, service providers experienced further anxiety while trying to support their clients in line with public health restrictions. Research suggests that self-efficacy beliefs and social support play important roles in preventing relapse, as examined by Nikmanesh et al. (2017) through a quantitative self-efficacy scale and a multidimensional scale of perceived social support. The current study reflects these findings, but the pandemic made it difficult for staff to reinforce these values through limited face-to-face contact when relying solely on virtual support methods.

However, as the world moved forward into more hybrid service provision with increased vaccination levels and services re-opening worldwide, there were opportunities to develop safer, more multifaceted service provision systems that incorporate the strengths of both virtual and in-person support to incorporate a wider reach. The pandemic resulted in a pivot to hybrid working models with an increase in telehealth utilised in a range of health services. The research on new working practices began to emerge at the time of this research, so it is difficult to draw conclusions about how different cohorts adjusted. Similar to the participants in the current study, some have argued that telehealth provision has facilitated easier access to services (Molfenter et al., 2021), and others are concerned that particular cohorts have struggled with access to technology and isolation (Moore et al., 2021). There is limited data from the service

users' perspective. It is anticipated that more research on this topic will emerge and that more informed conclusions could be drawn, and the use of telehealth may have had positives for some groups and negatives for others. Many frontline services have expressed concerns that the level of drug-related deaths increased during the pandemic. If this is the case, we need to understand if the lack of face-to-face service provision played a role. Until this is fully established, it is difficult to draw conclusions and make recommendations at this point.

Managing a client's drug death became significantly more challenging for staff during the pandemic, particularly with increased uncertainty surrounding the quality of their healthcare provision in unprecedented circumstances. Practitioners typically followed a set of principles when caring for their clients, but the pandemic circumstances altered many of these guidelines. This change left healthcare workers feeling less protected in their decision-making processes (e.g., methadone prescribing) as regulations around their responsibilities were loosely defined. This insecurity subsequently fostered further anxiety in staff surrounding their efforts to keep clients alive, concurrently intensifying their sense of self-blame following a drug-related death. These sentiments provided by Irish healthcare practitioners echo changes in international regulations, such as in the USA, where the Substance Abuse and Mental Health Services Administration has directed treatment providers to prescribe take-home medication more flexibly during the pandemic (SAMHSA, 2020, as cited by Volkow, 2020). To protect workers' wellbeing, it is important that they feel supported in their decision-making in times of high stress.

Similar to the current study, McAuley & Forsyth (2011) examined grief-related reactions in healthcare workers who work with people who use drugs. Many bereavement outcomes emerging from the 2011 study's surveys were prevalent in the current study's interviews. The extenuating circumstances emerging from the pandemic intensified bereavement outcomes such as self-blame. The findings of this study coincide with existing bereavement literature in recognising the drug death of a service user as a harrowing experience for health professionals (Lakeman, 2011; McAuley & Forsyth, 2011; Yule & Levin, 2019), but findings also highlighted that the pandemic compounded the grief process.

Given the long-term impact of complicated grief (Titlestad et al., 2019; Lambert et al., 2021), more rigorous employee welfare policies must be implemented to protect their wellbeing. More specifically, policies should aim to decrease anxiety around decision-making and provide targeted bereavement recovery programs that address complicated grief. From an organisational perspective, the procedural acknowledgement of a client's death involves the completion of the appropriate documents and contacting relevant people. However, this study highlighted clear emotional connections between the service provider and client, and organisations must not fail to address the emotional component of marking a death. Funerals play a significant role in closing the relationship from an emotional perspective, and the pandemic resulted in reduced access to these ceremonies. The authors recommend creating a space to mark these deaths for staff (and service users) within an organisation's framework.

8.5.1 Conclusion and Implications

Leading epidemiologists and climate scientists argue that pandemics are likely to become more common, and this COVID crisis provided an opportunity for learning and reflection to future-proof services. This study collects a broad scope of experiences across disciplines in healthcare and demonstrates how professionals navigated unprecedented circumstances. The in-depth methodology (Braun & Clarke, 2019) allowed for an intricate understanding of the internal conflict within participants and the difficulties they encountered in caring for their clients. For all participants, there was a concern for the mortality of those left behind by the system. While the numbers of those who have died due to drug-related deaths during the pandemic were unknown at the time of writing, the anecdotal evidence from front-line providers in Ireland is that there was a significant increase (O'Carroll, 2020).

Excessive occupational stress in healthcare workers has well-documented implications for wellbeing and is associated with elevated levels of employee burnout (Meng et al., 2015). This paper highlights some areas that are cause for concern and should be addressed for future service delivery. The inflexibility of service provision and the digital divide due to public health measures pushed marginalised groups further into the margins. Services should pivot to the provision of intensive individual care working within public health guidelines and aim for daily communication with people who live chaotic lives. The impacts of drug-related deaths on staff and service users are profound and require appropriate policies and support, with heavy investments into making services available with as few obstacles as possible.

This study provided an overview of different professions that shared many common difficulties. However, the first author conducted each interview with a single participant. This area would benefit from increased insight from the various healthcare roles represented in this study. Future studies could benefit from focus groups to gain further professional insight into how the pandemic influenced operations. Furthermore, highlighting any potential differences between disciplines would support the development of a measure to explore possible health outcome differences between occupations, with the aim of providing targeted support to addiction counsellors, general practitioners, and other healthcare workers as required. Finally, while the participants in this study provided a comprehensive overview of client experience, subsequent studies should aim to examine the impact of the pandemic on service users themselves.

Overall, the COVID-19 pandemic had a significant impact on the wellbeing of clinicians who work with people who use drugs, fostering a more anxious environment and compounding what can already be a high-stress occupation. However, service providers admirably continued to support marginalised populations in the face of unprecedented circumstances, and pandemic-related research provides an opportunity to future-proof services.

Chapter 9: The Internalisation of Stigma and the Shaping of the Grief Experience for Peers Bereaved by a Drug-Related Death

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9.1 Abstract

People who use drugs form a significant part of the community who are impacted by drug-related deaths, but their stigmatised positioning in society yields implications for their access to support and the social recognition of their grief. This project explores how the internalisation of drug-related stigmas shapes the grief experience for peers bereaved by a DRD. Six individuals who experienced the drug death of a peer during their own time in active addiction participated in semi-structured interviews, analysed by interpretative phenomenological analysis. Three superordinate themes are reported in this paper: (i) Forged Connections; (ii) The Condemnation Script; and (iii) Nowhere Left to Turn. Participants reported grief responses such as survivor's guilt, shame, and increased drug

use against the wider social invalidation of their close peer bonds. This paper appeals for a more health-based approach to supporting people in active addiction that recognises and validates their grief experiences.

9.2 Introduction

Drug-related deaths (DRDs) are a global public health concern, and bereavement for those socially connected to people who use drugs frequently results in a complicated grief with significant social and health implications (Bottomley et al., 2022; Titlestad et al., 2021). DRDs are deaths that occur directly due to the intake of narcotics but may also be a result of drug-related violence, suicide, or infectious disease (HRB, 2019; Titlestad et al., 2019). These characteristics, and the societal stigmas associated with drug use, often lead DRD bereaved individuals to contend with shame, isolation, and a lack of social support while grieving (Lambert et al., 2021; O’Callaghan et al., 2022). In approximation, 10-15 people experience bereavement from a single drug death (Dyregrov & Selseng, 2022), with research identifying complex and disenfranchised grief reactions in several family, community, and service provision contexts (Lambert et al., 2021; Meen et al., 2024; O’Callaghan & Lambert, 2023; Titlestad et al., 2021). Total deaths are increasing worldwide, such as in Europe (EMCDDA, 2023) and North America (CDC, 2022 as cited by Reime et al., 2022), identifying a critical and prompt requirement for targeted bereavement intervention protocols.

Research efforts in Ireland (Lambert et al., 2021), Norway (Titlestad et al., 2022), Britain (Templeton et al., 2017) and the United States (Feigelman et al., 2020; Sterling et al., 2022) continue to highlight the profound and complex impact of DRDs

for bereaved family members. Collectively, the literature underscores diverse pre-, peri-, and post-loss experiences, with psychological affect stemming from anticipatory grief (Feigelman et al., 2023), the negative characterisation of their loved one (Dyregrov & Selseng, 2022), and feelings of self-blame, shame, and disenfranchisement (Lambert et al., 2021; Valentine et al., 2016). The socially constructed narratives and moral stigmas associated with drug use compound grief processes to the extent that families often grieve in isolation, with prolonged exposure to complicated grief as a significant risk-factor for long-term health disorders (Doka, 2020). Family members are at increased risk for the development of depressive symptoms, prolonged grief disorder, post-traumatic stress disorder, generalised anxiety disorder (Bottomley et al., 2022), and a higher risk of natural cause mortality (Christiansen et al., 2020).

In accordance with Dyregrov & Selseng's (2022) position that DRDs have a broad psychosocial impact radius, people in active addiction navigate a multi-disciplinary network of social, health, and justice systems. Consequently, healthcare professionals (HCPs) are also at risk for complicated grief outcomes (Sperandio et al., 2023; Yule et al., 2023). In contending with internalised expectations of professional durability, HCPs reported grief-related reactions inclusive of severe stress (Yule et al., 2023), guilt, self-blame (Sperandio et al., 2023), fears of litigation, anxiety, and traumatic flashbacks (O'Callaghan & Lambert, 2023). Negative social norms, sometimes integrated within organisational structures, heavily influenced the support available to HCPs, who reported difficulties with openly discussing the impact of DRDs (O'Callaghan & Lambert, 2023; Yule et al., 2023). Barriers to help-seeking can be

further compounded by a complex amalgamation of internalised self-stigma and their societal positioning as experts in their profession (O’Callaghan & Lambert, 2023).

Evidently, the inhibiting properties of DRD stigma extend to the wider social context of drug use, and HCPs appealed for broader societal acknowledgement that people in active addiction form a vital constituent of the community directly impacted by DRDs (O’Callaghan & Lambert, 2023). People may witness multiple overdoses when in active addiction (Nolte et al., 2023) and, thus, are frequently positioned as first responders to overdoses among peers (Schneider et al., 2021). Overdose trauma has been associated with PTSD symptoms and, anecdotally, participants within the literature base reported that overdose deaths are increasing (Nolte et al., 2023; Schneider et al., 2021). Nolte et al. (2023) surveyed people who use drugs in New England (n =578), where 83.6% of the sample had witnessed an overdose, and 85.8% knew someone who had died by overdose within the previous 6 months. In Toronto, Kenny et al. (2022) surveyed 249 people who inject drugs, and in the 6 months prior to participation, 79.5% witnessed 2 or more overdoses, and 41.4% witnessed 2 or more deaths.

Few studies have investigated the grief experiences of people who use drugs, yet the existing evidence highlights the prevalence of complicated grief reactions. Wojtkowiak et al. (2019) interviewed 10 bereaved men who use drugs, using grounded theory to explore their meaning systems within the social context of drug use. The participants’ stigmatised societal position inhibited their grieving opportunities, with many describing shared social spaces of meaning making, such as funerals, as “uncomfortable.” These experiences align with findings by O’Callaghan & Lambert (2023), who reported that some clients were forbidden from attending funerals. Denied

of their right to engage in normative socioemotional grieving practices, social exclusion fostered a disenfranchised grief for participants, sometimes leading to increased drug use as a coping strategy (Wojtkowiak et al., 2019). This study presents a crucial insight into the lived experience of a critically under-researched population, but the exclusive focus on male participants may overlook potential gender-related variations.

Selseng and colleagues interviewed 13 drug death bereaved individuals to explore bereavement in the context of their own drug use (Selseng et al., 2023), and their experiences of support (Selseng et al., 2024). Both studies highlight the prevalence of complicated grief and a profound lack of social and professional support. Prompt and actionable supports are crucial (Selseng et al., 2024), as many participants reported using drugs to emotionally suppress their grief and avoid actualising the loss (Selseng et al., 2023). However, while seven of participants in these studies were using drugs at the time of death (Selseng et al., 2024), others were not actively using drugs or were in treatment. Some participants reported returning to drug use post-bereavement, highlighting implications for recovery while underscoring a requirement for a nuanced understanding of the varying stages of drug use at the time of death. The importance of understanding grief at different stages is reinforced by Bethune Scroggs et al. (2022), who suggest that the bereaved may not begin to process losses until entering recovery; the death potentially including secondary losses such as companionship or safety.

Macmadu et al. (2022) utilised thematic analysis to characterise drug use behaviours in people following the overdose of a peer, identifying grief-related symptoms associated with fatal overdoses and increased overdose risks particularly evident when losing someone emotionally close to them (Macmadu et al., 2022). While

this study included participants referring to both fatal and non-fatal overdoses, the work reinforces the scarce evidence base by highlighting grief-related symptoms in people who experience the fatal overdose of a social network member. The authors recommend future research to develop a more robust understanding, and identification, of mediators of these outcomes, including the effect of peer overdoses on individual overdose risk (Macmadu et al., 2022).

The lack of support for the bereaved reported by Selseng et al. (2024) may be further augmented by their limited social capital (Neale & Brown, 2016), with grief symptoms exacerbated by structural and socioeconomic inequalities such as poverty and criminalisation (Petterson et al., 2019). Legislative policies may yield inadvertent consequences as they reinforce dominant social norms that devalue the bereaved person's position in society, leading to poor health outcomes attributable to diminished help-seeking behaviours (Muncan et al., 2020). Thus, people who use drugs experience a double stigma, their experience of a stigmatised loss integrating with their socially stigmatised position as people who engage in behaviours perceived as unlawful (Selseng et al., 2023).

The current study aims to provide a phenomenologically rich exploration of how the internalisation of drug-related stigma shapes the grief experience for peers bereaved by a DRD while in active addiction. Although scarce, existing literature highlights unique challenges faced by this population in being recognised as bereaved (Selseng et al., 2023; Wojtkowiak et al., 2019), and the current paper seeks to contribute to the establishment of a more robust evidence base for a significantly under-researched population. Building on previous research that focused solely on men (Wojtkowiak et

al., 2019) or included people not actively using drugs (Selseng et al., 2023, 2024), this study specifically addresses people in active addiction, a subgroup highlighted for their grief-related reactions by Selseng et al. (2023, 2024). Addressing how stigma affects grieving processes in the context of ongoing addiction, this study aims to provide a holistic understanding of personally nuanced and complex lived experiences, offering a deeper insight into the intersectionality of grief, addiction, and stigma. Overall, it seeks to inform the development of culturally competent practice frameworks that are responsive to the influence of individual circumstances and experiences of trauma.

9.3. Methods

The current study adopts a phenomenological approach to exploring the experiential impact of drug-related bereavement for 6 individuals who were bereaved while in active addiction, utilising interpretative phenomenological analysis (IPA) to present idiographic narratives and convergent themes across cases.

9.3.1 Methodological Approach

The suitability of IPA as the chosen methodology is reflected in its hermeneutic capacity to explore individualised lived experiences, eliciting convergent perspectives which construct patterns of meaning across the sample (Bush et al., 2019). Emotional experiences of drug related bereavement carried a deep significance in the participants' lives, with peer loss representing a major transition within the stigmatised sociocultural context of their addiction. IPA provided a phenomenological lens through which the psychosocial variability within the group could be interpreted, exploring how grief takes

on a significance within the wider experience of active addiction (Smith et al., 2009; Larkin et al., 2021).

9.3.2 Participants and Sampling

This study includes 6 participants (4 men and 2 women) who are now in recovery but were previously in active addiction and engaged with drug-related healthcare services. Utilising purposive sampling, the authors sent emails containing information sheets to relevant organisations and other contacts within established professional networks. The email introduced the nature of the study and outlined the inclusion criteria, and the organisational leads circulated the information. Thus, participants could self-select to contact the first author by email or phone at their convenience.

After an initial distribution of the recruitment criteria that specified participants should be in recovery for at least 2 years, several people in recovery approached the first author expressing their desire to participate and share their stories. However, they did not fall within the specified timeframe for recovery. Thus, to minimise exclusionary criteria while ensuring emotional safety, experts in the field of addiction were subsequently consulted to determine a definition for recovery. These consultants reported that recovery is self-defined, wherein participants would have the right to self-determine. Thus, the inclusion criteria were finalised as follows: participants must have been over the age of 18, to have experienced the loss of a peer through a DRD during their own active addiction, to have completed a treatment program, and now be in recovery. Participants were also required to be actively linked with a support group, with access to support structures post-interview if necessary. There were no specific sex

or gender requirements. However, efforts were made to secure an equal gender distribution in the sample where possible. Table 9.1 lists the pseudonymised name, gender identification, and the duration each participant self-determined their recovery at the time of interview:

Table 9.1

Profile of Participants

Participant	Gender	Time in Recovery
Levi	Male	8 years
Kenny	Male	6 months
Marco	Male	1 year
Annie	Female	6 months
John	Male	10 years
Sasha	Female	13 years

9.3.3 Data Collection

The first author conducted 6 one-to-one semi-structured interviews between December 2022-June 2023. All interviews occurred in person, their duration ranging from 40-65 minutes, with an average of 46 minutes. Interviews adopted a semi-structured format via six open-ended questions designed to facilitate a participant-directed conversation about the experience of loss while in active addiction. Questions focused on their journey through addiction, the dynamics of their social relationships during this period, their experience with loss, the effects of stigma, and their sense of

self. Participants were briefed at the beginning of each interview and debriefed at its conclusion, including the signposting of relevant supports.

Interviews were recorded by an audio device, from which the data file was transferred to an encrypted drive. Once each interview was transcribed verbatim with all identifying information removed, the original audio file was permanently deleted.

9.3.4 Data Analysis

Data analyses utilised Smith and colleagues' (2009; Larkin et al., 2021) case-within-theme approach to interpretative phenomenological analysis (IPA), with findings outlined in adherence to the standards for reporting qualitative research as reported by O'Brien et al. (2014). Both authors are proficient in working with qualitative data that details the lived experience of socially excluded populations, and IPA presents as a double hermeneutic yet systematic approach to deconstructing the experiential transcripts and synthesising meaning within cases and across the dataset (Smith et al., 2009).

The first step involved familiarisation with the data, where the transcripts were read and re-read. This was followed by the development of initial non-hierarchical notes, with an exploratory focus on explicit meaning and semantic content. A subsequent mapping of these notes by their interrelated concepts resulted in emergent themes (Smith et al., 2009). In this process, some notes were merged or discarded in thoughtful consideration about how to reduce the size of the data while preserving its complexity. Lastly, in searching for connections across emergent themes, the authors made decisions about how to contextualise the data within each case, resulting in the

development of superordinate themes (Smith, 2009). In repeating this rigorous analytic process for each transcript, a cross-case analysis produced superordinate themes of higher-order concepts that best represented participants' experiences of drug-related peer loss (Larkin et al., 2021; Smith et al., 2009).

9.3.5 Roles, Reflexivity & Research Integrity

To faithfully represent the participants who kindly shared their stories for this project, the authors wished to ensure the highest methodological integrity. The first author has prior experience working with socially excluded populations through research-based practice, and the second author has both practitioner and research experience in addiction services. As the sole interviewer, the first author wrote post-interview memos and engaged in reflective journaling to diarise an audit trail from the beginning of the analytical process. These notes were generated to facilitate transparent discussions in peer debriefing sessions between the authors. Debriefing sessions adopted a reflexive bracketing framework (Smith, 2009), with consideration for emerging feelings, potential biases, and pre-existing assumptions. Addressing the risk of bias through reflective practice and peer debriefing established an iterative dialogue that coincided with our responsibilities as qualitative researchers (Dodgson, 2019).

9.3.6 Ethical Considerations

This study's design was not preregistered, and thus received entire ethical approval from the authors' home university through its social research ethics committee. All pre-interview materials ensured participants were fully informed of the study's nature, the details of participation, and the potential uses of their data. Participants

provided informed consent via signed consent forms before their interview. Any identifiable data was anonymised and confidential, and participants were informed of their right to withdraw their materials from the study up to 2 weeks post-interview. Upon completion of the anonymised transcripts, the original interview recording was deleted, and data was stored in written format (Microsoft Word) on an encrypted Microsoft OneDrive provided by the authors' home institution.

9.4 Results

Presented herein are three superordinate themes (Table 9.2) demonstrated through a case-in-theme approach to idiographic narratives: Forged Connections; The Condemnation Script; and Nowhere Left to Turn. Each superordinate theme contains three subthemes, which categorise narratives of particular focus under the broader superordinate theme. Collectively, these themes illustrate complex journeys of grief as participants navigated the loss of companionship amidst social invalidation of their peer bonds. Through discriminatory societal practices and belief systems that frame addiction as a criminal activity, grief-related reactions were inarguably shaped by how addiction is situated as a taboo within the social domain.

Table 9.2

Superordinate Themes with Descriptive Context and Associated Subthemes

Superordinate Theme	Subthemes	Description
Theme 1: Forged Connections	• Filling a Void • Social Resonance • Cost of Belonging	Explores how grief takes on a particular significance in the context of the intensity of peer relationships, where the shared experience of social exclusion enhances the peer bond.
Theme 2: The Condemnation Script	• Shattered Reflection • Social Fracture • Inhibited Grief	Illustrates how participants conceptualise their grief, disenfranchised by stigmatised societal belief systems that criminalise addiction and invalidate their grief.
Theme 3: Nowhere Left to Turn	• Drug Dependency • Death as an Escape • Survivor's Guilt	Demonstrates how participants respond to their grief in contention with stigma while bereft of social support.

All participants spoke solemnly about multiple peer losses throughout interviews, but each referenced close friends whose deaths were significantly impactful for them. To provide additional context to the individual lived experience of each

participant, Table 9.3 contains a brief overview of these relationships and the circumstances of their deaths.

Table 9.3

Participants' Relationships to Deceased and Circumstances of Drug-Related Death

Participant	Context of Death
Levi	Best friend and godfather to Levi's child.
Kenny	Close friend died by overdose and was found in a public bathroom by authorities.
Marco	Childhood best friend, Cody, who died while both were using together in Cody's home.
Annie	Close friend who Annie had met during an early treatment effort died when both left the treatment centre prematurely.
John	Best friend Ben, whose drug-related death caused significant pain as John still grieves his potential.
Sasha	Two closest friends, Henry and Ava, who died 3 weeks apart.

9.4.1 Forged Connections

Societally ingrained stereotypes about participants' place in the world created social barriers between themselves and the wider community. Accordingly, they constructed their social world within the margins that they felt socially relegated to. Adopting and internalising dominant social perceptions, addiction became a defining feature of their identity, pushing participants further to the periphery of society and

increasing their sense of isolation. As poignantly stated by John, the public fails to recognise just how pervasive such deeply prejudicial attitudes can be, severing the connection between people who use drugs and the wider community: “When you’re using [drugs], you feel every bit of [the stigma]. So, you just feel like you’re outside of society and you’re eh... You know, it’s just very isolating.” For all participants, however, existing on the fringes of society forged connections with others who were similarly alienated, serving as an acute juxtaposition to the hugely isolating nature of addiction. As highlighted by Sasha, the shared trauma histories and social exclusion pushed peers closer together, carving out an interdependent, non-judgmental social space:

I just feel that those relationships at the time, they did form something, they did provide some form of connection. And when you’re in a lonely place like addiction, you know... Any connection is better than none.

An often-unspoken interdependency, the shared nature of their socially assigned position on the outskirts of society constructed bonds that kept peers alive during severely chaotic life situations. As a result, drug-related stigmas yield the dual-outcome of exacerbating the social isolation of people in active addiction while concurrently enhancing peer bonds within this community. The critical role these connections played in the lives of participants, bolstered by stigma, often resulted in intensified grief reactions when a peer passed away.

9.4.1.1 Filling a Void

Many family figures in Levi’s life were unable to fulfil designated roles, and he positioned his peers as surrogate role models in place of absent caregivers: “I was diagnosed with all sorts of stuff from a very young age. Dad was in and out of jail, so I

turned to the streets for that friendship. For that male role model.” As his peers came to personify these roles in his life, Levi described a sense of kinship and familial bonding among a “community of people” that were situated on the margins of society; a conceptualisation of peer bonding that was reflected in the narratives of all participants. The concept of ‘family’ was a value of central importance for Levi who, in demonstrating how his personal values augmented the importance of his peer bonds, shared that many of his peers acted as a proxy for his biological family: “The friendships I formed were basically my family...I knew then, I wasn’t the only one in this situation.” In a similar manner, communal acceptance acted as a core cultural value for Kenny, and the disempowering effects of social exclusion were magnified due to how his personal self-worth was intrinsically linked to how he was perceived by those around him: “For me, I always felt that I was ‘less than’...and I had that even before I started taking drugs.” However, Kenny’s peers in active addiction afforded him a sense of belonging he had yearned for, forging bonds that replenished his sense of place with an implicit sense of acceptance:

It’s a cutthroat lifestyle. You have to be street wise, and you have to watch your back but there is kind of a community there as well, like you know? I think it’s like, “we all know we’re f**ked.” But we’re okay with each other like, we’re okay with each other...

Levi and Kenny’s narratives demonstrate how such relationships can become deeply meaningful as they represent the personal fulfilment of human connection that social exclusion deprived them of. Comparably, friendship and connection epitomised the core of Marco’s character, and despite underlying insecurities about his self-worth,

his morale was largely fortified by his attachment to his childhood best friend: “My best friend Cody, he felt like a brother to me. Basically, I would have taken a bullet for him. We’d travel the world together.” In contrast to other participants, Marco’s relationship with Cody existed before engaging with drugs, but drug use ultimately became a distinctive feature of their brotherhood as they traversed the threshold from recreational drug use into active addiction.

As the essence of Marco and Cody’s connection changed, the value remained. Marco cherished this friendship, with his reliance on their bond becoming more intense due to increasing levels of social isolation stemming from their drug use. This bond acted as an anchor to Marco’s sense of psychological safety, demonstrated by how Cody’s death took on such significance in Marco’s world as it began a sequential process of loss: “You feel invincible, bulletproof. Little did I know I was made of f**king eggshells... Lost my job, banned off the road, apartment gone. I literally went off the edge.” While Marco’s narrative highlights how existing relationships can change within the bounds of addiction, it further demonstrates how stigma and isolation can forge powerful and meaningful bonds among peers.

Levi longed for the wider societal recognition of these connections as authentic and meaningful; that the terms ‘family’ and ‘friend’ carry the same merit regardless of your social situation. Levi’s best friend died from a DRD, and he shared how he honoured this man’s humanity both in life and death: “I’ve a tattoo on my arm of him, he’s the godfather to my child. I didn’t make him that, or get tattooed, if it wasn’t a significant relationship in my life.” While many of these relationships were predicated

on a need's basis, particularly around drug distribution, such principles did not negate the development of meaningful friendships.

9.4.1.2 Social Resonance

The community of people who use drugs are regularly impacted by cycles of death, incarceration, and grief. The constancy of change emerging from the cyclical loop of trauma and crisis impedes opportunities to process and make sense of these experiences, but one constant for participants was the homogeneity of shared experience which often brought people closer together. Shared experience acted as a synergetic social mechanism by which the depth of peer connections authenticated, and within these friendships, participants were identified by the qualities of their person and not by the characteristics of addiction. Sasha found solace in the escape that drug use provided as a shared experience amongst peers and noted that deeply traumatic circumstances engendered a collective emotional understanding: "There's a lot of emotion around the pain we share. I look back on those times and I see those friendships as inevitable...If there is no safe adult, peers will lead peers."

Mutual understanding was particularly pertinent for Annie, whose close social contacts failed to understand that her addiction was a health issue, perceiving her as making poor 'lifestyle choices' and influencing her social and familial detachment. Among her peers, including those within various treatment centres, Annie felt "*seen*" in a way that contrasted how she felt socially imperceptible by wider society. She acknowledged that an unspoken communal essence among peers eventually manifested into the formation of strong connections, cultivating the sense of belonging and understanding that Annie had lost:

All those girls, I'm still in contact with a good few of them. There's just such a connection there, you know? Because you're so lost and you're so alone when you go into a treatment centre, and finally you have somebody that is experiencing the exact same things you're experiencing.

Participants did note that peer groups in this context were not in the best position to be supporting one another, but as they were marginalised by society and in deep crisis, the concepts of shared experience and mutual understanding played a significant role in buffering against the stigma from an intra-community perspective. With drug use interwoven into the fabric of their attachment, Levi acknowledged an underlying transactional element to these relationships, but he inherently sought to satisfy the intrinsic human desire for connection. Thus, shared experiences created solidarity amongst disenfranchised peers:

[We had] really close bonded friendships, even though it was around substances. But [my peers] were all coming from traumatic experiences as well. And they were on the streets too, so who better to support one another? You know, through substances, but also through friendship.

Sasha echoed these sentiments, acknowledging that many of these relationships were predicated on behaviours, actions, and principles that can be considered dangerous, but they bonded through the desire for belonging and the underlying sense of mutual understanding:

[The connections] weren't necessarily healthy, but people will peer up because we're social animals. And we gravitate, we're wired for connection, even if those

connections are toxic...So my peers at the time would have been all young people like me who were equally strung out and distressed for multiple reasons. And I would have had a couple of close friends... Everybody was dead by the time I hit 25.

9.4.1.3 Cost of Belonging

Such belongingness and intense peer bonds were costly, and the mortality risks of active addiction presented a perpetual threat to this socially constructed safety net. With stigma concealing their support needs from mainstream society, participants were left to grieve significant losses as they remained encircled within their own temporality without external intervention. Cycles of loss depicted the fragility in which each participant's sense of belonging was predicated on, and Kenny noted the challenges of dealing with the death of a peer that represented so much during a time of ongoing crisis: "There is a community. The people do kind of look out for each other. It is community and a death does hit people as well, and it does hit people who are, everyone's in crisis as well." As John stated, the lack of societal acknowledgement of the rupture caused by DRDs means that the grief and impact is often contained within the community "the community is left with it."

John spoke fondly of a close friend Ben, and to him, their closeness was as profound as any relationship in his life. However, when Ben died, he experienced a profound grief that he was left to contend with in isolation. John deeply connected with the loss of life and the loss of potential, grieving the humanity, kindness, character, and potential of Ben that would never reach beyond the limits of his social status:

He was a very close friend now. He was very funny as well. And he was a great singer. And he's from a nice family as well, he was good natured...When I think of when we do functions and social gatherings, stuff like that, I think of what Ben is missing out on.

The concept of 'potential' embodied a recurring thread within these narratives of grief. Participants paid respect to the peers they had lost by conceptualising their lives in terms of their humanity, remembering the human qualities which they never had the opportunity to actualise in wider society. Participants learned that such connections came at a high price; they provided psychological warmth during a time of crisis, which then resulted in a profound grief when a peer died by drug-related circumstances. Annie analogised such grief to the loss of a family member: "You're just so close to those people and I... I mean I grieved now like it was a parent." Drug-related peer loss detached the anchor of belongingness that Annie had fervently clenched, and she longed for the recognition that such connections carry authenticity.

Marco cited the loss of Cody as the driving force for what "really got [him] on heroin," accelerating his drug dependence and shattering his worldview as he transitioned from smoking to intravenous dependency. The psychosocial implications of the loss were amplified by the traumatic conditions in which it occurred, as Marco was not only forced to contend with the loss of his best friend, being the first to discern that he was in difficulty, but furthermore, to bear witness to the ensuing panic:

We were smoking in his house, and we goofed off, could have been hours, six or seven in the morning at this stage. I woke up, and he was blue on the floor. After not breathing. I tried to give him CPR, his dad came up then and was like "he's

fu**ing dead!” I was ringing the ambulance, they came and had the machine over him, a chest pumping machine and all his ribs were breaking. This was unbelievably traumatic. Because he was my best friend, and he was dead next to me in the bed.

9.4.2 The Condemnation Script

Drug-related peer deaths represented the loss of a key sustaining factor that provided solace from the pervading sense of loneliness that participants experienced while pushed to society’s margins, but also the loss of familial connection, friendship, and human potential. Articulated by Levi, outside of their community participants witnessed their peers reduced to dehumanised statistics in death, fostering a sense of futility about their own existence: “It’s not acknowledged or they’re ‘just another one’...We’re just another statistic.” As peer deaths caused a significant rupture in the social world of participants, this was not the case at a broader societal level. The divergence between the personal and societal reactions to the death created a psychological incongruity for participants whose meaning making processes were subsequently impeded by the social nullification of their peer bonds.

The invalidation of these relationships caused harmful introspection about the value of participants’ own lives and affected their ability to sustain other relationships. They were condemned for their association with drug use before they were recognised as human beings grieving their loved ones. Furthermore, all participants were disheartened to witness the same labels their peers had grappled with in life remain attached to them in death, prompting a reflection on the value of their own existence. As stated by Kenny, such condemnation perpetuated a fear that their own lives were

meaningless, with labels indoctrinating the false notion that one's life can carry less meaning based on social currency:

That was a big fear of mine then. That I'd be found dead in a toilet and labelled as a junkie. I'm a person too. No one wants to be like that, it's a brutal way to die as well.

9.4.2.1 Shattered Reflection

The psychological dissonance following the death of a close friend presented significant challenges for participants, as the value they placed on the lives of their peers ran contrary to society's incognisance of the loss of human life. Given the significance of shared experience, participants often saw themselves reflected in the lives, and deaths, of their peers. Contradictory belief systems convoluted their efforts to make sense of the loss, particularly as it instigated introspective processes of self-evaluation. Stigmatised reactions to the deaths forced them to contend with the double stigma of grieving a societally condemned death while also attributing these social attitudes to their own person. The ingrained belief system that drug use devalues an individual's place in the world was reflected in Annie's immediate familial context with little consideration for how this may prompt harmful introspection:

I see it in my own family. If I tell them someone has died [by natural causes], or someone has died from a drug related death their reaction is so different. It kills me. And sometimes I don't even talk about it. Because I'd get so angry, I'd internalise it and I'd feel it inside. I'd be frustrated, and so angry with them for their reaction to it. So, I don't talk about it.

Internalising these reactions led to a marred self-concept, but also inhibited Annie's help seeking behaviours due to substantiated fears that her grief would not be taken seriously. Furthermore, normative grief-related reactions such as anger and sadness intensified as they emerged from both the grief itself and the indifference of those around her. When grieving, Annie was starkly reminded that despite the love she held for the deceased, such compassion was not universally conveyed. Through tainted self-reflection, Annie made sense of the loss in the context of her own drug use as she became concerned that her own death might bring shame to her family amidst a backdrop of societal apathy:

I kind of worried, am I going to die from, is it going to be a drug-related death? Will it be shameful on the family, will people even care as much because it's a drug related death and not natural cause? And it's mad that I'm even thinking about, 'how am I gonna die?'

Kenny experienced similar challenges about his place in the world, consequently questioning the value of his own life. With no symbolic representation for a life outside of addiction, he acknowledged his grief through sorrowful compliance that his societal footprint would be minimal, shrouded by the socially defined undesirable characteristics of drug use. Seeing himself reflected in the faces of those who died, each death set in motion an internal grieving process as he questioned if he would be mourned:

I knew there was a potential that I could die any time and I just accepted it like, you know? Would anyone care? Part of you, then, wants to die, man. Part of you is okay with dying. Life is so s**t anyway.

The internalisation of dominant social norms stripped Kenny of both his humanity and individuality. Social condemnation and societal disregard for the death of their peers further diminished self-worth for all participants, as their already diminished sense of self was shattered by the perception of their peer community as meaningless. John spoke at length about his own self-worth during this time, his sense of self eroded as he internalised the socially perceived traits of the community as individual characteristics. However, he implored society to recognise that each person in this community is left with a complex and individualised grief: “There's a lot of grief left through the people that are using [drugs] and they're not f**ing robots; you know what I mean?”

This deindividuation resulted in the formation of a dual identity for participants, where the human beyond the addiction was not socially acknowledged. When John's best friend Ben died, society failed to align the dual identities that John carried, and in the wake of societal inattention towards his bereavement, his personal efforts to align both identities became more challenging. Ben was an individual who had boundless potential, and in grieving the loss of his close friend he also grieved for his future and his humanity. Despite John recognising his potential, Ben could not detach from the stigmatising labels imposed on him, resulting in self-questioning about what this suggests about his own prospects:

What he would have brought to life, and the potential he had, because when somebody dies... Not Ben the 30-year-old heroin addict. It's not just him that died. It's the father he could have been, it's the psychologist he could have been,

or the care worker, or whatever he wanted to do with his life. The contribution he could have made to society.

9.4.2.2 Social Fracture

The indifference of society towards the shared grief of the community impacted many existing relationships that participants held, exacerbating their sense of isolation following a death. Sasha recounted a lack of support, struggling to receive any help at all, so much so it impacted on her existing relationships. Following the deaths of her two close friends, Henry and Ava, Sasha's health deteriorated, and she retreated from her remaining social circles who did not recognise the depth of her grief. However, the attitudes by those around her, even those who would be able to provide support, exacerbated her grief:

After that, I hit rock bottom. And at this point no doctor would touch me. It was just "look, she's going to die anyway," d'you know? 'Cause I was just so, so using at that point. There was grief at the time, but then I realised how much trouble I was in myself and I kind of shut down around the relationships I had developed.

For Marco, grief-related reactions by those around him impelled Marco to internalise the perception he was complicit in Cody's death and permeating his own grief with socially reinforced self-blame. Marco recounted his desperation as he made vehement efforts to wake Cody and save his life, his best friend unresponsive in his arms as distress reverberated throughout the household. His efforts to revive him fostered feelings of intense futility and self-blame which were exacerbated by Marco's

vilification in the aftermath, his friendship with Cody now socially recognised as a blameworthy causal factor in his untimely death:

There was an inquest. When I went down, I felt like I was being attacked. All his family were after coming, and they were like “what the f**k...” Obviously, they were channelling their anger, their son was after dying and I understand that now. But at the time I was like “what the f**k, I’m his best friend, I wouldn’t do anything to hurt him.”

As vilification from people connected to Cody augmented Marco’s sense of failure and culpability, descent into such a belief system fuelled his crisis of self as he subscribed to the epithets imposed on him: “It was the absolute worst...All the demons came back tenfold, telling me I’m useless...Waster, a failure your whole life. Heroin was a big escape for me, and tablets.” In his efforts to find meaning in the loss of a cherished friendship, the intersectionality of complicated grief, existing traumas, and condemnation trapped him in perpetual rumination over his perceived role in the death. Their friendship transcended addiction, but the qualities of Marco and Cody’s relationship were disregarded as addiction became its key identity marker. Drug use altered the social perception of their bond and overrode Marco’s permission to grieve. After the breakdown of his connection to Cody’s family, in reflecting on how they were forced to contend with their own stigma Marco recognised that he now embodied the circumstances of their son’s death: “He [Cody’s father] probably still blames me to this day; I’d never spoken to him again and I used to be up with that family every Christmas.”

9.4.2.3 *Inhibited Grief*

The psychological retention of stigmatised labels impeded all participant's engagement with culturally normative grieving rituals, and these challenges manifested differently depending on circumstances personal to each participant. Layered with underlying stigma and given his positioning as complicit in his peer's death, Marco's interactions with others throughout the grieving process acted as further inhibitors to engagement with grieving rituals. Drug-related stigma and blame socially resituated him from 'brother' to 'unwelcome guest' at the funeral: "You get those eyes watching you like, 'oh he was with him when he died.'"

Annie's relationship with her family also became strained throughout the grieving process. In losing a close friend to drug use, Annie's expression of normative cultural grieving practices suddenly took on a new meaning due to stigmatisation associated with drug use. Publicly grieving the loss of her peer became a subject of question as the validity of her connection was disregarded, contributing further to Annie's sense of disenfranchisement:

I watched it online, the funeral. Jesus, I was just heartbroken. My family then looked at me saying "she hardly even knew her," you know? "She was only in treatment with her." But that connection you make with people in a treatment centre, it's just unbelievable.

Kenny's engagement with culturally normative grieving rituals such as funerals, as routine social practices to honour his friend's life became veiled in uncertainty and apprehension: "You don't fit in...I tried to pay my respects, though I find it hard going to funerals. I feel less than, I don't even know if the family wants me there. I still went

because he was a friend!” Such feelings of apprehension were reflected in the narratives of all participants; John reported similar psychological difficulties when attending funerals: “I remember going to the funeral. I didn't want to go. I just barely went to show my face and legged it again... Just felt really awkward about it, you know?” Participants’ inability to comfortably pay their respects due their association with drugs severed their sense of belonging, further contributing to their sense of disenfranchisement as drug-related stigmas obstructed their perceived right to grieve meaningful relationships. However, their proclivity to attend funerals despite prejudice and while actively in crisis illustrates the high regard to which participants hold these connections.

9.4.3 Nowhere Left to Turn

The reactions of others to the deaths of their peers confirmed participants’ fears that the wider public considered their lives and deaths as inconsequential. Left to cope with complicated grief on their own while their sense of belonging dissipated, this gradually bore significant repercussions for their social network, adversely affecting their intrinsic sense of community and access to support. With limited options for support, Levi described his social world as “absolute chaos” following the death of his best friend as the bereavement inflated an excessive emotional load already saturated by a myriad of social, justice, and health complications:

You had all the life situations as well that were going down, with social workers, kids, courts. Family members, dependency, money. All that stuff that you couldn't deal with anyway. So, then you throw this loss on top of it. You're just scattered.

The overwhelming combination of grief, trauma, and fear with no social support to assist in the process of overcoming this immense suffering left participants with little option but to remain trapped in cycles of suppression. Sasha recounted similarly chaotic experiences as she could not regulate around the death of her friends: “We learned to shove down grief and just keep surviving ourselves.” With depleted capacities for emotional regulation and no external intervention, herself and her peers were forced to rely on each other as they had nowhere left to turn. However, as most members of the community had inhibited coping skills, they were often not in the best position to support one another. Their community was in crisis and existence within this domain exacerbated her sense of grief and trauma:

Suicide attempts, overdoses. It was a lot of chaos, and there was very genuine reasons for all of it. And the help certainly wasn't there. But I think in our peer mix we just could not help one another. Because we were all in that boat. And I think our efforts to help one another were probably more harmful and more toxic.

Society could not recognise the psychological turmoil that Sasha and her peers were experiencing. She highlighted the complexity of emotions that, upon reflection and therapeutic intervention, are now discernible but created a cascade of disarray during a time of crisis:

Yeah, drug use increased. I think when Henry died, I would have been particularly close to him and I had just been to Ava's funeral 3 weeks earlier, and we were all kind of in a circle...We were very close. I just felt at the time, there was guilt. There was shame. There was a lot of things. Fear. And definitely, I

suppose, in lucid moments, just a reflection on how we were living our lives, but also a deep frustration about not knowing why the circle was continuing and nobody was asking ‘why,’ or looking to help.

9.4.3.1 Drug Dependency

With a limited emotional bandwidth to engage in loss-oriented practices, and a scarcity of professional resources to assist with psychological restoration, participants’ existing drug dependency continued to function as their core coping mechanism. Overwhelmed by grief, the duality of mourning a stigmatised loss in a stigmatised community initiated a causal sequence of increased drug use, where all six participants reported a rise in drug intake following peer loss. For John, with a lack of targeted supports and his life socially governed by stigma, the grief compelled him to rely on drug use as a numbing agent:

Because I didn't want to feel what I was feeling. It didn't scare me away from using drugs. In fact, it just spurred me on to use more. Because the grief, the upset, the hurt, the pain. You don't want to feel that, and you just want to take more tablets.

Following the DRD of a peer, Kenny’s fear centre became considerably over-activated as he faced the reality of grief and, subconsciously, what that loss represented for his own mortality. Entrapped within the boundaries of social stigma with little options for support, he entered a phase of psychological paralysis, compelled to draw on his existing coping strategies to quell the emotional noise in his head:

It could happen to me tomorrow... It didn't stop me using [drugs]... If anything, I'd have used more. Just to kind of push down the feelings, and now that you're in danger yourself. It's a reality, but if you're using [drugs], you're not worrying about it.

Increased levels of drug use placed participants at a further risk of fatal overdose, and this grief response involved the very behaviour that participants were socially condemned for. Levi acknowledged that masking the grief with substances may be societally misconstrued as indifference towards the loss of his close friend, however, this was not the case: "They weren't understanding the different situations that I was after going through. That led me to picking up that substance." The unseen reality was, as Levi articulated, that drugs acted as a suppressing agent for participants as there was no capacity to manage more emotional pain:

I didn't know how to manage [the death], and the only way I knew how, by every other situation in my life, was to use drugs. So, the drug use increased. Because I just wanted to numb all of the feelings. I didn't want to feel anything. And that's what drugs do.

The presence of drugs as a causal circumstance in Cody's death had an inverse effect on Marco's opportunities to grieve and isolated him in the aftermath. Internalised feelings of blame and shame through stigmatised vilification negated his propensity to engage in help-seeking behaviours as his drug use escalated. A relationship that had once provided him psychological warmth shifted to a source of psychological trauma; the conceptual reorientation of a cherished bond resulting in increased drug use and long-term psychological outcomes:

I was diagnosed with PTSD from that, from all the stigma. When I was at the inquest the dad was shouting and roaring at me...Heroin and tablets went just through the roof. I mean, bad. It was just downward, a proper “forget everything” type of thing. 30 Xanax a day, and a bag of heroin. I’m lucky to be alive like, I swear to God.

9.4.3.2 Death as an Escape

The concatenation of events following the death ruptured Marco’s ideological interpretation of the world and he struggled to find meaning within the remnants of his social domain. Ultimately, a sense of hopelessness prevailed as Marco expressed his difficulties living in a world without a place for him. His world had become psychologically cold, and a very dark place: “If anything, I wanted to be in [Cody’s] position. At that time, I wanted to die like. My whole world was after falling apart.” Sasha disclosed similar expressions of envy, struggling to exist in a world where she felt so isolated and could not attribute meaning to her own life: “I can almost remember being envious of young people that were part of my peer group because their pain was over, and I couldn’t understand.” For Annie, the ceaseless condemnation of her peer group over years of social exclusion and apathy towards their deaths eroded her self-worth as she projected society’s indifference on to herself, she was envious of the fact that her peers were no longer suffering while she was left behind without a place to belong, and to endure continuous denunciation:

When I heard about somebody who died from drugs, I was jealous. Which is awful, but I wasn’t in a good place myself and I felt I was never going to get out

of this, and I just wanted to die myself. And I was like “why can’t that happen to me?”.

Given what such meaningful connections represented for participants during times of severe crisis, such as kinship and mutual understanding, the impact of the deaths of individuals representing these intrinsic human values became far more complex. All participants spoke about their relationship with death during their time in active addiction, with Annie disclosing that, trapped in a cycle of trauma but longing for peace, she attempted death by suicide:

It started to impact on every area of my life. Friends, financial, and mental health was very, very bad...I was taking drugs quite a lot. It really did take over so I started stealing money from everywhere I could. I would try pay for things and everything, so my family started to find out. And work, everything. And so, then I tried to take my own life twice.

Annie’s drug use permeated multiple facets of her life as existing relationships became strained over time and some, including her marriage, deteriorated entirely. Expressions of suicidal ideation or attempts to die by suicide emerged throughout interviews as participants felt that they had nowhere else to turn. Kenny’s primary coping resources cantered around repressing extant traumas, and the reinforced sense of disenfranchisement emerging from the bereavement necessitated more urgent coping strategies. However, Kenny was so emotionally overwhelmed that he could not permit himself to grieve, nor could he allocate the psychological resources to make sense of the loss in the context of broader society. As a result, he became enmeshed in a cycle of emotional suppression and suicidal ideation:

I made the decision to kill myself... I was very badly strung out, I was like, “so I’m stoned today, but tomorrow is coming. I’m going to have to come down sometime and I just can’t do any more sicknesses.” And I just was like “alright then, it’s okay, you’re going to kill yourself, you don’t have to do it anymore.”

9.4.3.3 *Survivor's Guilt*

Many of the participants explicitly stated that, to this day, they live with survivor’s guilt that manifests in personally individualised ways. Marco, who felt blameworthy for Cody’s death and has not reconnected with Cody’s family, questioned the sanctity of his own life as he dwelled on his survivor’s guilt. Even in his recovery, the internalised shame of his past remains very much alive:

I was driving, his mother walked past me, and I put my head down. To hide. Because I was ashamed. Over that stigma being put into me, I used to use [drugs] with her son. And now he’s dead and I’m alive, and here I am driving a car. I just felt awkward and guilty, and I know this woman since I was 10 years old. That’s the madness of it.

John wished for more conscious efforts to recognise the potential and humanity of people in active addiction; to create visibility for life outside of addiction and to break the cycle of psychosocial entrapment within a continuum of trauma and social neglect. However, following Ben’s death, John experienced profound survivor’s guilt as he considered his own life in comparison to how he viewed Ben as a beacon of potential. Contending with survivor’s guilt alongside the social conceptualisation of his grief as unsanctioned hindered his efforts to make sense of the loss:

I'm feeling like, "how the f*** did he die?" He's only using [drugs] about the last 12 months, and he's innocent. I'm using about the last 10 years, heavily, and I'm here and he's not, you know?

9.5 Discussion

The current study shared the voices of six bereaved individuals who experienced a DRD while in active addiction, using IPA to centre on their narratives and explore how their grief experience and identities as bereaved were shaped by stigma. For participants, their peer bonds represented mutual understanding, companionship, and familial connection, where drug-related peer loss resulted in profound grief-related reactions. Influenced by the twofold stigma of grieving a DRD while positioned within a stigmatised community, participants reported a diminished self-concept, survivor's guilt, self-blame, shame, and increased drug use against the societal invalidation of their bereavement. The findings highlighted an urgency for targeted bereavement intervention protocols that acknowledge an increased risk of fatal overdose and disenfranchised grief for a community in crisis. The firsthand stories of grief portrayed by the bereaved in this paper corroborate healthcare professionals' implorations that people who use drugs are critically underacknowledged as a group who are impacted by DRDs (O'Callaghan & Lambert, 2023).

9.5.1 Discussion of Empirical Findings

This study further reinforces the conceptualisation of drug-related bereavement as a complex area with no uniform approach to support. In providing an in-depth phenomenological insight into individual mediators of grief for people in active

addiction, and the convergence of bereavement experiences across this group, this paper demonstrates that grief outcomes are influenced by a nuanced interplay between personal experience, systemic belief systems, and legislative structures. However, while the participants in this study reported many similar complexities in their grief responses to other social groups such as families (Lambert et al., 2021; Titlestad et al., 2019) and HCPs (O’Callaghan & Lambert, 2023; Sperandio et al., 2023), there are significant contextual differences. The narratives provided by participants provide a crucial insight into the complex mental processes involved in grieving a stigmatised loss while socially situated within a stigmatised community.

To this end, the current study supports the identification of a unique double stigma highlighted by the work of Selseng et al. (2023, 2024), and comprehensively explores the health implications of grieving while experiencing marginalisation and compromised wellbeing. Most crucially, this study underscores the immediate aftermath of a peer’s DRD as a critical period for crisis intervention as participants expressed suicidal ideation, attempts to die by suicide, and increased drug use with a further risk of overdose. With systemic stigmas generating both internal and external barriers to help-seeking and support, the psychological integration of these experiences stretches beyond the individual capacity of those who are already in crisis. With difficulties regulating around the loss of their peers, the findings reinforce a growing evidence base that identifies increased drug use as a persistent grief response for people who use drugs (Macmadu et al., 2022; Selseng et al., 2023), necessitating urgent community-based strategic interventions to prevent further loss of life.

This paper advocates for drug-related policies and procedures in addiction, health, and homelessness that recognise and employ actionable responses to the increased risk of further deaths by overdose and/or suicide within communities after a DRD. Furthermore, this study provides in-depth contextual and relational information about barriers to help seeking through an exploration of socioemotional intricacies, which services can utilise to mitigate these barriers and increase the efficiency of crisis support provision. Broadly, participants noted that their grief was unrecognised by the wider public, echoing the findings by Selseng et al. (2023, 2024) who reported that, with their humanity and grief neglected, the bereaved remain solely positioned as people who use drugs and not as people who grieving a profound loss.

While participants acknowledged the risk factors of forming attachments while in crisis, this study provides additional in-depth context to the evidence base regarding the function and importance of peer relationships in active addiction. All six participants analogised many relationships to various roles within a family structure, with their peers representing social intimacy, belongingness, and potential, adding further credence to Bethune Scroggs and colleagues' (2022) reporting of drug-related peer loss invoking secondary losses. Macmadu et al (2022) noted that increased overdose risks were evident when the DRD of an emotionally close peer occurred, and in the current study, all six participants acknowledged the loss of at least one close relationship that had profound implications on their wellbeing. However, drug-related stigmas eroded the social validity of these peer bonds.

Their peer bonds delegitimised during life, and their grief disregarded during death, this report highlights a unique disenfranchisement for people who use drugs as

their connection to the deceased is not formally defined. Although participants used heartfelt familial terms to describe their peers, the personal meaning of such connections may not be socially acknowledged in the same way as more universally recognised relationships, such as a parent's connection to their child. Wojtkowiak and colleagues' (2019) work demonstrated a fragmented and delayed grief for this population, and Bethune Scroggs et al. (2022) stated that the individual may not begin to fully process the loss until entering recovery. These findings are reflected in the current study, as participants struggled to find meaning in the loss of their peers, which had further psychological implications for their self-concept.

Given the prevalence of loss in the lived experience of each participant, and the broader context of active addiction, urgent action is required on behalf of addiction and recovery services to provide information on delayed or disenfranchised grief. Currently, there is a societal failure to look beyond addiction to recognise the individual who is grieving in crisis, and the professional acknowledgement of grief within services would serve to validate and support those who have been bereaved by a DRD, including recognising 'survivors' guilt' experienced by peers. Furthermore, strengths-based therapeutic interventions that assist the bereaved in making sense of the loss are recommended, especially given the profound impact on participants' self-concept reported in the findings.

Validating the peer bonds for this population may yield implications for posttraumatic growth as, amidst the stigma, both families (O'Callaghan et al., 2022) and HCPs (O'Callaghan & Lambert, 2023) identified role constancy as a pathway to healing. Parents maintaining continuing bonds with their children through symbolic means and

HCPS utilising their professional responsibilities as practical coping mechanisms functioned as both loss-oriented and restoration-oriented methods of healing (O’Callaghan et al., 2022; Stroebe & Schut, 2010). By internalising the social undermining of their peer bonds, participants’ roles in the lives of their contemporaries became unclear and, in some cases, nullified. Coinciding with the findings of Wojtkowiak et al. (2019), opportunities to honour the lives of their peers were severely inhibited, as participants felt unwelcome at funerals and shared spaces of mourning evolved into areas of judgement and condemnation despite their efforts to pay respects.

Dominant social norms construct attributional beliefs at a societal level that frame drug use as a behaviour that is morally wrong, neglecting to recognise addiction’s association with trauma. These norms, reinforced by inequitable societal and legislative structures, can perpetuate stigma and hinder support practices through a justice led reaction to a mental health problem (Muncan et al., 2020). Service providers in health and social care settings, particularly those who regularly work with people who use drugs should work towards the implementation of the recommendations outlined in this paper; this has the potential to decrease service user death and reduce psychological distress associated with complicated bereavements.

9.5.2 Recommendations for Policy and Practice

Policies and procedures in addiction must recognise and respond to drug-related complicated grief outcomes as significant public health risks, and it is crucial that responses employ case-sensitive and evidence-based models of practice. The concept of a double stigma acts as an under-acknowledged and hidden harm within the community of people who use drugs, with severe implications for psychological health and

mortality. The development of specialised training and education opportunities for staff in social and healthcare settings that cultivate a greater professional understanding of such unique grief experiences would serve to enhance the capabilities of services to address an individualised and complicated grief.

As acknowledged above, given the increasing instances of DRDs, the implementation of therapeutic interventions that integrate both grief and addiction support within service frameworks is crucial. Furthermore, this paper recommends public health campaigns to address the stigma but also raise awareness about the impact of DRDs for the community of people who use drugs. Current research has appealed for the recognition of overdose as a severe psychological trauma (Nolte et al., 2023; Schneider et al., 2021), which finds further credence in the current study as at least one participant disclosed a diagnosis of post-traumatic stress disorder (PTSD) following the DRD of his best friend, but all six participants witnessed fatal and non-fatal overdoses while in active addiction.

9.5.3 Strengths, Limitations, and Directions for Future Research

From the individual perspectives of six drug death bereaved individuals, this study presents further evidence that people in active addiction grieve for the loss of their peers within their community. However, recruitment from this project took place in an area where all participants' experiences reflect active addiction, grief, and recovery within urban settings. Literature suggests that people who use drugs in rural areas are often exposed to more isolation, so future research should aim to understand the experiences of those who may not be routinely connected to communal spaces.

Furthermore, there are avenues to explore cultural differences, such as the experiences of ethnic minority groups.

9.5.4 Conclusion

The findings of this paper contribute to the understanding of disenfranchised grief within a community that is already marginalised due to systemic stigmas associated with addiction. Individual grief correlates emerge based on group characteristics, but also from distinct within-group individualised factors such as connection to the deceased, allostatic load, and social positioning. The findings contribute to a broader understanding of the social context of drug-related bereavement, and how the intricacies of social positioning can exacerbate grief outcomes in different ways. As a critically under-researched area of inquiry, understanding variability in experience and support needs is crucial to the development of functional and adaptive practice frameworks that address specific psychological harms.

Chapter 10: Discussion

With the aim of producing meaningful research that advocates for social change, this doctoral thesis sought to address the impact of DRDs for families, communities and services across multiple dimensions of wellbeing. A pervasive social and public health issue, the continuous rise of DRDs in Ireland (HRB, 2023) and globally (EMCDDA, 2024; CDC, 2024) urgently necessitates adaptive harm-reduction and prevention initiatives. Through an in-depth analysis of complex bereavement experiences, this doctoral thesis underscores a parallel requirement for the enhancement of postvention practices across diverse relational contexts. To support the development of appropriate policy and response frameworks, the research proposes practical solutions regarding the implementation of grief intervention strategies and resource networks for the bereaved.

In line with the values of psychological justice, the work presented in this thesis aimed to empower those who seldom have their voices heard in empirical research or care practice. To encourage the development of person-centred bereavement supports (World Health Organisation & United Nations, 2023), this thesis adopted a socially engaged research paradigm. By involving relevant stakeholders in the co-production and ethical verification of each empirical design, the approach ensured that the research outcomes were pertinent to the values and experiences of the population who bravely gave their voices for each study (Barkin et al., 2013; Han et al., 2021). In this chapter, I will briefly summarise the key findings of the thesis and proceed to discuss the key contributions of the work with regards to applied research, policy, and practice.

10.1 Recapturing the Context: A Thesis Summary

Through the integration of bereavement theory (Klass, 2006; Stroebe & Schut, 2010) and applied research, this thesis reinforces the conceptualisation of DRDs as deeply complex losses, characterised by unique psychological, social, and health factors. By providing a holistic analysis of bereavement experiences for families, HCPs, and peers, this research contributes advanced knowledge regarding the widespread relational impact of these deaths. In mapping bereavement outcomes across a diverse and interrelated social context, the work provides a critical insight into the needs of the individual while demonstrating the broader implications of DRDs for community-level social and occupational health. Dyregrov & Selseng (2022), who examined stigma towards those bereaved by a DRD, reported that approximately 10-15 people may be impacted by a single death, a finding for which this thesis adds credence by highlighting multiple impacted social groups.

Upon its initial conceptualisation, this thesis aimed to address a significant evidence gap at the intersection of addiction and bereavement. The scoping review presented in Chapter 2 cultivated the direction of this thesis by identifying complex grief outcomes in additional social groups, building on the evidence base for DRD bereaved families reviewed and collated by Valentine et al. (2018) and Titlestad et al. (2019). However, as a portion of this research took place during the COVID-19 pandemic, an unanticipated research objective emerged; to explore the challenges of service provision for HCPs working with people who use drugs, and how the context of loss is influenced by such unprecedented circumstances. Overall, this doctoral thesis explores the healing trajectories of DRD bereaved families and provides a more intricate contextual

exploration of grief outcomes for bereaved peers in active addiction and healthcare professionals working with clients who use drugs.

In Chapter 4 (O’Callaghan et al., 2022), the experiences of posttraumatic growth for bereaved families highlighted the importance of bereavement supports that address both individual- and group-level processes. In coping with significantly complex bereavement outcomes, families expressed the critical value of social support and reclaiming their purpose in life. In Chapter 6 (O’Callaghan & Lambert, 2023), HCPs in a range of professions reported complex grief reactions that occurred at the intersection of their professional responsibilities and personal emotions. The connections established between HCPs and their clients exacerbated their grief. Chapter 8 (O’Callaghan & Lambert, 2022) addressed the challenges in supporting clients in addiction during the COVID-19 pandemic, with HCPs feeling severely disempowered in their roles as service providers. In the final empirical study, Chapter 9 (O’Callaghan & Lambert, 2024) demonstrated the complex processes involved in grieving the loss of a peer while in active addiction.

The dual process model of coping with bereavement (Stroebe & Schut, 1999, 2010) and its revision for family-level processes (Fiore, 2021; Stroebe & Schut, 2015) provided substantial theoretical support for this doctoral thesis. Adopting this framework and applying it to the bereavement experiences of participants enabled the research to contextualise the intricacies of their grief and coping strategies while articulating their unique challenges to adaptation within an evidence-based system.

10.2 Key Findings & Contributions

Contrary to the systemic belief systems and social hierarchies that invalidate the lives and deaths of people who use drugs, this thesis illuminates the human value of every life lost. In each empirical chapter, the profound impact of a single death is observed through the heartfelt stories of love and compassion shared by participants. Most importantly, the grief they experience echoes the affection they carry for those who have passed, appealing for a cultural shift towards recognising the humanity of people who use drugs and an acknowledgement of the value of all human life as meaningful.

This thesis explored DRD bereavement in three distinct social groups, and while each one was investigated in a separate research endeavour, collectively their disenfranchised grief experiences are consequential of their shared existence in a sociocultural framework that condemns the deceased. As the principal finding within this thesis, the establishment of a holistic, community-level, and integrated bereavement support system is paramount to the effective response to the psychological impacts of the rising death totals in Ireland (HRB, 2023) and worldwide (CDC, 2024; EMCDDA, 2024). These supports must address diverse grief outcomes across multiple social groups, but also understand that DRDs are situated within a broad relational context involving interactions between these groups. Thus, response initiatives should also incorporate education and training, encourage cultures of compassion, and promote awareness-raising initiatives in the same way the country responds to other traumatic deaths such as road accidents (Road Safety Authority, 2024).

The intrinsically complicated nature of grief is well-documented within general bereavement literature, and the findings of this thesis corroborate the notion that the grief experience, while personally individualised, is also culturally defined (De Stefano et al., 2021). However, the cultural script that DRDs are etched within yields detrimental effects on those who exist within this social system. Prior to beginning this thesis, the impacts of cultural and systemically embedded stigmas on DRD bereaved families began to generate more empirical interest, highlighting profoundly disenfranchised bereavement experiences (Lambert et al., 2021; Templeton et al., 2017; Titlestad et al., 2019, 2020; Dyregrov et al., 2020). This thesis, then, builds on the knowledge base by making contributions to the academic literature that identify the presence of similarly disenfranchised grief reactions in peers in active addiction (O’Callaghan & Lambert, 2024) and HCPs (O’Callaghan & Lambert, 2022, 2023). Furthermore, this body of work explores the intricacies of these grief experiences through the application of in-depth qualitative methodologies alongside evidence-informed bereavement theories.

For each of the bereaved represented in this thesis, the prevalence of drug-related stigmas removed their agency to construct their personal meaning of the loss, their grief directed by enduring prejudicial beliefs that criminalise the deceased (Muncan et al., 2020; Scher et al., 2023). Meaning making processes are crucial to the mitigation of complicated grief outcomes (Neimeyer & Thompson, 2014; Thimm & Holland, 2017), but families, HCPs, and peers found their meaning systems obstructed in various ways related to their social positioning. Instead, their grief was socially constructed and governed by the pervasive societal stigmas which are imposed on them (Stout & Fleury-

Steiner, 2023), forced to grieve in silence as their grief became disenfranchised (Doka, 2020; Selseng et al., 2024; Sterling et al., 2022).

Participants' disenfranchisement is reflected in their difficulties with openly expressing the loss, perpetuated by regulatory stigmatised sociolegal structures (Scher, et al., 2023) and expounded by the lack of available support pathways (Titlestad et al., 2019). While previous and ongoing literature highlights how this disenfranchisement emerges for families (Thatcher, 2022; Titlestad et al., 2019), this thesis demonstrates that HCPs (O'Callaghan et al., 2023), and peers who use drugs (O'Callaghan & Lambert, 2024) experience a similar disenfranchisement. The unique contribution of this thesis, however, is how it addresses the different situational contexts in which DRD bereavement and grief become disenfranchised.

Indeed, the identification of grief reactions and disenfranchisement in the broader relational context of drug use is a significant contribution to the academic literature that builds on a limited evidence base (McAuley & Forsyth, 2011; Wojtkowiak et al., 2019). Such information can be utilised to acknowledge the presence of grief reactions in additional social groups, accentuating the need for intervention at a community level when a DRD occurs. However, identification is only the first step in the support process, and the work presented in this thesis demonstrates that the implementation of follow-up protocols is where therapeutic strategies should diverge to cater to specific contextual needs.

While participants reported many similar grief related reactions, primarily due to the sociocultural positioning of drug use as a criminal activity, each group also reported significant variability. Grief reactions, such as self-blame, manifest very differently for

each individual dependent on their situational context, personal and interpersonal resources, social positioning, and relationship to the deceased (O’Callaghan et al., 2022; O’Callaghan & Lambert, 2023, 2024). These findings echo back to general bereavement literature, which highlights the interaction between these interpersonal, relational, and contextual factors is fundamentally complex (Breen & O’Connor, 2007; Mason et al., 2020; Overad & Wagoner, 2020). Through qualitative inquiry and phenomenological framing, this thesis provides valuable knowledge regarding how this interaction is influenced by the permeation of drug-related stigmas.

To develop a comprehensive framework of DRD bereavement support, the individual needs of each specific group must be understood before they can be integrated into an inclusive cross-disciplinary assistance scheme. Thus, the following sections will address each group individually before culminating in recommendations for the interactional context in which the bereaved exist.

10.2.1 Considerations for DRD Bereaved Families

As outlined in the introduction of this thesis and explored throughout the various chapters, families bereaved by a DRD are at a profound risk for complicated and disenfranchised grief outcomes (Lambert et al., 2021; Titlestad et al., 2019; Titlestad & Dyregrov, 2022). The growing literature base has demonstrated the role of various pre- and post-loss factors in engendering complex grief reactions, as families may have lived with active drug use in the home (Turnbull & Standing, 2016; Valentine et al., 2016) and contend with complex emotions in the aftermath (Titlestad et al., 2019). Families encounter various psychological and social challenges such as guilt for perceived failure at their role (Templeton et al., 2016), self-blame, shame (Bottomley et al., 2022; Reime

et al., 2024a), anticipatory grief (Feigelman et al., 2023; Templeton et al., 2016), identity changes (Guy & Holloway, 2007), and the negative characterisation of their loved one (Dyregrov & Selseng, 2022).

The findings of this doctoral thesis build on the growing evidence base surrounding DRD bereaved families (Hicks et al., 2024; Kalsås et al., 2023; Lorås et al., 2023; Titlestad et al., 2020) by highlighting their experiences and pathways to healing. By amalgamating our understanding of the key challenges and potential indicators for posttraumatic growth, services can target these specific challenges using therapeutic approaches that are scientifically grounded within the identified facilitators to adaptation (O’Callaghan et al., 2022). Across the literature, social support (Feigelman et al., 2020; Hill & O’Brien, 2023; Titlestad et al., 2022a), self-compassion (Sperandio et al., 2021; Titlestad et al., 2022a), and meaning making processes (O’Callaghan et al., 2022) have emerged as strong predictors of posttraumatic growth.

The association between individual self-compassion and posttraumatic growth following a DRD has now been well-documented (Titlestad et al., 2022a; Sperandio et al., 2021), which can further support healing within the family system as highlighted by O’Callaghan et al. (2022). Furthermore, social support emerging as a key component of positive adaptation demonstrates the value of shared experience amongst groups who are often disenfranchised (Hill & O’Brien, 2023; O’Callaghan et al., 2022). However, Reime et al. (2024a) reported that families often have limited contact with other people who are bereaved, and such challenges are reflected in an Irish context with the recent closure of the National Family Support Network.

When considering the importance of social support, it is also pertinent to consider the challenges families face with respect to receiving such assistance as they are marginalised at times when they require support (Dyregrov & Selseng, 2022). Given the stigmatised nature of DRD bereavement, and the nature of disenfranchised grief, then, the onus also falls on the services to ensure that families are included in community responses to drug deaths, with particular emphasis on increased visibility and accessibility. Additionally, it is crucial that support frameworks consider the complex intrafamilial processes that occur when a family is contending with loss, internalised stigma, and fractured family dynamics from before the loss (O’Callaghan et al., 2022).

Through the theoretical application of Stroebe & Schut’s (2015) DPM-R framework, the work in this thesis (O’Callaghan et al., 2022) has highlighted an interwoven bereavement experience that consists of synchronous individual-level and family level processes. To achieve adaptation, family members often needed to integrate these processes, oscillating between loss-oriented and restoration-oriented coping strategies (O’Callaghan et al., 2022; Stroebe & Schut, 2015). Misaligned or misunderstood coping strategies within familial frameworks can often inhibit individual and group adaptation (O’Callaghan et al., 2023; Stroebe et al., 2015).

Support practices that endeavour to assist families with psychologically integrating the loss of their loved one should account for both individual and group-level variables, recognising the needs of the individual within the family system while addressing family-level stressors. Postvention services should include the option of group support and bond-strengthening initiatives within and between family units. The

foundational principles of these services should thereby be to address psychosocial constructs such as peer support, resilience and self-compassion building, and meaning making (Hill & O'Brien, 2023; O'Callaghan et al., 2022; Sperandio et al., 2021; Titlestad et al., 2022a).

10.2.2 Considerations for DRD Bereaved HCPs

As HCPs experience their bereavement within the context of their work, their grief is situated at a psychological crossroads between organisational and personal responses. Staff must respond to deaths according to professional protocols, but they also grieve for the loss of life and potential when a client dies. A key finding of this thesis is that only one of these responses is broadly recognised (O'Callaghan & Lambert, 2023); their personal grief responses and connections to their clients are often overlooked. Through the internalisation of broader expectations of professional endurance in the face of adversity, HCPs often carry silent and unprocessed grief (O'Callaghan & Lambert, 2023; Yule et al., 2023). A human loss within an organisation evokes a human response from those affected (O'Callaghan & Lambert, 2023).

Following the DRD of a client, HCPs reported emotionally intense self-blame, self-stigma, and in a finding comparable to families (Templeton et al., 2016), guilt for the perceived failure at their role (O'Callaghan & Lambert, 2022, 2023). However, one's role as a carer can manifest differently across both groups; for HCPs, the role is professionally and organisationally defined, and within familial structures, caring carries a socially defined meaning. Thus, while grief reactions may be similar, the context in which they manifest and the positioning of the bereaved can influence how grief occurs.

In the aftermath of a client's DRD, HCPs must continue to honour their duty of care for other clients. However, participants reported feelings symptomatic of burnout, which has well-documented implications for diminished clinical practice and client outcomes (Boerner et al., 2017; Maslach et al., 1997). Participants bereaved by DRDs reported many similar depersonalisation and exhaustion experiences to that of HCPs in other disciplines which require high quality care (Boerner et al., 2017). Thus, burnout should be considered as a key construct to address and mitigate within bereavement interventions, particularly as many participants reported unprocessed grief experiences (O'Callaghan & Lambert, 2023). Existing quality improvement interventions to address burnout should be tailored to the specific contexts in which they are required (Green et al., 2020), coinciding with findings that demonstrate the importance of DRD-specific postvention protocols.

Since the inception of this PhD, the work exploring DRD bereavement in HCPs has marginally increased, with a growing number of publications now addressing their bereavement experiences (Kolla et al., 2024; Sperandio et al., 2023; Yule et al., 2023). Methodologically, Kolla et al. (2024) and Sperandio et al. (2023) conducted semi-structured interviews with practitioners to explore their experiences with client death, while Yule et al. (2023) utilised a cross-sectional survey. The findings have been consistent across the literature, coinciding with the work presented in this thesis (O'Callaghan & Lambert, 2023), where HCPs reported severe stress, fears of litigation, and difficulties talking about the psychological impacts of the loss (O'Callaghan et al., 2023; Yule et al., 2023).

With regards to the theoretical DPM framework, HCPs who participated in the work presented in this thesis detailed their oscillation processes between loss-oriented and restoration-oriented coping strategies (O’Callaghan & Lambert, 2023; Stroebe & Schut, 2015). However, their personal and emotional reactions to the loss were inhibited by how they internalised broader expectations about their professional conduct. Furthermore, their meaning making processes were heavily inhibited by the lack of recognition of the personal aspect of the loss; as they were compelled to react professionally, this raised internal questions about the meaning of the loss outside of the organisational context. Sense-making processes were particularly inhibited by the unprecedented circumstances surrounding the pandemic, for which the research in this thesis can be utilised to implement structures that mitigate complex outcomes in unforeseen conditions, where possible (O’Callaghan & Lambert, 2022).

DRD bereavement for HCPs is a complex process that generates an impact at the intersection of their personal and professional selves. The stigma surrounding drug use also intersects with the self-stigma regarding help-seeking behaviour (Yule et al., 2023), where HCPs questioned the validity of their grief given the nature of working with clients who use drugs. The development of, or enhancement of existing, bereavement supports should endeavour to recognise the stigmatised nature of the loss within organisational structures and validate the human responses of staff members who often form very meaningful connections with their clients. This is reinforced by the theory of continuing bonds, where HCPs represented in this thesis kept mementos to remember clients and often credited them for forming and refining their professional practice (O’Callaghan & Lambert, 2023).

10.2.3 Considerations for DRD Bereaved Peers Who Use Drugs

People in active addiction who experienced the DRD of a peer reported thematically similar grief reactions to family members and HCPs, such as shame, self-blame, and a profound lack of social support (O’Callaghan & Lambert, 2024). Similar grief reactions are also reflected and reinforced in other interview studies with people who use drugs that have recently emerged on this topic (Selseng et al., 2023; 2024). However, for this group, the concept of social positioning and the context in which their grief occurs plays a profound role in the exacerbation of their disenfranchisement. As family members contend with stigmatised grief and the rupture of their identity within familial contexts (Titlestad et al., 2020; Valentine & Walter, 2015), and HCPs must integrate their grief across personal and established professional contexts (O’Callaghan & Lambert, 2023), people in active addiction already exist within a deeply marginalised group in society prior to a death.

For people who use drugs, their grief is uniquely shaped and further complexified by their dual membership of two stigmatised social groups; those who are grieving a DRD, and those who are in active addiction. The intersectionality of both identities, which are individually marginalised by social and legislative constructs (Muncan et al., 2020; Scher et al., 2023), creates a double disenfranchisement (Selseng et al., 2023). Furthermore, peer connections in active addiction are invalidated by broader society (O’Callaghan & Lambert, 2024).

The work presented in this thesis raises a number of critical considerations for people who are bereaved in this context, signifying the necessitation of immediate crisis response protocols that support peers who are bereaved by a DRD. Peers were often

present when a death occurred, exacerbating their sense of self-blame and exposing them to overdose trauma where they may not know how to intervene (Nolte et al., 2023). Their stigmatised positioning as people who use drugs has a detrimental impact on the availability of support in the immediate aftermath (Nolte et al., 2023; O’Callaghan & Lambert., 2024), and each participant in Chapter 9 reported increased drug use to cope with the excessive trauma alongside a myriad of health, social, and justice issues. Some participants reported suicidal ideation and attempts to die by suicide, corroborated by findings in studies by Macmadu et al. (2022) and Selseng et al. (2023, 2024), which highlight participants’ difficulties towards regulating around the death of their peers and their predisposition to using drugs to cope with the excess trauma.

Peers in active addiction who participated in interviews for Chapter 9 spoke fondly of their peers and aimed to maintain bonds with them in various ways, which proved to be an adaptive coping mechanism and a means to honour their peers against a society that disregards them (Klass et al., 2014; Stroebe et al., 2010). Through artistic expression such as tattoos or pursuing a career in healthcare to honour those who had passed, the bonds developed between peers in this context were socially formative in diverse ways. Much of their bond maintenance occurred after entering recovery, however, as their coping mechanisms were severely impacted by their active addiction. Their oscillation between loss-oriented and restoration-oriented processes was also inhibited as they struggled to regulate around the death of their peers (O’Callaghan & Lambert, 2024; Stroebe & Schut, 2010), demonstrating that external intervention is required to support the process of positive adaptation.

Peers reported profound struggles with internalised stigma from their dual position as people who use drugs that are grieving a DRD. In line with existing literature on internalised stigma (Macmadu et al., 2020), this experience inhibited participants' capacity to engage with help-seeking behaviours and significantly diminished their sense of self-worth. Coupled with anticipatory stigma and how they would be perceived by professionals, authorities, or the family of the deceased (Lo Hog Tian et al., 2023; Macmadu et al., 2020), the concept of stigma functioned as a core experiential framework and psychologically immobilising mechanism by which people who use drugs became trapped and isolated in cycles of loss.

In the aftermath of a DRD, peers' self-compassion and sense of self become further eroded by the broader societal reactions to such deaths (Selseng et al., 2023). In seeing themselves reflected in their peers, they retain their identity as people who use drugs but not as those who are mourning the loss of a cherished friend (Selseng et al., 2024). Thus, crisis response initiatives should aim to validate and understand the connection between peers in active addiction who, despite the transactional nature of some relationships, often represent psychological warmth on the colder margins of society (O'Callaghan & Lambert, 2024). Through a trauma-informed approach that promotes safety and inclusion of peers within death response protocols, the development of wrap-around care that focuses on harm reduction while acknowledging grief can support the bereaved in integrating their experiences.

10.2.4 Interactional Context

When someone passes away, multiple aspects of that person's life come together to pay respect to the deceased. When amalgamating the individual components of this

thesis, the experiences of families, HCPs, and peers collectively identify a complex interactional context in which their journeys of grief intersect. Each group is linked together through their bereavement and grief over the loss of human life. Contrary to normative grieving processes, however, the bereaved are also connected through the fact that their grief is shrouded in social stigmas (da Silva et al., 2007), and the process of paying respects is inhibited by shame, a lack of recognition for the humanity of the deceased, and uncertainty (Lambert et al., 2021; Wojtkowiak et al., 2019). Such complexities permeate this interactional system and affects the various exchanges within. Additionally, with DRDs, death is often the first time that many individuals connected to the deceased will meet. Many of these connections are formed independently across familial, health, justice and social systems that often do not intersect until the person passes away.

Throughout the findings, various degrees of communication between families, HCPs, and peers emerged, which is also reflected in other literature. Family members and peers have reported a lack of compassion and feeling stigmatised in interactions with professionals in areas inclusive of law enforcement (Stout & Fleury-Steiner, 2023), healthcare (Templeton et al., 2017), and religious services (Lambert et al., 2021). Such encounters exacerbated their grief symptoms and increased their feelings of disenfranchisement and isolation. Correspondingly, HCPs in O'Callaghan & Lambert (2023) reported trepidation and anxiety around speaking to family members, particularly when relaying details of the death (Sperandio et al., 2023; Valentine et al., 2016). A times, HCPs felt blamed for the death by family members, which compounded their own

sense of self-blame, and some emergency medicine practitioners reported violent encounters (O’Callaghan & Lambert, 2023).

In many cases, HCPs had no prior contact with families and, while they wanted to honour their clients, they were unsure if family members would wish to have that aspect of their life represented at the funeral (O’Callaghan et al., 2023). Similar trepidation emerged from peers who use drugs (O’Callaghan & Lambert, 2024; Wojtkowiak et al., 2019), who felt out of place at funerals or stigmatised based on their association with drug use. In other instances, there can be positive interactions, as Templeton et al. (2016) reported that some families talked about the value of meeting peers at funerals, and seeing how their loved one was appreciated. Navigating the complex intersection of these relationships compounded grief outcomes as it added an additional concern for the bereaved in an already excessive emotional load.

Research efforts have begun to explore how these various social contacts relate, such as Løseth et al. (2022), who explored how HCPs related to the bereaved following a DRD and reported that professionals should be trained to understand DRDs as complex deaths that require specialised support and compassion. This thesis adds a profound contribution to understanding that throughout each of these interactions, each person is grieving and contending with unique levels of stigma. The multifaceted nature of the social context highlights the need for integrated care models that address multiple levels of social bereavement. A comprehensive and integrated care model that works towards the enrichment of communities and supports all affected parties in the aftermath of a DRD can help to mediate complex encounters between those who are grieving, creating a culture of compassion, respect, and mutual understanding.

10.3 Practical Contributions

The findings address a gap in the growing evidence base surrounding familial bereavement by exploring posttraumatic growth in the context of intra-group dynamics. Understanding group processes in coping with bereavement, while considering the synchronous individualised mechanisms within family structures, provides valuable knowledge for the enrichment of therapeutic interventions. The integration of these findings into support structures can help to accelerate family journeys to posttraumatic growth in an evidence-informed and context-sensitive manner. Furthermore, with consideration for how group members grieve in different ways, the findings delineate scope for adaptive bereavement support pathways that support bereaved family members at both an individual and group level.

By extending the scope of the research beyond the family system, this thesis also initiates important considerations for those impacted by DRDs in a broader social context. In highlighting the psychosocial health correlates of drug-related bereavement for HCPs, the findings demonstrate complex grief reactions in staff that are distinguishable from other forms of client loss. Thus, the empirical work identifies a space for targeted bereavement supports in organisational structures. The integration of strategic enhancements to address drug-related complications within grief support can improve their capacity to process loss, subsequently mitigating against health and practice risks such as burnout and PTSD.

The research also appeals for the recognition of grief within communities of people who use drugs, identifying profound grief reactions consequential of grieving a

stigmatised loss within a stigmatised community. Overall, the findings expound the urgent requirement for prompt crisis response protocols in community settings when a death occurs, with the immediate aftermath of a DRD as a critical period for intervention. In sharing the voices of people who were bereaved by a DRD while in active addiction themselves, there is a clear need to integrate bereavement support within addiction treatment and social work structures. These findings contribute to an increased understanding of the intricacies of their experience, which can augment the precision of response strategies to address the intersection of grief, trauma, and addiction.

By exploring the social, psychological, and health outcomes of drug-related bereavement across three impacted groups, the empirical work provides a holistic insight into the experiences of the bereaved across multiple intersectional social contexts. In applying the dual process model of coping with bereavement as a mechanism to portray the challenges to adaptation (Stroebe & Schut, 1999, 2010), the work presented in this thesis provides a theoretically grounded conceptualisation of drug-related bereavement. Through this lens, the research provides critical and foundational evidence for the integration of education, training, and support across organisational practice and communal support frameworks. Improving standards of evidence is fundamental to the provision of appropriately tailored services (Zisook & Shear, 2009), and targeted supports that address the unique complexities of drug-related bereavement are imperative. Fundamentally, this thesis honours the lives of those who have died while recognising that human loss evokes grief-responses regardless of the circumstances.

Table 10.1 presents a list of practice recommendations to support the bereaved through an integrated care model.

Table 10.1

Practice Recommendations for Integrated Care Model

Families	• Strengths-based supports that build self-compassion. • Public health campaign that signposts the bereaved to specialist services. • Out-reach and in-reach peer support networks with other DRD bereaved family members.
Healthcare Professionals	• The integration of DRD bereavement supports in organisational structures that recognise and address the personal impact of client deaths. • Pro-active responses from management structures. When there is a DRD in the service, it is immediately acknowledged, and staff are given the supports and space required.
Peers in Active Addiction	• Crisis response protocols that recognise the increased risk of death for peers. • The integration of bereavement support into treatment programmes.

10.4 Directions for Future Research

This thesis encapsulates a broad spectrum of social groups who experience profound grief symptoms when a DRD occurs within a community. However, this cohort is not exhaustive, and further research is required to discern other social groups who may be impacted by these losses. Throughout the various interviews conducted during this research process, participants anecdotally referenced other groups who may have connections with people who use drugs or be the first to discern that someone is at risk of overdose. A community mapping exercise would identify such groups (e.g. ex-partners, front office staff for services, maintenance and cleaning personnel).

Additionally, it is important to examine individual grief experiences within subgroups of each population and the role if any of other identities such as class, ethnicity, gender and sexuality. For example, some research to date has examined the bereavement experiences for specific individual identities within family structures, such as parents (Feigelman et al., 2020; Sterling et al., 2022; Titlestad et al., 2020) and siblings (Dyregrov et al., 2022; Lorås et al., 2022; Meen et al., 2024) and partners (Standing et al., 2019) of the deceased. Furthermore, young children who lose a parent, legal guardian, or other loved one to a DRD are critically underrepresented in the literature. This is critically important, with consideration for the association between adverse childhood experiences and negative long-term health outcomes (Dube et al., 2003). In a recent systematic review, Reime et al. (2024b) examined support processes for children bereaved by a substance-related death or suicide. However, within their inclusion criteria they found no studies that addressed support after a substance-related

death. Evidently, there is a significant knowledge gap regarding grief experiences in young children and their support needs.

With respect to intra-group differences, HCPs who participated in the empirical work for this thesis represented a broad range of professions and roles. While grief reactions were prevalent across social work, addiction support and recovery, and emergency medicine, and McAuley & Forsyth (2011) found no significant differences in self-reported grief reactions across different healthcare sectors, variance did exist (O'Callaghan & Lambert, 2022). Thus, it is also important to understand how HCPs can be supported within the organisational frameworks in which they are situated. For example, voluntary sectors and private healthcare sectors have varying levels of employee assistance programmes.

The comparative outcomes of families who were aware and unaware of their loved one's drug use has not been extensively explored beyond da Silva and colleagues' (2007) study. Furthermore, exploring the intricacies of bereavement from a DRD consequential of recreational use is also an under-explored venture in the research. Drug use is a multifaceted health issue, and it is also important to consider those who may be engaged in recreational levels of drug use, as families may have to cope with several unique complexities in their bereavement.

Exploring the intricacies of posttraumatic growth for family members bereaved by a DRD provided crucial insights into the healing processes which can be facilitated by targeted service provision. While Chapter 6 and Chapter 9 provided critical evidence surrounding the bereavement experiences of HCPs and peers, future research endeavours should seek to build on this evidence by exploring posttraumatic growth

within these populations. In doing so, the findings would build towards a more comprehensive evidence base that can inform holistic services to address both complicated grief and posttraumatic growth following a DRD in diverse social contexts.

10.5 Strengths and Limitations

This thesis was supported by a strong foundation of community-based engagement and consultation. The published work represents the only work published on this topic in Ireland, and it also adds to a small body of international literature, therefore the work sets the foundations of the knowledge base on the topic. In exploring the sensitive topics of death and bereavement in a context that is predominantly stigmatised by societal beliefs and legislative structures, engaging experts in the design process supported the cultivation of an empathetic and psychologically sensitive approach. It also ensured the findings of this PhD are directly applicable to the populations involved. As a critically under-researched area of inquiry, the use of qualitative approaches to work with participants is significantly beneficial of humanising the experiences of the bereaved. In terms of research for impact and visibility purposes, this is a critical benefit in terms of sharing unheard voices. Equally, the development of quantitative measures or prevalence data may be useful for translating findings directly to policy.

The utilisation of a more thorough and systematic definition of posttraumatic growth in the study design of Chapter 4 to would serve to ground the findings more theoretically within the posttraumatic growth literature. While the study succeeded in highlighting key examples of posttraumatic growth in DRD bereaved families, framing

these findings directly within Tedeschi & Calhoun's (2004) theoretical constructs would provide a more deductive framework for posttraumatic growth following a DRD. As such, the findings in Chapter 4 produced a more dynamic perspective that warrants further inquiry.

A more culturally diverse sample may assist in understanding critical details associated with bereavement. Exploring DRDs in the context of ethnic minority groups may highlight unique contextual factors that were omitted from the current thesis.

10.6 Thesis Reflection

I was confident, until I wasn't.

Prior to beginning this PhD, I had completed a master's in applied psychology and achieved a first-class honours degree. Afterwards, I took some time out from education and worked on six different research projects across four different organisations in addiction, homelessness, intellectual disability, and social policy. This experience gave me a strong grounding in issues related to social inclusion, and cemented my view that research was the route I wanted to pursue in my professional career. Having developed a multidisciplinary skillset grounded in the production of impactful research, I felt fully prepared to engage with this PhD programme and approached it with a confidence I felt I had earned. After all, up to this point my skills as a researcher had consistently grown to match each challenge placed in front of me; I was ready for my next endeavour.

Early on into my PhD tenure, my confidence took a hit. Everything I thought I knew about ethical research practice was eroded by the COVID-19 pandemic and,

suddenly, the skills I had developed felt nullified. While this situation presented its own significant challenges for my work, addressed in Chapter 7, the psychological fallout from that period is something that I carried with me for the duration of the PhD. To me, it felt like I was starting from scratch. I found myself increasingly frustrated with my struggle to build myself back up and approach the work with the confidence and integrity I had worked so hard to develop. The frustration was manifesting internally, and as everything slowed down around me, I began to question my potential to make an impact and make change for those who needed it.

Sometimes, in academia, it's very difficult to see the transferrable impact of the research you produce. Change takes time, and this research was a very sharp contrast to the teaching work I was doing simultaneously, which operates on a more instant gratification and on-site feedback manner. Thus, during my internal difficulties with my academic confidence, I found myself leaning further into that side of my work to offset my concerns about my value as a researcher.

It was upon meeting the participants in my research that I was reminded, "this is why I do it." Working with people who have experienced such profound and traumatic losses and learning that I was often the first person who asked them about these experiences acted as a significant motivator for me to continue the work. Taking my last empirical study as an example, I worked with six individuals who had been in active addiction at some stage in their lives, some of whom quite recently completed treatment. During interviews, I had these wonderful, kind, intelligent and motivated individuals sharing such traumatic experiences. Months prior, they were shunned by society. The

stories of growth stuck a chord with me, reminded me that I am in a privileged position to be able to share their voices.

Despite the challenges, I know now that I have grown significantly as a researcher because of them. In this PhD alone, I have added 4 publications to the academic literature in a field that is so severely underrepresented. I have worked hard to develop my research and teaching practice through participation in modules specifically catered to teaching, learning, and qualitative analysis. I utilised multiple qualitative methodologies throughout this thesis, upskilling my ability to apply appropriate frameworks to psychological research. Through increasing my academic profile, I have formed connections that will support my endeavours to make positive change for marginalised populations as I progress in my career. Upon completing this PhD, I now understand that there is very little I would change. Every personal and professional challenge I have experienced to date has cultivated the passion and drive I now carry with me to pursue a career in academia.

10.7 Conclusion

Drug-related deaths continue to persist as a source of hidden harm for those who are left behind. Communities and services need to recognise that the profound impact of a single death can reverberate across a broad social context. This not only speaks to the impact of grief, but also to the value of the human who lost their life. This thesis appeals for the sociocultural shift towards recognising the link between addiction and trauma, acknowledging addiction through the lens of healthcare and building a community of support for people who grieve such untimely and preventable deaths.

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Appendix I: Articles Selected for Full-Text Screening (Chapter 2)

Empirical Research Selected for Full-Text Review

No	Publication Details	Sample Details	Method	Details of Deceased
1	Guy 2004 United Kingdom	4 Family Members	Interviews x4 No statement of analysis	3x Male, 1x Female
		Mother, Grandfather, Sister, Father 2x Male, 2x Female		
2	da Silva; Noto; Formigoni 2007 Brazil	6 Family Members	Interviews x6 Content Analysis 2 categories: i) those who knew about drug use and ii) those who were not aware	5x Male, 1x Female
		Mother x2, Father x2, Sister x2 3x Male, 3x Female		
3	Guy; Holloway 2007 United Kingdom	3 Family Members	Interviews x3 No statement of analysis	2x Male 19yrs & 19yrs, 1x Female 21yrs
		Father x2, Mother x1 2x Male, 1x Female		
4	Feigelman; Jordan; Gorman 2011 USA	571 Family Members 48 bereaved by a DRD	Surveys Comparative analysis: drug deaths, suicide, other traumatic deaths, natural deaths	

5	McAuley; Forsyth 2011 Scotland	65 Healthcare Professionals Health sector (52%); social work (28%); voluntary (20%) 43% Male, 57% Female	Surveys Primarily reports frequencies, means, SDs	75% Male, 25% Female, largest proportion between 24-34
	Valentine; Walter 2015 England & Scotland	6 Family Members Daughter x2, Brother x1, Niece x1, Mother x2 1x Male, 5x Female	Interviews x6 Thematic Analysis	
7	Nowak 2015 USA	8 Parents Mother x6, Father x2 2x Male, 6x Female	Interviews Grounded Theory	7x Male, 1x Female, 18-27yrs
	Templeton; Ford; McKell; Valentine; Walter; Vellemen; Bauld; Hay; Hollywood 2016 England & Scotland	106 Family Members and Friends (some interviewed as couple) Parent x56; Child x21; Partner x13; Sibling x13; Friend x6; Niece x3 27x Male, 79x Female	Interviews x100 (majority 1-1, some with couples) Thematic analysis with a grounded theory and IPA approach	79x Male, 23x Female Mean Age (England) = 41 Mean Age (Scotland) = 33

9	Templeton; Valentine; McKell; Ford; Vellemen; Walter; Hay; Bauld; Hollywood 2017 England & Scotland	32 Family Members and Friends Mother x19; Father x4; Friends x4; 3x Siblings; 2x Partners 9x Male, 79x Female	Interviews x30 Thematic analysis with a grounded theory and IPA approach	28x Male 1x Female Age rang approx. 17-43, majority aged 21-29
10	Walter; Ford; Templeton; Valentine; Vellement 2017 England & Scotland	106 Family Members and Friends Parent x56; Child x21; Partner x13; Sibling x13; Friend x6; Niece x3; 27x Male, 79x Female	Interviews x100 (majority 1-1, some with couples) Thematic analysis with a grounded theory and IPA approach	79x Male 23x Female Mean Age = 38
11	Valentine; McKell; Ford 2018 England & Scotland	106 Family Members and Friends, 40 Practitioners Parent x56; Child x21; Partner x13; Sibling x13; Friend x6; Niece x3; 27x Male, 79x Female Police, Coroner, Family Support, NHS, Funeral, Government, Media, Clergy 16x Male, 24x Female	Interviews with families x100 (majority 1-1, some with couples) Focus groups with practitioners x6 Thematic analysis with a grounded theory and IPA approach	5x Male 1x Female

12	Cartwright 2019 United Kingdom	20 people bereaved by a DRD Mother x7; father x2; 3x partner; 2x siblings; 2x daughter; others 4x Male, 16x Female	Interviews 1-10 scale about quality of counselling Thematic analysis with iterative categorisation	18x Male 2x Female
	Wojtkowiak; Vanherf; Schuhmann 2019 The Netherlands	10 people who use drugs bereaved a social contact's DRD 10x Male	Interviews Grounded Theory	Overlapping identities: 7x friends, 2x girlfriends, 1x female friend, 1x uncle, 1x cousin, 1x colleague, 1x fellow user, 1x acquaintance
14	Christiansen; Reneflot; Stene-Larsen; Hauge 2020 Norway	8730 Parents Fathers x3707; Mothers x4663	Collected from Norwegian Central Population Register from 1986-2015 Cox regression models	
	Feigelman; Feigelman; Range 2018 USA	11 Parents Fathers x9; Mothers x2	Interviews Chronological reporting of findings	10x Male 1x Female Mean age = 26.8yrs

16	Templeton 2020 United Kingdom	4 Practitioners; gender not stated 6 Family Members; 6x female	Practitioners utilised adapted version of 5-step method to support family members + 13x interviews	4x Male
				2x Female 3x in 30s, 1x in 20s, 1x in 50s, 1x unknown
17	Titlestad; Stroebe; Dyregrov 2020 Norway	14 Parents 7x Male, 7x Female	Interviews Reflexive Thematic Analysis	10x parents had lost a son, 4x parents had lost a daughter Age range 19yrs to 45yrs Mean age = 27.36yrs
18	Titlestad; Mellingen; Stroebe; Dyregrov 2020 Norway	14 Parents 7x Male, 7x Female	Interviews Reflexive Thematic Analysis	10x parents had lost a son, 4x parents had lost a daughter Age range 19yrs to 45yrs Mean age = 27.36yrs

Review Articles and Documents Selected for Full-Text Review

No	Publication Details	Sample Details	Type of Report	Type of DRD
19	Turnbull; Standing 2016 United Kingdom	Drug and alcohol bereaved	Academic Report	Drugs and alcohol
20	Valentine; Bauld; Walter 2016 United Kingdom	Families	Scoping Review	Drugs and alcohol
21	Standing; Dickie; Templeton 2019 United Kingdom	Bereaved partner	Review of findings from 2 other studies	Alcohol
22	Yule; Levin 2019	Healthcare Professionals	Literature Review	Drug overdose
23	Titlestad; Lindeman; Lund; Dyregrov 2019 Norway	Families	Systematic Review	Drug-related deaths
24	Urmanche 2020	Healthcare Professionals	Literature Review	Drug-related deaths

Dyregrov; Møgster; Løseth;			
25	Lorås; Titlestad	Family and close friends	Review & Think Piece
	2020		Drug-related deaths
Norway			
Excluded due to limited or restricted access: <i>Valentine (2017); Valentine (2018); Hartmann (2018)</i>			

Appendix II: Interview Schedule for Chapter 4 as per Lambert et al. (2021).

The interview schedule was developed, and interviews conducted, by the first author and took place in the family home or in the office of the National Family Support Network (NFSN). I then conducted a secondary data analysis on this data for the purposes of this thesis. Five core questions formed the basis of the interview schedule, and the semi-structured nature of the interview allowed for the exploration of topics of interest as they emerged. Interviews ranged from 1 hour and 11 minutes to 2 hours and 40 minutes. Several weeks following the interview, participants were sent a feedback sheet by which they could provide comments on their experience of the interview process.

Interview Schedule:

1. Can you tell me a little about yourselves?
2. What do you think are the impacts on your family of experiencing a drug-related death?
3. Do you think your experiences are the same or different to those who lose a family member in other ways?
4. Have you any recommendations for what is needed to support families who have experienced this loss?
5. On a scale of 1–10, how difficult was this interview for you?

Appendix III: Interview Schedule for Chapter 6 and Chapter 8

Interview Schedule

1. Can you speak about your role?
2. Can you talk about the clinician/staff-client relationships you form throughout your work?
3. Can you tell me about your experience with drug-related deaths in your practice?
 - a. How do you understand these deaths to be distinguishable from other death causes in the social care domain, for example death by suicide?
4. Can you detail past experiences of drug-related deaths that have impacted you on a professional, personal, or other level?
 - a. Was there a large emotional impact attached to the drug-related death of a client?
 - b. Managing fear of possible death prior to drug-related death?
 - c. How did you manage in the aftermath?
 - d. Have you created any personal methods to help deal with possible emotional difficulty?
 - e. Confidence in professional role?
5. On a personal level, and given the demands of healthcare, do you find space to process such losses if required?
 - a. Do you feel that families are well-supported in the aftermath of a drug-related death?

- b.** How do you find other clients react to the drug-related death of a fellow service-user, and is there difficulty in managing this as a professional who may also have been emotionally impacted by the death?
- 6.** Are you aware of current protocols and supports available to you as a front-line worker in the event of drug-related client loss?
 - a.** Is there a current organisational protocol in place? (e.g team debriefings, quality assurance?)
 - b.** Should current protocols be adapted in order address the compounding variables associated with a drug-related death?
 - c.** Would training be beneficial for staff in this context?
- 7.** Reflecting on your experience with drug-related client loss, are there any supports you feel would have been beneficial that were not available at the time?
 - a.** What works for you?
 - b.** What could be improved?
 - c.** Has there been times where you felt you could have been more supported?
- 8.** Can you tell me about how things were affected during the COVID-19 closure?
- 9. Any other comments?**

Appendix IV: Interview Schedule for Chapter 9

Interview Schedule

1. Can you tell me about the relationships you had, or formed, with others during your active addiction?
2. Can you tell me about your experience with drug-related deaths?
 - a. Emotional impact?
 - b. Frequency?
3. As someone who was experiencing addiction at the time, what did this/these deaths mean to you?
 - a. Can you talk about how this affected your (social) world?
4. How did you notice your social interactions were impacted or changed following a death?
 - a. Staff?
 - b. Peers?
5. Can you tell me about any supports, formal or informal, that were available to you in the aftermath of a death?
 - a. Can you talk about how you dealt with these losses?
 - b. What could be improved for those who are currently in similar situations?
6. **Any other comments?**

Appendix V: Published Article from Chapter 4



Death Studies



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Posttraumatic growth following a drug-related death: A family perspective

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Posttraumatic growth following a drug-related death: A family perspective

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ABSTRACT

This paper explores the experience of posttraumatic growth in families who have lost a family member to a drug-related death. Seven family units (17 participants) were interviewed, and interviews were analyzed using reflexive thematic analysis. Analyses revealed themes that reflected positive adaptation and growth, including (a) reframing the loss, (b) open dialogue and social support, and (c) reclamation of purpose. Themes are presented in this paper for their pertinence in understanding how best to negotiate adaptation through complicated grief. The paper concludes that posttraumatic growth can occur once families begin a process of acceptance and receive support through the journey.

Introduction

Positive adaptation following the loss of a loved one is a deeply personal journey influenced by diverse personal characteristics and environmental factors (Jordan & Litz, 2014). The grieving experience is inherently complicated, and healing trajectories can be shaped by an individual's existing or underlying vulnerabilities, relationship to the deceased, gender, age, social supports, spirituality, and the cultural script that guides their society (Kaltman & Bonanno, 2003; Tedeschi & Calhoun, 2004). Research suggests that "normative" grieving patterns begin with intense emotional reactions that begin to reduce after six months (Zisook et al., 2010), but the circumstances surrounding death play a significant role in determining the trajectory of the healing process and, consequently, adaptation strategies.

As the nature of a death can influence adaptation following a loss, traumatic deaths may lead to an increased risk of complicated grief. Traumatic deaths refer to deaths that occur with a degree of suddenness or violence (Feigelman et al., 2012) and may be perceived as preventable (Tay et al., 2016), where the untimely or violent nature of the death may leave the bereaved paralyzed by grief, anxiety, or intrusive flashbacks (Bonanno et al., 2008; Neimeyer, 2006). Such complicated grief does not typically remit over time, preventing a person from accommodating their

bereavement (Lambert et al., 2021; Tobin et al., 2020) and placing them at risk for prolonged grief outcomes such as depression, anxiety, and post-traumatic stress (Bonanno et al., 2008; Tedeschi & Calhoun, 2004). Within traumatic death literature, a systematic review by Titlestad et al. (2019) identified families bereaved by a drug-related death as a critically understudied group who are at a considerable risk for complicated grief. Furthermore, this population also reported more severe mental health difficulties than those bereaved by accident or natural deaths.

DRDs (Drug-Related Deaths) are deaths that occur due to the intake of narcotics, or a result of violence, suicide, or infectious disease (Titlestad et al., 2019). These losses are often very abrupt, and the positioning of drug dependence as a criminal activity within many sociocultural contexts can result in a disenfranchised grief that is not socially sanctioned, openly acknowledged, or met with social sympathy (Doka, 1999; Feigelman et al., 2020). Many families struggle to find meaning in such loss as outcomes including stigmatization, guilt, self-blame, and a lack of support from family and peers compound their sense of disenfranchisement (da Silva et al., 2007; Lambert et al., 2021; Neimeyer, 2006). Furthermore, Christiansen et al. (2020) reported that parents bereaved by DRDs have a higher natural cause mortality rate than those bereaved by other causes of death and face an increased risk of death by suicide and substance

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dependence during the most intense stages of grief. Additionally, Lambert et al. (2021) found that families attributed physical illness outcomes to the combined stress of living with active drug use and navigating the emotional complexities of the loss.

While there is limited literature to date, two studies have engaged with family members bereaved by DRDs to understand their pathways to healing and adjustment. In Norway, a study by Titlestad et al. (2020) examined how parents bereaved by DRDs advanced emotionally following the death of their child. The authors interviewed 14 parents bereaved by DRDs and used reflexive thematic analysis to explore their coping experiences. Participants stated that going back to work, ceasing to blame others, and permitting themselves to grieve facilitated overall positive adaptation. Participants also stated that recognizing and avoiding some triggers (places and things associated with the deceased) was an adaptive coping strategy. Similarly, Feigelman et al. (2020) interviewed 11 family members bereaved by DRDs in the United States where posttraumatic growth occurred following acceptance and open disclosure of the nature of the death to others. However, those who had experienced healing were only able to do so after many years as the complex outcomes associated with DRD bereavement can impede coping strategies.

Recent research efforts exploring bereaved parents who use meaning making as a process to cope with traumatic child loss from chronic illness have shown that meaning reconstruction can facilitate posttraumatic growth (Dutta et al., 2020). Meaning making typically involves understanding the value of one's life after death, making sense of the loss, and finding purpose (Martela & Steger, 2016). In the context of DRDs, both Titlestad et al. (2020) and Feigelman et al. (2020) identified meaning making as a positive process of adaptive rumination, which assists families in understanding complex emotional reactions. These studies highlight the early intense grief stages as a critical period for intervention, which supports findings by Christiansen et al. (2020) who identified an increased risk of external mortality for families bereaved by DRDs during this period. Social support can buffer against the pathogenic effects of distress, grief, and isolation by promoting feelings of safety, connectedness, and intimacy (Cohen & Wills, 1985; Doka, 2002). In contrast, family members bereaved by DRDs often feel isolated, misunderstood, and disconnected from their community and their family (Lambert et al., 2021; Titlestad et al., 2019).

The findings from Titlestad et al. (2020) in Norway and Feigelman et al. (2020) in the United States have provided an in-depth understanding of the healing trajectories of families bereaved by DRDs with international implications. In 2021, Lambert et al. conducted a study examining DRD bereavement in an Irish context. The study explored the impact of complicated grief on the family system and intra-family dynamics following the DRD of a family member. The authors interviewed multiple members of each family together, and highlighted outcomes such as familial relationship breakdown, the renegotiation of relationships, family shame, and isolation from their community. On an individual level, the study reflected international findings that highlight stigma, helplessness, internalized feelings of shame, guilt, and physical health difficulties as outcomes (Lambert et al., 2021; Titlestad et al., 2019). However, while the Irish study demonstrated the negative social and health implications of a DRD, it did not highlight potential healing trajectories for these families.

The current study aims to examine how the families interviewed by Lambert et al. (2021) engaged in positive adaptation and experienced posttraumatic growth following the DRD of a family member. According to the European Monitoring Center for Drugs and Drug Addiction (EMCDDA, 2021, p. 17), an expert-led network which collects data and analyzes information to provide an evidence-based overview of European drug trends, total DRDs in Ireland are now twice above the European average. Research has highlighted that these families require more robust policies to challenge stigma and provide early intervention for their unique grief (Lambert et al., 2021). Understanding the key facilitators to positive adaptation for families following the loss of a loved one in an Irish context will help inform appropriately targeted family-based interventions and individual supports concerning Irish policy and best practice, while also aiming to inform interventions on an international level.

Materials and methods

Approach

The current research is part of a study by Lambert et al. (2021) which examined the impact of DRD bereavement on families in Ireland. In this paper, we investigated how the families recruited and interviewed by Lambert et al. (2021) experienced posttraumatic growth following a DRD, aiming to provide a phenomenological understanding of potential healing

Table 1. Demographic and essential participants' details.

	Participant	Time (years) since bereavement	Relationship to the deceased
Interview 1	1	1	Mother
	2	1	Brother
Interview 2	3	9	Sister
	4	9	Father
Interview 3	5	27	Father
	6	27	Mother
	7	27	Sister
Interview 4	8	13 and 5	Father
	9	13 and 5	Mother
Interview 5	10	21	Mother
	11	21	Sister
	12	21	Niece
Interview 6	13	9	Mother
Interview 7	14	3	Mother
	15	3	Niece
	16	3	Sister
	17	3	Sister

trajectories. In identifying an appropriate qualitative framework, we wanted to ensure that the family unit, at the center of the phenomenon, was the primary focus. Furthermore, we wished to consider the personal nature of bereavement and the individualized impact of disenfranchised grief. As such, reflexive thematic analysis emerged as a tool to explore common patterns and experiences across the data, while also allowing the authors to account for potential biases throughout the process (Braun & Clarke, 2019).

Participants & sampling

As per Lambert et al.' (2021) recruitment, this study included 17 family members bereaved by DRDs representing seven families across seven interviews (Table 1). As a method of purposive sampling and to ensure transferability of the findings, contact with an independent organization, which supports families affected by drug dependence, facilitated the recruitment process. Staff within the organization approached family members with information leaflets including details of the study's aims and the professional qualifications of the interviewer. Family members subsequently self-selected to contact the research team by phone, by email, or allowing a staff member to contact the team on their behalf. Those who expressed such interest received a detailed information pack inviting them to participate. These packs outlined the study parameters, potential uses of their anonymized data, the role of the research team in working with the data, and information about their role in the interview process. All who received this information pack decided to participate and invited members of their own family to be involved in a focus group interview. There were no incidents where

participants sought to withdraw from the study at any point.

As primary inclusion criteria, participants had to be active members of a family support organization, and to have experienced the DRD of a family member. In line with the requirements of the ethics committee at the researchers' home institution, persons who were under 18, recently bereaved (under twelve months), and those who disclosed an active addiction or mental health issue were excluded from the recruitment process. Follow-up support services from the support organization were available to any participants who wished it after taking part in the research.

Participants included four males and thirteen females, (six mothers, three fathers, one brother, five sisters and two nieces). The study investigated the deaths of seven men (two of whom were brothers) and one woman, between the ages of 19 and 46. Four deaths occurred by accidental overdose involving opiates and benzodiazepines and three were suicide by hanging. At the time of interview, time since death ranged from one year to 27 years. One family was from the south of Ireland, two from the southeast, and four from the east.

Data collection

As per the methodology of Lambert et al. (2021), a semi-structured interview schedule guided six focus group interviews alongside one in-depth individual interview with a mother parenting alone. Six interviews took place in the family home, and one occurred in the office of the support network. The semi-structured nature of the interview allowed for the exploration of unanticipated topics while ensuring thematic consistency across cases. The interview schedule contained five open-ended core questions

that were supported by general interview protocol such as paraphrasing, follow-up questions, and prompts: (1) "Can you tell me a little about yourselves?" (2) "What do you think are the impacts on your family of experiencing a drug-related death?" (3) "Do you think your experiences are the same or different to those who lose a family member in other ways?" (4) "Have you any recommendations for what is needed to support families who have experienced this loss?" and (5) "On a scale of 1–10, how difficult was this interview for you?"

Adopting this flexible interview format allowed participants to provide a continuous narrative about their experiences at a comfortable pace. Overall, the interviews provided information about the impact of experiencing a DRD, challenges, supports, and future recommendations. However, a recurring, yet unanticipated, concept that emerged throughout the data was the journey of healing which highlighted how families had adapted in the time since death. Interview lengths ranged from 1 hour and 11 minutes to 2 hours and 40 minutes. The second author conducted all interviews and used a recording device to record the interviews, which were subsequently transcribed verbatim.

Data analysis

The analysis followed Braun and Clarke's (2019) framework for reflexive thematic analysis with findings presented in adherence to O'Brien et al. (2014) standards for reporting qualitative research. All authors have experience in working with marginalized populations and we considered this methodology as the most systematic, yet flexible, tool to bring our skills and values in research to the data. The authors followed six steps as recommended by Braun & Clarke's protocol: (1) familiarization with the data, (2) coding the transcripts, (3) generating initial themes, (4) reviewing emergent themes, (5) defining the themes, and (6) writing up the findings. At times, there was back-and-forth movement between phases when discussions encouraged revisions of certain emerging concepts. To ensure credibility, transferability, confirmability, and dependability of the results, we followed recommendations cited in the four-dimension criteria for assessing rigor in qualitative research outlined by Forero et al. (2018).

All authors familiarized themselves with the data by reading and re-reading the anonymized transcripts. The first and third author coded the transcripts utilizing NVivo qualitative analysis software and adopted a-priori approach to deconstruct the data and develop nonhierarchical codes, followed by a second round of

coding. To ensure dependability and inter-coder reliability, this process was followed by open discussions between the first, second, and third authors about the coding, potential discrepancies, and how to synthesize the codes across the entire data set. As new codes began to decrease in frequency over time, all authors made an informed decision that data saturation had been achieved. The authors moved to initial theme generation with specific focus on any required changes, additions, or biases. Through rigorous reorganization, initial codes from all transcripts transitioned into preliminary themes. All authors reviewed and named the themes, and the first author drafted the report with input and feedback from each coauthor.

Roles and reflexivity

In line with Dodgson's (2019) recommendations for qualitative research, we adopted a reflexive approach to the analysis to ensure that the process was confirmable, clear, and methodical. Prior to coding the data, all authors met to discuss and reflect on the anonymized transcripts. This discussion encouraged an open dialogue about how our experiences may influence our thoughts, pre-formulated assumptions, and ideas about the content. To reinforce the credibility of the analysis, the authors who coded the data wrote reflective memos and journals to keep a record of emerging thought processes. Each coauthor brought individual experiences to the research team, and to account for potential influences in interpretations, we engaged in reflective practice to minimize the risk of biased analysis.

As drug use is a sensitive topic often associated with criminality, we ensured that the terminology used in the coding and write up was sensitive, appropriate, and non-stigmatizing. The second author conducted all interviews, as they have professional experience working therapeutically with families through addiction services. To augment the credibility of the research process, this individual was considered the most suitable to conduct sensitive interviews while being cognizant of their own prior assumptions. This researcher was the only person present alongside the participants during interviews, and peer debriefing occurred during initial discussions about the data.

To understand bereaved families' experiences with participating in engaged research, and to continue to develop suitable practices, participants were given an opportunity to provide feedback on the research process. The feedback was exclusively positive as

participants spoke appreciatively of the therapeutic value of the interviews: "It was most positive for me as I bottled a lot of anger and resentment over the death of my son, and this was the first time that I ever spoke about his death openly," and about the opportunity to potentially help other families through their own experience: "The most positive aspect for me was the knowledge that recounting my son's life and death might in some way help in the future."

Ethical considerations

The departmental ethics committee within the authors' home institution granted ethical approval for this research. All components of the research process adhered to the guidelines within the Code of Ethics of the Psychological Society of Ireland (PSI). All participants in this study were briefed, informed how their data would be used, provided informed consent, and offered follow up support network. Participation in this study was voluntary, confidential, and family members could withdraw from the study up to 6 weeks post-interview. Once the final report emerged, withdrawal from participation was no longer viable. Data for this research was stored in an encrypted data repository provided by the university.

Results

The analysis revealed varying degrees of individuals' posttraumatic growth in the aftermath of a DRD and identified three core themes: (a) Reframing the Loss, (b) Dialogue and Social Support, and (c) Reclamation of Purpose. The findings suggest that each of the participants experienced a profound sense of loss and pain following the death of their loved one, but most reported a sense of personal growth and healing. By making sense of the death through various active engagements, bereaved family members expressed that they were able to come to terms with the loss.

Reframing the loss

The period of active addiction before death was tumultuous for families. Years of uncertainty, stigma, and hopelessness permeated throughout the family system and left heavy emotional scarring as they lived in constant fear for the safety of their loved one, and sometimes for themselves. Following the death, this fear alleviated as the unpredictability surrounding the location of loved ones, issues with police, looming threats, and death began to fade. Participant 6

described finding comfort in knowing her son was now safer than he once was:

He could have ended up getting killed on the streets and he didn't suffer, so I am happy with that... I wouldn't have liked to have seen him found dead outside somewhere or over a lot of drugs or one thing or another.

Although she initially felt guilty about experiencing relief, all this mother truly wanted for her son was peace. She understood his life in addiction was painful for him and would not provide such comfort. As a mother, she experienced a prevailing sense of helplessness in this role that transformed to solace post-death in knowing her son was no longer suffering:

I am happy with where he is "cos, you know," if he was here and going on with heroin and the life that he was leading, I'd say he was going to end up in really bad crime and drugs and that. So, if he is where he is and in no pain and happy, sure that's all a mother wants for their kids.

In the data, there was a distinguishable difference between living one's life and simply trying to survive chaotic circumstances. Positioning loved ones in "a better place" and references to "God's will" was commonplace as family members drew on their faith to bring peace to their loved one, make sense of the death, and reach acceptance. Finding meaning in the loss in the context of fate also provided some solace for her husband (Participant 5). They had lost their son 27 years prior, and although the memory of the death remained, he was eventually able to reframe the loss in such a way that helped him transcend the grief:

I have come to accept (son's) death but maybe it was something that was meant to happen. His life wasn't going to change, you know? And I think he was happy to go... It was meant to happen or something, that's what I keep saying to myself.

This family's experience echoed many of the other participants' struggles with their loved one's active addiction. Families spoke about harrowing emotional experiences following the death, but they did find peace in knowing that their loved one's hardship, and the uncertainty about their health, had ceased. Participant 1's comments mirrored these sentiments: "I know he didn't want to die. But to me, I think he'd be happier up there because he wasn't going to have a good ending."

One father (Participant 4) only permitted himself to begin healing after a prolonged period of self-blame for his son's DRD. In holding himself accountable for the loss of his son, this father's guilt negotiated his

healing trajectory, as he did not consider himself within his own right to grieve. Nine years on, he eventually came to understand that his son's behavior was beyond his direct control. Over time and with the support of his daughter (Participant 3), a greater awareness unfolded that his son's death ended the associated hardships. This realization facilitated the eventual relief of his guilt and felt that even in his last moments; their son was trying to protect them: "Personally, I think that my son had an insight into where his life was going, and he didn't want to bring that to us. So, we lost him to the street, there's no two ways about that." As an overall family unit, they experienced posttraumatic growth by supporting each other, but the journey to self-acceptance was very much individualized even within the family structure.

Despite the emotional trauma associated with his son's addiction, Participant 4 managed to absolve himself of guilt and remembered his son with fondness. Such memory reconstruction was challenging for others as some participants struggled with identity fluidity. Conflicting memories of loved ones from life before addiction and the suffering experienced during addiction generated confusion when trying to reframe the loss. Efforts to align these versions of their loved one proved difficult for some, such as Participant 16: "You have to go back and pick out the bits you loved about him and knock out the other bits, that was very confusing." Emerging from this conflict was the concept of a double loss, where families felt they lost their loved ones to addiction and, consequently, experienced an exacerbated grief following their death. Participant 2 stated: "We always talk about this, she didn't just grieve for [our brother] when he died, she grieved for [our brother] when he went on drugs."

Dialogue and social support

Bereavement support groups, where the unique grief associated with a DRD was recognized, offered an empathic space where families could unburden their sense of shame and helplessness. Many found comfort through interaction with others who had experienced this unique loss and sense of seclusion. For Participants 8 and 9, parents who had lost two sons to DRDs, the support groups fostered a deep sense of resiliency, self-preservation, and vitality. This mother (Participant 9) demonstrated that as parents, they moved from prolonged self-blame toward healing after engaging in support groups:

We blamed ourselves for years but then through the family support we got a little bit of learning that it wasn't our fault at all... And I always say we are the lucky ones, because God knows where we would be today without the support we have gotten from the groups. You know people that have encouraged us to look at things differently, with a different view, and that's what we do.

Reframing the loss helped the family move toward positive adaptation, but family support groups mediated this journey. Both family members spoke at length about how the clarity and guidance they received helped them to navigate the painful journey of loss: "Dialogue, to us, is the most important thing." A key outcome of this engagement was that the parents found greater self-compassion, and Participant 8 reflected on recognizing the importance of their own well-being: "I am no good to anyone if I am not well. I can't do anything for myself if I'm not well, so our whole objective now is to keep ourselves as well as possible, so we keep going to our meetings." Opening a dialogue with other families created a space of deep reflection where different perspectives, sensitivity, and a culture of mutual understanding fostered posttraumatic growth.

Upon reflection, Participant 14 came to understand that constructing her entire world around intense support provision consumed her quality of life: "If you focus on your children all the time when they are in addiction, you are never going to get well yourself." However, the parental instinct to care for one's child took precedence, and many parents experienced a sense of failure, questioning their parental self-efficacy when their loved one passed. As acute stress had already compromised the health of many family members prior to the death, learning the value of prioritizing one's own health was instrumental to recovery. Engagement with support groups guided families through the process of rebuilding their sense of self-worth and strengthening familial bonds. Open dialogue and reflection facilitated the development of emotional practices to build resilience and maintain wellbeing during daily functioning. In gaining a new perspective and renegotiating their sense of self-worth, families were able to pass on the value of their reflections to others, as shown by Participant 3:

It brings great peace into your life. We often speak to people. We have had a bereavement group here for the last 4 years. We often say to people, when they realize that their children are not able to stay in this world anymore it is better for everybody, you know it's hard to come to that you know, to that realization but we have come to it. That they are not meant to

be there, their time to go you know and prolonging it doesn't really help.

Speaking to others in the groups who are all at various stages of their recovery cultivated a community of learning where people with similarly complex experiences could establish supportive relationships, validate their grief, and share coping mechanisms. Participant 17, who had lost her older sister three years earlier, described how she found "reassurance from hearing other people's stories." Participant 10, whose son passed away 21 years prior to the time of interview, showed considerable posttraumatic growth following engagement with bereavement services and reflected on the value these groups would have had at an early stage: "One good thing is all the work I've done on myself through the family support. I probably should have got that done 20 years ago." This mother still had unprocessed trauma even 20 years post-death and demonstrates that there are benefits to social support that cannot be offered solely by the passing of time.

Although group-based social therapy fostered post-traumatic growth for most families who were in a position to access it, the individualized nature of grief demonstrates that this solution may not work for everyone. Participant 6 expressed her personal discomfort with support groups:

I went but I didn't like it, for the simple reason I don't think [group member] should've ever mentioned her son's name. She should have never been telling us stories about her son. But yeah, that kind of group was all about that. When I found I was passing that same person on the street I'd say "Jesus I know all their business."

Her desire to keep details about the death confidential may reflect the stigma and shame that families burdened by their loved one's addiction must live with. For those who had not previously engaged with a bereavement group, the thought of having to speak openly about their anguish tempered their orientation toward counseling. Participant 6 mentioned that dealing with the grief was something done internally: "It's a struggle that a family has to work through themselves, there's no outsider can help you." Speaking about her distress magnified her sense of vulnerability and unease, particularly with respect to engaging in open dialogue about personal issues with strangers from the locality. Evident from her concerns, understanding how participants define their own parameters of anonymity is a crucial component of developing individualized support packages for individualized grief processes.

Reclamation of purpose

During their loved one's active addiction, one constant for family members among the uncertainty was their role as a parent, caregiver, or sibling. Fathers, mothers, and other family members found their identities and roles fractured by a loss that trapped them in cycles of guilt, but many participants demonstrated how they reclaimed and continued these roles in diverse ways. Through self-determination to maintain their identities post-death, many achieved a constructive reorientation of their grief experience to make sense of the loss and find a new purpose in life. Participant 1 spoke about how she continued her role as a mother, taking care of her son even after he had passed away: "I would drive out to the grave, it was like I was making his bed, I would pat the whole thing down and fix it and everything." As she continued to care for her son while conducting tactile actions to maintain her sense of maternal identity, this role constancy helped her to contend with grief.

While some conducted personal rituals in memory of their loved one, others channeled their energies into loss-inspired activism. Participants 10 and 11 (mother and daughter) cultivated a sense of purpose through advocacy work and drug awareness campaigns, where their new roles as activists served the dual purpose of honoring their loved one while also supporting them to find meaning in the loss. Participant 10 and her daughter reconstructed their lives by becoming proactive in their community, supporting others in similar circumstances, and creating a legacy in honor of their loved one:

I felt that I was doing something, for [my son]. Yeah, I just poured all my life into it...I was doing voluntary work up there for a year, family support up there for a year. I then got the job as [houseworker], and then they got funding for a family support worker, so I was doing that as well.

Over time, participants who attended group support services transitioned their roles and purpose within that framework from solely seeking support to concurrently providing support to others. Participant 8 reflected on how they used their stories and coping efforts as opportunities to support fellow attendees the way others had supported them in the past, developing a communal environment among people who felt isolated from their respective communities:

It reminds us of how important it is to stay well and maybe our story might help people and we might be able to encourage people, but we know ourselves [it's difficult] when somebody comes in and they are only starting off on their journey.

At the time of the interview, Participant 7 had not engaged in any advocacy work but spoke at length about her experience with her own addiction years prior. She stated that the death of her brother acted as a catalyst for her desire to use her first-hand experience of the different social supports to guide and mentor others through recovery:

I'd like to do that, to let people know that social workers are not there to hurt or harm them. I've been through a process. So, if an individual comes in now that's new, I can sit down and I can guide them the best I can and say try it this way. There is good information coming back from my mouth to them.

Forging a new identity by taking up new active engagements nurtured posttraumatic growth. Participant 5 spoke about the benefits of "breaking the cycle," where falling into inactivity and languishing made it difficult for him to transcend the loss and overcome his grief. He described intense mental anguish in the early years following his child's death:

I didn't handle it very well... I started drinking, not every day drinking that's not the way it was, but I was drinking more than I was, I felt I couldn't grieve the way I wanted to.

His family (Participants 6 and 7) emphasized the importance of participating in activities as it alleviated their own sense of helplessness and gave their life a sense of order. This value was pertinent in the case of Participant 6, as while she did not feel comfortable in family therapy, focusing on extracurricular activities provided her with a sense of purpose: "I'll tell you what I excelled with over the death as well—with crochet, because my whole focus is gone into it." She encouraged her husband to engage in similar activities, demonstrating an intra-family support network that was vital to recovery. This family experienced posttraumatic growth in diverse ways and at a different pace, but as a family unit they all engaged in other activities that they were passionate about, as Participant 5 highlights:

I nearly used to fish every day [before son's death]. I got to a stage one time it was like déjà vu. Every day was the same, day in day out, and I was getting depressed about [son's death], so I got my fishing rod and just threw it in... I did that for a few days to break up the monotony of every day being the same because I was doing everything the exact same every morning.

DRDs can result in the breakdown of family dynamics, but some of the participants in this study spoke about the strengthening of intra-family social bonds. With less emotional distance among family

members and a willingness to communicate openly, Participant 3 strengthened her bonds with her parents: "There are a lot of positives that came out of it. Like, I'm very, very close to mom and dad because of (brother's) passing as well." When speaking to her father in the interview she noted that he is more empathetic and emotionally available: "I think that a positive thing with you Dad is that you have softened, you are easier to talk to."

Discussion

The process of experiencing positive psychological change following the DRD of a loved one is multifaceted. Healing trajectories are impacted by unique compounding variables such as stigma, the cultural perception of drug use, and the preventable nature of the death (Lambert et al., 2021; Titlestad et al., 2019), and as research suggests that for every DRD, there are at least ten people directly affected (Dyregrov et al., 2020). As total DRDs in Ireland are now twice the European average (EMCDDA, 2021), the current study provided a crucial insight into the healing trajectories of families and aims to inform services about how to support this population at an early intervention stage. The most common tools that facilitated posttraumatic growth, as shown by the thematic analysis, included reframing the loss, opening a dialogue among social supports, and finding purpose following the death.

The amalgamation of acute stress from providing support during life and processing the death yields significant implications for how families cope in the initial grief stages, which Christiansen et al. (2020) identified as a critical period due to a substantial risk of negative health outcomes and increased mortality rates for the bereaved. Services should endeavor to assist families in making sense of the complex and unfamiliar emotional outcomes associated with DRDs. For example, families reported experiencing a sense of relief when their loved one passed, but this relief was initially enveloped in guilt and exacerbated by a sense of remorse for feeling this way. These findings coincide with previous research that reported some families experienced a similar sense of ambivalence in the aftermath of a DRD (da Silva et al., 2007). In struggling to understand and accept the complexities of their own emotions, family members were trapped in cycles of shame. More specifically, in the absence of support to provide guidance and clarity, it was unclear to them at first that this relief was stemming from having their loved one's peace at heart.

Finding peace for their loved ones was a priority for families. Death offered a stillness from the tumultuous nature of addiction, but families could not begin to process their own grief until they psychologically separated their loved one from chaotic circumstances. Many participants reframed their loss in the context of fate, with spiritual references to God and "a better place." While their personal sadness did not remit and remained intense, drawing on their faith to position their loved one in a happier place provided a sense of solace with their loved one's best interests at heart. For those who did not reference religion or spirituality, the fact that their loved one was at peace acted as a form of comfort. Using the various spiritual and emotional tools at their disposal was an essential component of posttraumatic growth and services should aim to support families in drawing from these. Closing this chapter acted as a catalyst for families to finally transition their priorities from their loved ones to themselves. This research was conducted in a predominantly Christian country and future research could examine how spirituality and religion within various cultures may facilitate positive adaptation with reference to how drug use is culturally perceived.

Social support has long been understood to be a protective factor against the negative health outcomes associated with complicated grief (Cohen & Wills, 1985; Doka, 2002), and Feigelman et al. (2020) found evidence of posttraumatic growth following open disclosure about the nature of the death to other people. The current study supports these findings as many families spoke approvingly about the incomparable value of social support. Opening a dialogue amongst other individuals and families bereaved by DRDs cultivated a judgment-free culture of understanding, empathy, and compassion. As family members bereaved by DRDs often feel isolated and disconnected from their community (Lambert et al., 2021; Titlestad et al., 2019), these support groups helped to legitimize their experience and foster a newfound sense of community. As documented by Lambert et al. (2021), some family members in Ireland, who were already experiencing isolation, were met with stigmatization when seeking social and professional support for a DRD. Therefore, it is of pivotal importance that the individual at the first point of contact within a service is cognizant of bereaved families' emotional complexities, and meets them with compassion, direction, and empathy.

Support between members of the same family proved valuable for participants, but family members

within the same unit often grieve in different ways. Lambert et al. (2021) reported that some families experienced a breakdown of relationships following the death. Intra family support that addresses complex needs and emotions in socially excluded populations should aim to be trauma informed with professionals educated in how to navigate the intricacies of family dynamics, assisting them in developing emotional tools to support one another during daily functioning. Within the development of targeted support frameworks, it is important to consider individualized response plans alongside familial projects as some participants felt uncomfortable about disclosing information in a group setting. All families in this study were registered with a family support network at the time of interview, but not at the time of death. National support efforts should consider how to bring practice-based frameworks to those who require it, especially considering some families in the current study reflected on how the knowledge of available supports and their value would have been beneficial to them many years ago.

The current study has also yielded similar findings to recent literature exploring the lived experience of bereaved parents who lost children to chronic illness (Dutta et al., 2020), where parents developed new meaning structures by positively reappraising their trauma through rituals and fostering a new outlook on life. Many of the successful coping strategies in the current study involved reclaiming a sense of what was lost after the death, such as parental/sibling identity, community participation, or emotional connection to the deceased. Reestablishing their identity was vital to positive adaptation, and family members maintained their bonds with their children through religion and physical actions such as candle lighting and grave maintenance. Others engaged in advocacy work to keep their loved one's memory alive. The value of rituals to empower one's sense of identity and purpose was a key finding of the current study and coincides with literature from other traumatic deaths (Dutta et al., 2020). Wheeler (2001) found that parents coped with the loss of their child to suicide by preserving memories, conducting rituals, and engaging in reflective processes to maintain bonds with their children.

For DRD bereavement, Titlestad et al. (2020) and Feigelman et al. (2020) specified meaning making as a tool for making sense of the loss. Martela and Steger (2016) suggest that people achieve meaning making when understanding that an individual's life matters, it has value, and that it has a broader purpose in life. By becoming active members in their own

community, engaging in new hobbies, or focusing on their own well-being, the pain of bereavement shifted from paralyzing to transformative as family members in the current study established a newfound sense of purpose. Some family members found their roles within support groups transitioning from simply being supported to providing support and guidance to more recently bereaved families. This new role helped them find meaning and purpose in the loss where they once felt disenfranchized.

Recent meaning focused narrative interventions have shown promise in supporting families living with a child with chronic illness (Dutta et al., 2022). While their research deals with pre-loss interventions for anticipatory grief, the framework has success in implementing a narrative e-writing tool through a therapist facilitated smartphone app to assist meaning-making processes for families. In improving psychological and spiritual wellbeing for families, the tool resulted in increased hopefulness for their own future and the quality of social support available to them. Given some of the similarities between positive adaptation strategies for DRDs and other traumatic deaths, future research could seek to conceptualize a similar support tool for families bereaved by a DRD that incorporates meaning making as a supportive intervention.

Overall, the families in this study found their identities and sense of community shattered by DRDs, and experienced posttraumatic growth through various active engagements that helped them to find purpose and meaning in the loss. Services should aim to support the strengthening of intra-family bonds where possible, while also assisting family members to make sense of unfamiliar and complex grief reactions. Some coping strategies associated with other traumatic deaths are similar, and the development of DRD supports could employ transferable elements of existing frameworks. Furthermore, support efforts must assist the bereaved in reconnecting with themselves and their communities while keeping themselves actively involved in fulfilling engagements. Policy and practice should consider these families in the specialized responses to complicated grief associated with other special deaths. For example, specific services in Ireland support suicide bereavement, but there are currently no extensive formal networks that specifically address DRD bereavement.

Strengths and limitations

A strength of this study lies in its in-depth methodology and approach that allowed participants to voice

their experiences, which are seldom heard voices in empirical research. In analyzing the experiences of families of which the members were interviewed together, the analysis allowed for a comprehensive overview of how these participants experienced post-traumatic growth, both individually and as a family unit.

This study included a purposive sample, and all participants were white Irish in a similar urban socio-economic position. Future directions for this research may benefit from a more culturally diverse sample to address any potential differences that were not identified. Future studies could also look to explore intersectionality of experiences with addiction while experiencing social exclusion, considering groups such as the traveler community and other ethnic minority groups. This study included DRDs due to accidental overdose and death by suicide. Researchers should consider the possibility of comparing bereavement experiences and healing trajectories among those who are bereaved from accidental overdose death, intentional overdose death, and other drug-related causes of death, and whether grief and health outcomes differ in a considerable manner. Finally, future research could investigate individuals' and families' experiences of posttraumatic growth in more discrete—and narrower—post-death time intervals, as the participants in this study represented a broad range of years since the death of their loved one.

There is a need for targeted supports to help those bereaved by DRDs, not only in the immediate aftermath of the death but as an ongoing support structure to facilitate adjustment. Services could implement bereavement screening to ascertain the specific psychosocial needs of families grieving DRDs. These could be coupled with information sessions where participants are provided with an opportunity to understand the nature of group support and how the sessions are facilitated. Specialized interventions are warranted to help those dealing with complex, disenfranchized grief reactions.

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Appendix VI: Published Article from Chapter 6

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The experience of drug-related client loss for healthcare professionals who support people in addiction

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ABSTRACT

Introduction: Addiction support and recovery is a multi-faceted support context in which practitioners work with clients who present with increased mortality risks. Drug-related deaths are understood to be a risk factor for complicated grief-reactions but, to date, research has neglected to explore the intricacies of drug-related client loss for practitioners who work with clients experiencing addiction. Due to wider expectations of professional endurance and the demanding nature of health care, grief-related reactions associated with the loss of a client may go unprocessed and, therefore, result in long-term health implications.

Method: Fifteen health care professionals took part in individual semi-structured interviews, which were analysed using reflexive thematic analysis. Participants represented various disciplines in addiction support and recovery, including homelessness, inclusion health, addiction, and emergency medicine.

Results: Three core themes emerged encapsulating the experience of drug-related bereavement for HCPs who support people experiencing addiction, as follows: (i) Grief Beneath the Surface, (ii) The Cost of Caring, and (iii) Finding Closure. The findings identified acute grief-related reactions in HCPs such as self-blame and shame, alongside fears of litigation and questions of clinical competency. Participants' accounts of drug-related client loss emphasized a deep professional connection with those that they work with, with grief-responses akin to the loss of peers, family members, and other close connections. The bereavement experience was complicated by unique compounding variables associated with drug-related deaths, but also by incongruity between their emotional responses to death and their professional responsibilities.

Conclusions: This article highlights the complex nature of drug-related client loss, and despite their social positioning as experts in their field, HCPs' reactions to client deaths were predominantly human responses to loss. The article identified a need for targeted postvention protocols that address complicated grief while also allowing staff to resume occupational functioning in a measured manner.

1. Introduction

Exposure to death in the workplace has well-documented health and practice implications for healthcare professionals (HCPs). Research in areas such as homelessness (Lakeman, 2011), suicide (Veilleux, 2011), and long-term care of patients near the end of life (Rickerson et al., 2005) identifies HCPs as an at-risk group for negative health outcomes following a client's death. Bereavement experiences can be influenced by individual factors, existing support structures, the nature of the death, and closeness to the deceased (Stroebe & Schut, 2010), and considerable variance in grief-related reactions across professions exists within HCP literature. For example, death by natural causes for elderly patients typically follows a normative grieving cycle (Da Silva et al., 2007), but a death by suicide, which is sudden and traumatic, can result in a complicated grief that requires specific postvention protocols (Morrissey & Higgins, 2021; Murphy et al., 2022).

A recent focus in the social sciences has seen increased inquiry into the implications of drug-related bereavement for affected individuals, who are an underrepresented social group within traumatic death literature. Drug-related deaths refer to deaths due to overdose, but the cause of death may also be violence, suicide, or infectious disease consequential of opioid intake (Health Research Board, 2019; Titlestad et al., 2019). To date, the research has focused on drug death bereaved families, identifying unique and complex grief reactions such as shame,

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guilt, and isolation, with long-term health outcomes such as anxiety, depression, and an increased risk of physical illness and natural cause mortality (Christiansen et al., 2020; Lambert et al., 2021; Titledstad et al., 2019). The cultural perception of drug deaths as 'bad deaths' is not conducive to the fact that the bereaved require specialized support to facilitate positive adaptation after a loss (Feigelman et al., 2020; O'Callaghan et al., 2023; Titledstad et al., 2020).

Almost all individuals who use drugs exist within a social context in which they interact with family members, HCPs, and peers, and research suggests that for every drug-related death at least 10 bereaved individuals may be connected (Dyregrov et al., 2020). Yet research efforts have neglected to investigate the direct impact of client drug deaths on HCPs who support people experiencing addiction. Practitioners in areas such as homelessness, addiction, social care, and emergency medicine play crucial roles in addiction support and recovery, and clients will navigate a range of health, social and justice systems. At each of these touchpoints, people using drugs connect with general practitioners, key workers, and other HCPs, often forming various levels of sustained professional relationships. Branson (2019) reported that HCPs who engage in empathic relationships with clients are at increased risk for vicarious trauma, which can result in accumulative changes emerging in one's personal or professional life. The emotional impact of exposure to clients' traumatic experiences can lead to outcomes such as intrusive imagery, loss of clinical motivation, and stress-induced health conditions (Branson, 2019).

An empirical study by McAuley and Forsyth (2011) examined the impact of drug-related deaths on staff that experience death within their caseload in Scotland. Utilizing a self-report grief questionnaire adapted from a study by Rickerson et al. (2005), the authors investigated the emotional responses to a client's drug death in 65 HCPs in health, social, and voluntary care sectors. Participants identified grief-related reactions from a list of 22 set items and provided a brief description of their grieving process. Although no significant differences existed among staff of different professions, grief-related reactions were present in 90 % of the sample, and staff exhibited similar reactions to drug death bereaved families (Lambert et al., 2021) with self-blame, helplessness, anger, and thoughts about their own morbidity being among the most common outcomes (McAuley & Forsyth, 2011). However, one of the identified limitations of this study is that participant responses were limited to set items, potentially increasing the risk of participant response bias. To truly discern the experience of HCPs who are bereaved due to a client's drug death, the authors recommended further qualitative inquiry.

More recently, Yule and Levin (2019) & Urmache (2020) conducted literature reviews investigating grief outcomes in HCPs after the overdose death of a client. Given the current lack of HCP drug death-specific research, both reviews draw from existing family drug death bereavement literature and HCP research in other areas, primarily exploring client death by suicide. For practitioners, such grief is often disenfranchised, as Morrissey and Higgins (2021) identified intense grief responses to client suicide including isolation, guilt, and questions of professional competency. Veilleux (2011) reported that HCP reactions are often categorized into two distinct pathways; while HCPs commit to professional response requirements while on duty, they must also contend with personal responses that are akin to other forms of loss, such as grieving for peers (Morrissey & Higgins, 2021; Veilleux, 2011).

Due to the countertransference reactions evident in HCPs with other traumatic deaths, and the complicated grief outcomes associated with drug deaths, HCPs should be supported with peer supervision that specifically encompasses the complexities of drug-related client loss (Urmache, 2020; Yule & Levin, 2019). In McAuley and Forsyth (2011)'s study, most participants said they would avail themselves of such a service if it existed. However, to inform the development of such targeted support packages for HCPs, it is crucial to understand their needs, outcomes, and experiences with this specific form of grief.

An interview study in Norway (Løseth et al., 2022) examining HCPs' first-hand experiences supporting drug death bereaved persons reported

that first responders and other municipal HCPs encountered resentment from family members who were critical of the care system's ability to help their loved one during life. A key finding of the study highlighted how organizational structures and personal attitudes towards drug use can contribute to how HCPs relate to drug death bereaved persons, and an Irish study echoed these concerns as Lambert et al. (2021) reported that some families were met with prejudice and unfavorable reactions from professionals. On the other hand, such encounters with families can lead to reduced self-esteem and doubts about one's occupational competency. Løseth et al. (2022) examined how HCPs relate to drug death bereaved persons with the aim of informing best practice for support provision, and the authors suggested that practitioners should be trained in how to respond to such complicated grief.

While not directly exploring the grief experience of HCPs, the Norwegian study by Løseth et al. (2022) provided a crucial insight into the intricacies of providing an appropriate response to drug death bereaved individuals, and the complexities involved in providing diverse assistance in a multi-faceted support context. However, the current study argues that to truly provide context-sensitive support, we must also understand the emotional intricacies and trauma responses for HCPs themselves. O'Brien (2011), as cited by Urmache (2020) spoke about the 'wounded healer', where although our experience and personal histories can help us relate to clients, unresolved or neglected wounds can inhibit our ability to deliver effective therapeutic practice. Continuing to work under elevated levels of stress is an often-accepted aspect of the occupational culture in healthcare, but exposure to traumatic deaths has clear implications for HCP well-being (Murphy et al., 2022) and occupational functioning, as vicarious trauma is associated with poor clinical decision making (Branson, 2019). In this paper, we argue that HCPs should also be considered as an at-risk group worthy of targeted support following the drug death of a client.

The current study intends to fill a gap in the literature by examining the impact of client drug deaths on HCPs in a range of professions in Ireland. In an Irish context, Lakeman (2011) conducted a thorough grounded theory study of how homeless sector workers experience the death of a client. However, the 2011 study addressed deaths of significant variety, inclusive of death by suicide, shooting, and overdose. Annual drug deaths in Ireland are now twice the European average (EMCDDA, 2021), and the country recorded its highest number of overdose cases since 2008 in 2018. In interviewing service providers specifically about their experience with drug-related client loss, this study also presents international implications as drug-related deaths are increasing in both Europe (EMCDDA, 2021) and North America (CDC, 2022 as cited by Reime et al., 2022). Understanding the nature of bereavement for HCPs in this context has implications for best practice and can identify opportunities for supporting and protecting the well-being of professionals, who are often overlooked in the support process, and ensure they can sustain optimal levels of occupational functioning when working with drug death bereaved individuals and families.

2. Methods

The current study adopts a phenomenological approach to understanding the impact of client drug deaths on HCPs who support people experiencing addiction. It covers a wide range of professional roles where exposure to drug-related deaths is an acute risk within client caseloads. The first author conducted 15 in-depth interviews with HCPs who support people in active addiction. Participants represented a range of disciplines in healthcare such as homelessness, emergency medicine, addiction, and social work. In a sub-study of the current paper, the authors previously examined a subset of the data with respect to the specifics of supporting people experiencing addiction during the COVID-19 pandemic (O'Callaghan & Lambert, 2022).

2.1. Participants and sampling

This study includes 15 participants (8 women and 7 men) working as HCPs in addition, homelessness, emergency medicine, social care, and public health. Using convenience sampling, the authors sent emails containing information sheets to organizations where HCPs support clients experiencing addiction. Information provided to potential participants at this point included details of both authors, the objectives of the study, and the ethical framework for participation. Departmental leads within these organizations circulated the information sheet to relevant staff, and those who expressed interest in taking part contacted the first author directly.

For inclusion eligibility, participants had to be over 18, employed in professional support roles working directly with service users experiencing addiction, and had experienced the drug-related death of a client during their time of employment. The study had no sex or gender restrictions, but made efforts to include a balanced sample. All participants who expressed interest in the study committed to participation, and none sought to withdraw from the study post-interview. Table 1 lists the current occupation of each participant (at time of interview). However, participants also spoke retrospectively of previous relevant roles they had worked in.

Participants were based throughout the Republic of Ireland, and the geographical spread covers staff based in the South, Southeast, Mid-West, West, and East of the country. Specific locations of each participant have been withheld for the purpose of anonymity.

2.2. Data collection

To collect data, the first author conducted 15 one-to-one semi-structured interviews between October 2020–January 2021. Two interviews occurred by telephone, and 13 took place online via the Microsoft Teams video call function. The duration of interviews ranged from 30 min to 57 min, with the average duration being 44 min. To maintain anonymity, the first author recorded the interviews using an external audio recorder and transcribed each interview verbatim while ensuring to remove any information that would be considered identifiable.

Interviews followed a list of seven open-ended questions about drug-related client loss to ensure a level of topic constancy across cases: (1) "Can you speak about your role?," (2) "Can you tell me about the nature of staff-client engagement in your work?," (3) "Can you tell me about your experience with drug-related deaths in your practice?," (4) "How have such losses had an impact on you personally or your occupational functioning?," (5) "On a personal level, and given the demands of healthcare, do you find space to process such losses if required?," (6) "Are you aware of current protocols and supports available to you as a

front-line worker in the event of drug-related client loss?," (7) "Reflecting on your experience with drug-related client loss, are there any supports you feel would have been beneficial that were not available at the time?"

The flexible nature of the semi-structured interview and the use of prompts allowed for the exploration of unanticipated topics while participants spoke at their own pace. Participants spoke compassionately about the impact of client drug deaths on their own well-being. At the beginning of each interview, staff again briefed participants on the study's aims and methods and informed them of their right to pass on questions or end the interview at any time. At the conclusion of each interview, we debriefed participants and reminded them of relevant support services if required.

2.3. Data analysis

Data analyses utilized Braun and Clarke (2019)'s reflexive thematic analysis framework, and we subsequently outlined findings in accordance with the standards for reporting qualitative research as presented by O'Brien et al. (2014). Both authors are experienced qualitative researchers who work with socially excluded populations, and we considered reflexive thematic analysis to be the most appropriate methodology for presenting the experiences of drug death bereaved HCPs. More specifically, reflexive thematic analysis acted as a systematic methodology where we could draw from our research values, skills, and training to synthesize theories and concepts when engaging with, and attaching meaning to, the data (Braun & Clarke, 2021). The stages in Braun and Clarke (2019, 2021)'s are sequential, but fluid movement between phases allows for the necessary rigor involved in deconstructing the data and presenting it through synthesized patterns of latent meaning.

The stages of analysis conducted in this study were as follows: (i) familiarization with the data, (ii) coding the transcripts, (iii) generating initial themes, (iv) reviewing emergent themes, (v) defining the themes, and (vi) writing up the findings.

Each author familiarized themselves with the anonymized data transcripts, and the first author carried out inductive coding using NVivo qualitative analysis software (released in March 2020), adopting a ground-up approach and creating non-hierarchical codes through direct examination of the data. Upon completion of the initial coding, both authors engaged in continuous dialogue regarding the nuances of the codes and the generation of initial themes. The authors carried out this process through rigorous reorganization of the non-hierarchical codes from individual transcripts into more refined coding patterns across the entire data set. Back-and-forth movement between phases was common at this stage of the analysis when new codes and concepts emerged from conversations related to the data. Using our own knowledge and experience, we reviewed and defined emergent themes through arbitrary decisions about how to reconstruct and contextualize the data within HCPs' experience with drug-related deaths and bereavement.

2.4. Reflexivity

Due to the inherently subjective nature of the coding process, the authors aimed to ensure that the analytical strategy was transparent and systematic. The authors engaged in reflective journaling and used reflective memos to build a history of thought progression from the beginning of the analysis. These memos involved written reflections about how the first author's experience around drug-related bereavement may have fostered pre-existing assumptions and biases. Through journaling and ongoing conversations between both authors, we aimed to address researcher bias by demonstrating rigor and approaching the data in a most inductive manner.

The first author has prior experience in working with socially excluded populations in addiction services through research-based practice, and the second author has both practitioner and research

Table 1.
Profile of participants.

Participant	Role	Participant	Role
Participant 1	General Practitioner	Participant 9	Community Detox
Participant 2	Inclusion Health Social Worker	Participant 10	Addiction Counsellor
Participant 3	Homelessness Project Manager	Participant 11	Emergency Medicine Consultant
Participant 4	General Practitioner	Participant 12	Community Drug-Alcohol Worker
Participant 5	Addiction Project Manager	Participant 13	Housing Support/Addiction After-Care
Participant 6	Clinical Nurse Manager	Participant 14	Addiction Counsellor
Participant 7	Researcher in Social Services	Participant 15	General Practitioner
Participant 8	Paramedic		

experience in addiction services. The first author was the sole interviewer, but after each interview the authors met to debrief and discuss the data. Our use of reflective practice ensured our efforts to address the risk of bias and deductive coding were extensive and coincided with our responsibilities as qualitative researchers (Dodgson, 2019).

2.5. Ethical considerations

The current study received ethical approval from the departmental ethics committee at the University where both authors are employed. The information sheet provided to participants outlined the voluntary nature of the study, the potential uses of their data, and ensured that all information would be confidential with anonymized identities. All consent forms were electronically signed and returned to the first author prior to the corresponding participant's interview. Upon completion of the anonymized transcripts, the original interview recording was deleted, and the collected data was stored in written format (Microsoft Word document) on an encrypted Microsoft OneDrive provided by the authors' home institution.

3. Results

Exploring the emotional intricacies of drug-related client loss unveiled diverse grief-related reactions for HCPs which were compounded by the unique stigma associated with drug dependence. Three core themes that illustrate the experience of drug-related client loss emerged from the data, (i) Grief Beneath the Surface, (ii) The Cost of Caring, and (iii) Finding Closure. Each core theme includes associated subthemes.

3.1. Grief beneath the surface

Due to the nature of healthcare, the emotions of grieving staff members are often masked by professional composure as they deliver a service in times of difficulty, stress, and trauma. This professional resilience can result in a belief system that HCPs are expected to work with a detached emotional competence, a perception which some staff internalized as an accepted component of their role: "It's not the most straightforward thing. It's not like the sudden death of a 60-year-old that dies of a heart attack either. Like, when you're trying to explain to somebody else, you have the whole stigma around drug use." Due to the way patients lived their lives, practitioners felt that this grief had to remain beneath the surface. However, despite these expectations of professional endurance, when sharing stories of clients who passed away due to drug-related complications, all participants addressed complex psychological outcomes that centered around their roles as decision makers, self-blame, and vivid recollections of a death's details.

3.1.1. Intrusive flashbacks

Participant 14 highlighted that it is important not to neglect the reality that HCPs are exposed to primary trauma despite their tendency to carry on with work: "A lot of it is primary trauma in terms of witnessing, finding bodies, or identifying bodies. Or going to the inquests or getting assaulted or getting threatened." Many participants detailed hostile encounters stemming from high tension in emergency situations. Participant 8 mentioned having paramedics "assaulted in the past" and Participant 11, also working in emergency medicine, spoke of an encounter with a grieving father:

I have been attacked by a father...The son was in his late teens, early 20s, and died from an overdose. And, I mean, I never saw a human being froth at the mouth the way this dad came at me because I had stopped resuscitating. There was nothing we could do he, he...

Such tense and aggressive energies were consequential of traumatic situations, for which participants empathized, but being a tenured professional did not always negate the long-term cumulative impacts of traumatic events. Evocative recollections of these encounters rekindled

emotions of fear and panic and, similarly, many participants spoke of haunting imagery that stayed with them after the harrowing experience of finding a client's body. Discoveries of this proportion can lead to such sensory overload that not only do HCPs carry the emotional weight of the moment, but the visual experience becomes ingrained in their mind, as illustrated Participant 7:

I heard a thud from [client's] room and I thought "oh she must be moving furniture around...I'll pop up and check she's alright in a minute or if she needs a hand". And I remember sitting there and this was ten years ago, and I can still feel it, I can still see it. So, if I can connect that deeply with the visual and the emotional experience it means I probably haven't integrated it, you know? I can see her face, I can see the mucus, I can hear the sound of her falling.

The multisensory integration of this experience left a lasting impression on Participant 7, who visualized scarring imagery to a thoroughly vivid extent. In the absence of targeted professional support to address and recognize the trauma, the experience was concealed by the demands of professional responsibility. In the same way participants carry positive facets of their connections with clients for many years, so, too, can adverse experiences linger, and with damaging effects. Such animated recollections were commonplace, as Participant 14 elaborated on how such experiences can have a profound impact on daily functioning:

I knew from the stench and the smell what I would face when I opened the bedroom door. He was gone and he was rigor mortis, he was pooling. It would have been physically not a very attractive sight...I had to ring my staff member maybe 48 hours later and I said, "How are you?" and he said he wasn't sleeping, I said "neither am I". Couldn't get the smell out of my nostrils... I couldn't eat after that... You get a vision of the person lying on his bed, with the stench and the smell, and the contents that were coming from his air passages, just make you gag.

Practitioners are primed to respond professionally in the moment, but such events impacting HCPs' well-being, appetite, and sleep highlight the very real physiological aftermath of drug-related client loss. Occupational functioning, as crucial as it is to healthcare, can mask the implications of drug-related bereavement that exist beneath the surface. Timely and targeted support to address trauma in this context is pivotal as experiences may be repressed to ensure one's capacity to meet professional demands. As shown with Participant 14, neglecting to address trauma can have long-term health implications that even practitioners may not recognize within themselves:

Without a doubt it had a massive impact on me. I didn't realize it at the time. I had partners and they may have been able to see it but, definitely you know I... I had a panic attack once when I was managing [service], maybe six months after the incident, right? I had one, and I didn't know what it was at the time, it was horrific.

3.1.2. The clinical carer's burden

The coalescence of a HCP's duty of care and the potentially preventable nature of the death often engendered feelings of culpability surrounding a client's drug death. Participants ruminated on alternative outcomes as they cross-examined their decisions: "It's an awful knee jerk reaction but first thing, did I miss something? Did I give the wrong dose? Did I, should I have asked different questions?" In this quote, Participant 4 highlighted the emergent process of self-questioning that stemmed from his position as the advocate within the staff-client relationship. Similarly, Participant 6, a clinical nurse manager, captured how the emergence of self-blame often compelled staff to retrospectively assess the accuracy of their own case management:

There's always this anxiety...Were they on high-risk checks? Were there signs? Did they have a support plan around their overdose risk? From a mental health point of view, were there any previous

overdoses, did we do everything we needed to do? So, it's almost like it's somebody's fault.

Engagement in contemplative processes is documented as a valuable loss-oriented mechanism for making sense of loss, but the traumatic nature of a drug death can shroud these processes in guilt, self-questioning, and blame. In the absence of appropriate external support that recognizes these emotional responses, Participant 3 explicated that grief can further manifest into feelings of futility, hopelessness, failure, and decreased occupational self-efficacy: "It was impacting on us. It was making us really angry and sad. What's the point of doing this? They're dying. No matter what we do they're all dying. And they were dying so young."

Self-blame resulted in even the most experienced staff questioning the efficacy of their decision making, as uncertainty surrounding procedural correctness became a primary initial concern. A key function of their role in this healthcare context is to mitigate the risk of a drug-related death, and an embodied sense of responsibility for the outcome can yield implications for HCPs' trust in their own clinical competence. Through the process of self-blame, internalized fears were compounded by external factors such as legal disputes and fears of litigation, as voiced by Participant 4: "I know my colleagues have ended up in court over the years. Because someone has died, and the family has taken it further."

Amidst such inner conflict, participants spoke of needing to "box off" adverse experiences to meet the urgency at which healthcare demands their services. Correspondingly, many participants, such as Participant 3, recognized during the interviews that although they returned to higher levels of occupational functioning, they still had unprocessed emotions from client drug deaths: "I think for me in this conversation what struck me is that I'm still really angry and sad about the lads that died last year." The demands of healthcare may lead practitioners to prioritize their work and create a silent, unprocessed, and unrecognized grief that, as professionals, is their own burden to bear.

3.2. The cost of caring

The duty of care to others is a key competency of a HCP's job description, but an emotional investment in their clients' recovery complemented participants' occupational responsibilities. Participants spoke of clients with compassion, fondness, and privilege, ensuring to humanize them in a manner that far exceeded the simplicity of the term 'service user'. HCPs frequently developed empathic connections with their clients that transcended surface level interactions one would expect to occur between them as "part of the job". Participant 9, a community detox manager, eloquently shared how a staff/client dynamic becomes a deep and authentic human connection within the boundaries of professional conduct:

Sometimes you see more of the clients you work with than you do of your own family members. Sometimes you know this person so well you have more of an understanding of where their trauma is. More of an understanding as to why this is the road they're on in life... Sometimes the long-term staff member is on the journey with that person.

However, this deep emotional investment often came at a cost as it also compounded their distress when a client passed away, and grief-related reactions were further exacerbated by unique complexities associated with drug-related client loss. Participant 8 showed that the possibility of death by overdose can cast a shadow over these interactions: "It does have a burden, but maybe it's, maybe there is a sense of inevitability about it."

3.2.1. Occupation and vocation

HCPs emphasized staff/client connections as a facet of healthcare that should be professionally and socially acknowledged. Paramedics,

addiction counsellors, and general practitioners engaged with clients at different stages of their journey, but the relationships progressed beyond familiarity and into authenticity by virtue of proximity, frequency of interaction, and rapport. Due to their clinical knowledge of addiction, however, HCPs considered an intrinsic preparation for the possibility of client death to be a key professional requisite. Yet, as detailed by Participant 2, understanding the nature of the work does not diminish the psychological impact of the loss of a client's life:

The nature of the work we do and the clients we work with, you are going to have drug-related deaths. It would be very naïve of us to think that we're not going to experience death...But obviously, you build a particular relationship or a bond. Then when [clients] pass, particularly if it's sudden or violent, you would really grieve.

Evidently, an internal dissonance exists between maintaining a pragmatic perspective on client outcomes and coping with the emotional sadness of loss. Responding to death is a professional demand, but participants stressed that the response to losing a client was not simply procedural in nature. As they connect to the humanity of their work, Participant 12 demonstrated that a strong emotional connection exists that merits recognition:

I worked with her for so long. It's fascinating to me to think that, gosh, she died a number of years ago and I would still think of her often, and that I would feel so emotional just talking about her. It's not fair to underestimate. It's a work situation but people working in services, you build up a connection with people. It can still make a massive impact.

For HCPs, this stigmatized and disenfranchised grief is complicated by societal and organizational expectations of professional endurance which, at times, resulted in self-stigma that can have implications for help-seeking behavior, as illustrated by Participant 1: "Maybe you do internalize that a bit and think, can I really go and tell somebody I'm sad that someone who was injecting heroin for 20 years has died suddenly?" Endeavoring to rationalize their emotions, participants struggled to align their professional persona, crafted by external social and organizational norms, with their internal personal sense of grief. However, Participant 9 underlined that drug-related client loss is as devastating and valid as any other, and despite being a trained professional, human loss of any kind invokes a human reaction: "There was an awful lot of emotion that came up for me in that death, that type of emotion that you'd think you would only identify with if it was somebody of your own family."

3.2.2. Mutual learning & lost potential

Beyond the transactional nature of service provision, participants emphasized the importance of cultivating trust with clients. In exploring the more in-depth aspects of these exchanges, HCPs revealed a reciprocal facet to their interactions that often go unnoticed in the wider sphere of healthcare, particularly given their positioning as the 'provider' in the dynamic. As HCPs shared heartening anecdotes of clients who had passed on, many participants, such as Participant 9, treated these relationships as connections of mutual learning:

This lady was really unique. I've never met anyone like her in life before, I'd imagine I never will again. And I was very, very lucky to be her person. It was a very privileged position, and I think it is that privilege that has brought me to where I am today in my career.

Crediting clients for shaping their professional practice highlighted how such dynamics can foster a meaningful space of shared personal growth. Many participants carried these lessons forward to improve their practice but also to honor their client, holding memories dear to their heart and showing that death is not where these relationships end. Arising from this affinity, Participant 9 stated that the abrupt and traumatic end to this potential from an untimely and preventable death was one of the most difficult aspects of drug-related client loss to contend with: "It's not

just that person is gone, it's the loss of potential. It's the fact that they never got to resolve some of the things that brought them to this life in the first place."

In mourning their clients, HCPs could imagine the future potential for an individual's life beyond addiction. Thus, accepting the finality of death was difficult and the loss of potential engendered feelings of frustration and discouragement. Exploring this frustration, Participant 2 acknowledged that the stigma surrounding drug use often leads society to condemn people in active addiction and subsequently disregard their death, rather than recognizing their potential for life: "In the drug related side of things, there's all this stigma around 'oh, he was using.' I don't care that he was using, he was a person. With the drug side of things, it's like 'oh they chose that'." Participant 7 stressed the importance of shifting this condemnation into a social acknowledgement of the significance of each loss, both within services and the community:

It definitely felt like it was more of the expected part of the job, and you just got on with things...But are we saying it's an acceptable part of life and we don't even notice it? And if not then what's that doing to us, to our hearts, to our respect for life, or our compassion for people, or our hope for their potential?

3.2.3. Shock to the system

HCPs are acutely aware of the increased mortality risks associated with addiction and specified an underlying preparation for the possibility of client loss. However, clinical knowledge does not grant immunity from traumatic shock, as anticipatory grief can be inhibited within certain contexts and leaves HCPs emotionally vulnerable to unexpected deaths. While they participated in a veiled preparation for many deaths, a sub-group existed in which death is less anticipated depending on the timing of the death and what stage the client was at in their recovery. In some cases, deaths occurred when clients were perceived to be on a positive trajectory towards recovery, as illustrated by Participant 6:

With this recent gentleman, he was doing so well. He was overdosing quite regularly, and then he had a period of doing so well, and then [he died]. And I guess, you're expecting it when they're going over all the time and you're not expecting it as much when they're doing well. It's very difficult for the staff who are supporting people to stabilize.

Times of prosperity during a client's journey to recovery may be associated with less professional proximity to services and losses during this time can be harrowing for HCPs. For Participant 6, the loss of a client in this manner generated a range of complex emotions. The perilous nature of addiction yet unexpected nature of the death created an incongruity between the characteristics of the work and the emotional impact of the loss. Such complex emotional dissension can inhibit one's capacity to grieve, as efforts to make sense of the loss are obstructed by wider misconceptions of how professional expertise should function as a coping mechanism.

In other circumstances, participants experienced traumatic shock when a client passed away during an ongoing dialogue and planning process about their future. When a death occurred during this apex of hope and ambition, anticipatory grief was diminished and resulted in traumatic shock, as shared in this anecdote by Participant 10:

I had real traumatic shock where I needed the support of my colleagues. One client went to residential treatment, lasted 3 weeks, and rang me to say he wasn't staying there after I worked 9 or 10 months to get him in. And then, he said 'I promise you I'll come in and see you next week'. All the promises. You are invested in their recovery. And then I got a call on Monday to say that he had overdosed. On heroin, which was not his drug of choice.

Participant 10 mourned the loss of life, but also struggled with an unfamiliar sense of incongruence as she found herself predominantly experiencing anger and frustration towards her client, alongside the

sadness for his loss:

I found myself being pissed off. Pissed off with him for all the promises. And then I thought he was trying to not let me down, trying to make me proud by staying off the benzos. He probably went off to try and get painkillers and then someone offered him heroin.

Participant 10 struggled to make sense of her emotions and felt guilty for harboring anger towards her client. However, she also recognized the respect she had earned from a client who sought not to disappoint her. While this accentuated her sense of guilt, earning that esteem was not something she took for granted and highlights the degree of mutual respect that can develop in healthcare contexts. Participant 10 truly mourned the loss of potential for this young man and the working relationship she had developed with him. Such anecdotes highlight the complexity of drug-related client loss, demonstrating that the anticipatory knowledge that HCPs carry does not always mitigate the emotional impact.

3.3. Finding closure

Achieving emotional closure was sentimentally important to HCPs and considered to be an entirely separate journey of personal healing to professionally closing a client's engagement with a service. Fulfilling these professional commitments did contribute to the process of healing, as shown by Participant 10:

The policy did provide me with support, I suppose it gave me a practical lens because from an emotional standpoint I was really angry...The policy was a good way to keep my rational mind. I needed to ensure my files were up to date.

A key aspect of this quotation that applied to all participants was the identification of an emotional facet of finding closure. Honoring their client was a very personal matter and closing the relationship with them on their own terms, independent of professional responsibility, was pertinent for participants. However, at times it was difficult to separate professional and personal closure, as Participant 2 spoke of the process of retaining mementos for clients:

In my office at the moment, there's four- or five-people's belongings, the belongings of people that have died recently, that I'm trying to get back to their families. So, it's nearly like a little shrine in here sometimes. But I have artwork and stuff that people who have passed away and left me things as well, which is nicer to have than their belongings.

Due to the complexities associated with drug-related client loss, closing relationships post-death was often a journey of trepidation, balance, and uncertainty.

3.3.1. Trepid last respects

Attending client funerals was considered standard practice in some health care frameworks, but situational context played an important role. Specifically, due to the shame and stigma surrounding drug-related deaths, Participant 7 showed that the process of attending funerals became shrouded in uncertainty: "Is it appropriate for us to go to his funeral? We've been working with him for a long time but, his family may not want that part of his life represented at a funeral." All participants sought to be considerate of families' wishes but upholding this respect sometimes inhibited HCPs' own opportunities to grieve. Funerals are an integral component of emotional closure in many cultures, and marking the death in this capacity was an important value that HCPs wished to uphold. Participant 9 demonstrated the significance of attending funerals as it pertains to achieving closure: "If I don't go, I always expect them to come back. Closure. It's me closing that relationship with them." As Participant 9 elaborated, this desire was not solely for their own emotional closure, but also out of respect for their client: "You didn't know whether you were leaving the person down,

even though they were gone, by the fact you didn't attend their funeral."

When clients passed away, a previously estranged part of their lives then emerged, and HCPs often had not previously engaged with parents and other family members grieving this person. Entering this new dynamic was a source of trepidation for practitioners who often dealt with an internalized sense of culpability for the death, with Participant 10 showing she was conflicted about respecting her client but also respecting those who were left behind: "I didn't know how they were going to respond to me, react or what way it was going to go. I do remember driving to the funeral home, you don't know if it's the right thing to do or not." Evidently, the stigma and shame surrounding drug-related deaths added an extra layer of complication to the process of achieving closure.

In some cases, fulfilling communication occurred with families where HCPs were welcomed to funerals, mitigating their feelings of apprehension. Participant 10 highlighted how such transparency allowed her to bypass some emotional complications at another funeral: "No blame... Didn't have the fear someone was going to blame me, and I could concentrate on myself then." In other cases, family withheld or modified funeral details to mask the shame and stigma associated with the use of drug-related services. Participant 14 showed that, sometimes, tensions can exist between a family and a service post-death: "I suppose it was the impact for me. It was that the family went through a coroner. I met the family afterwards; they were very bitter towards the service." Participants compassionately accepted families' decisions, but stigma and shame often created a barrier to achieving closure in the traditional sense as participants grieved for their client, and Participant 9 also lamented over the community they belonged to:

It's not that you want to be acknowledged or thanked or whatever. But I think the acknowledgment needs to be that this person was part of a very important community in our society that's always overlooked.

3.3.2. *Balancing act*

Due to the level of vicarious trauma and grief that HCPs are exposed to throughout their professional tenure, Participant 7 highlighted that finding the delicate balance between grieving and moving on was identified as a critical professional skill:

I think anyone working in crisis type services has to disconnect from the emotional impact. Like, if every time something happens you allow yourself to feel the full force of the emotional impact as if it was the first time, then you would probably be quite unwell, you know? I don't think you'd be able to do your job and I think there's a required amount of it in order to enable you to act and do your job and continue to be there.

As professional longevity emerged as a protective factor, Participant 6 stated that she developed undefined coping strategies for dealing with vicarious trauma but reinforced that she preserved her compassion: "Personally, I don't like to use the word desensitized, because I'm not desensitized to it. They're actual people... Whatever I've developed, I've developed to continue to do this work." Participant 9, then, spoke of how she drives forward to remain at a functioning level: "It's skimming over, it's driving on, it's getting on with it. Because if I stop, I'm going to be flattened by all the loss I've experienced."

Tenured professionals developed their own mechanisms for coping with occupational hazards, but these techniques are not universal. Many participants, such as Participant 3, admittedly struggled with finding this balance or had suppressed emotions stemming from previous traumatic experiences: "I don't know how to meet that need fully. Because I'm conscious that working in this area, I'm going to come across [drug-related deaths] every year." Developing these coping mechanisms without appropriate guidance, however, presents a high risk for negative health outcomes, and Participant 7 highlighted the importance of proper support infrastructures where practitioners can feel safe in their

help-seeking behaviors:

I think without proper structures in place to allow you to recognize that, to say 'I am disconnecting from this in order to sustain my capacity to work with people who are at such crisis all the time', if that's not done in a planned measured way then people do it in a negative, unplanned way which turns into burnout and turns into disconnection and turns into compassion fatigue.

Participants wished to validate the loss of human life to an extent that reflects and recognizes the depth of connection they shared with their clients, while also allowing them to continue their work. Across the different professions represented in this article, numerous support packages are available for HCPs such as employee assistance programs, internal supervision, and peer support. However, all participants identified a gap in the support process as it pertained to drug-related client loss beyond debriefing, where the availability of a structured, external support program that tackles complicated loss would be of significant benefit to achieving this balance, as Participant 4, a general practitioner stated:

You try and box it, and park it off, Unconsciously, in your own head and so there's that. And then *functionally*, the service isn't doing anything about it... I feel very strongly about it, I have been trying to ask people for the last two years that we as doctors, and nurses within the service, get supervision the same as our comrades do.

When mentioning "comrades", the participant was referring to those who work in other disciplines that support people experiencing addiction such as therapists, homelessness project workers, and social care workers. For those staff, however, while some organisation-specific supports had been developed in relation to supervision, the concept of external supervision was highlighted as important to provide an impartial space, as was peer support.

The importance of carrying on with your job was explicated throughout interviews, but not at the cost of staying connected to the humanity of the work. Participant 7 spoke of achieving this balance: "Recognition processes, symbolic things. If there were discussions after you lose someone. That we don't allow our desensitization, that we build as professionals to cope, to go over into our capacity to actually grieve and mourn." Balancing the two unique constructs, the requirements of work and humanity, was a difficult one to strike. Crucially, participants spoke about how it is important that organizations do not overestimate the capacity of staff or underestimate the impact of a death.

4. Discussion

The current study explored the experience of drug-related client loss for HCPs who support people experiencing addiction. The findings identified acute grief-related reactions in HCPs akin to the loss of peers, family members, and other close connections. The bereavement experience was complicated by unique compounding variables associated with drug-related deaths, but also by incongruity between their emotional responses to death and their professional responsibilities. Despite their social positioning as tenured practitioners, HCPs' reactions to client deaths were predominantly human responses to loss, for which participants wished for wider societal acknowledgement. As the key finding in this paper, HCPs experience a profound grief from drug-related client loss that requires further targeted professional intervention and wider social acknowledgement.

Research on drug death bereaved family members has consistently identified complicated grief reactions inclusive of shame, self-blame, frustration, rumination, and a fractured sense of purpose (O'Callaghan & Lambert, 2022; Titlestad et al., 2020). Similar reactions emerged in drug death bereaved HCPs (McAuley & Forsyth, 2011), as practitioners in the 2011 study reported self-blame, shame, and anger. In its exploratory approach, the current paper coincides with these studies, and provides a critical insight into emotional processing difficulties

consequential of drug-related client loss. In a similar manner to how drug death bereaved parents relayed feelings of self-blame for the loss of their loved one due to their role as a primary carer, HCPs reported self-blame stemming from their position as an advocate in the staff/client dynamic. HCPs, however, are societally situated as experts, where the function of their role to mitigate such outcomes is publicly defined. As participants internalized these external professional expectations, and the preventable nature of drug-related deaths, grief-reactions manifested into a sense of failure, culpability, and self-questions of clinical competence.

Participant reactions to client drug deaths were two-pronged, often involving a bilateral relationship between distinct professional responsibilities and personal responses. Previous literature conveyed the divergence of grief reactions in this manner (Lakeman, 2011; Morrissey & Higgins, 2021; Veilleux, 2011), where rituals and behaviors linked to death response were categorized based on their association with organizational necessity or individualized emotional processing. Similar to the current findings, Lakeman (2011) demonstrated that homelessness sector practitioners fulfilled procedural death response protocols but required another outlet for their personal grief, resulting in both formal and personal methods of marking deaths. In the case of drug-related client loss, however, this study found that many personal coping methods, such as attending client funerals or openly grieving the death, were inhibited, undermined, or socially unsanctioned due to drug-related stigmas.

Despite their occupational necessity, in a comparable finding to Lakeman (2011), participants reported some professional mechanisms to be beneficial, such as documenting a client's closed engagement with a service or tending to other clients in the aftermath. However, while these processes were important for the purposes of pragmatism, the emotional weight of drug-related client loss was profound, and the personal impact transcended what could be managed in a purely procedural capacity. Throughout interviews, participants emphasized the depth of connection they shared with their clients, and while this presented itself differently across professions, such rapport with a client intensified traumatic grief reactions. Yet, participants sometimes felt the need to censor their emotions, an experience mirrored in literature addressing other traumatic deaths such as death by suicide (Morrissey & Higgins, 2021). In the wider healthcare context, help-seeking behaviors among HCPs are impeded by the prevalence of self-stigma emerging from projections of professional fortitude (Ellis & Korman, 2022). However, for those who experience drug-related client loss, the amalgamation of self-stigma and the broader societal stigma surrounding drug use generates a disenfranchised and complicated grief.

Peer support has been identified in the literature as a significant facilitator of positive organizational attitudes to help seeking (Urmanche, 2020; Yule & Levin, 2019), particularly through the lens of creating a shared sense of understanding about the emotional and physical taxes of the job. It has also been identified as a protective factor against vicarious trauma. Targeted organizational supports that recognize the emergence of blame or claims of incompetence that exist in healthcare roles is important, as practitioners have an extent of individual responsibility over client welfare during life and may experience the heavy burden of death in silence. Positionality played a key role in the experience of drug-related client loss, both from HCPs' position as clinical specialists, and the social positioning of clients shaping them as autonomous active agents in their death due to perceived choices to engage in risky behavior. Participants expressed frustration at the current social belief system that constructs addiction in neglect of a trauma-informed understanding, with implications for how HCPs internally validate their own grief.

Anticipatory grief can be considered a functional aspect of coping with loss and similar to research on Irish families (Lambert et al., 2021), but this did not always protect HCPs from traumatic shock. Clients sometimes passed away while they were perceived to be on a positive trajectory, with aspirations for their potential abruptly shattered.

Participants spoke about the mutual respect between them and their clients, evident from dialogue related to not wanting to let each other down. Contending with sudden loss against a backdrop of anticipatory grief inhibited efforts to make sense of the loss, and participants explained that the traumatic shock from such events is profound. Furthermore, HCPs often have to contend with visceral experience of finding client bodies, and the generation of intrusive recollections (Lakeman, 2011). Evidently, strong postvention protocols are required to mitigate posttraumatic stress responses.

HCPs who support people experiencing addiction require targeted support to mitigate the unique and complex grief-related reactions consequential of drug-related client loss. These findings suggest that a balance between both personal and professional processes is important, but participants openly acknowledged difficulties in achieving this. The process of internally validating their own grief was punctuated by self-stigma and a lack of external social acknowledgement on a broader societal level. Through relational based models of care, frameworks should aim to separate, recognize, and normalize grief-related emotional responses to client drug deaths. Normalizing such grief experiences at a broader societal level would assist in the internal validation of their grief and mitigate against experiences of disenfranchisement. Lead staff and healthcare professionals need to be accountable for making sure people do this in an effective way to avoid burnout and compassion fatigue, with targeted bereavement programs that understand that staff do not work with a detached emotional proficiency, that normalize grief-related reactions, and that support HCPs to re-enter work at a functional level; these policies should be an organizational priority.

4.1. Strengths, limitations, and directions for future research

The development of a conceptual framework and targeted support should aim to support HCPs in harmonizing their professional and personal equilibrium. However, in order to achieve this, the emotional facets of drug-related client loss cannot be neglected within organizational support structures. The concept of a dual process model to coping with grief was developed by Stroebe and Schut (2010) and recently applied to drug-related bereavement in families (Dyregrov et al., 2020). Subsequent findings by Dyregrov et al. (2020) posit that a healthy balance between loss-oriented and restoration-oriented processes is an important mechanism for reorientation following drug-related bereavement. HCPs certainly oscillated between two distinct processes when coping with drug-related client loss, but the true application of this model in a professional context requires further study. The demarcation between what functions as loss-oriented or restoration-oriented in this instance is undefined, particularly because many professional responses are borne out of organizational necessity, and personal responses are inhibited by internalized expectations of standardized professional conduct.

As McAuley and Forsyth (2011) noted in their study, no significant differences existed between grief-related reactions in staff of different disciplines. The current study explored this in further depth, and although no clear anecdotal differences emerged between staff of different professions, HCPs engage with clients in different capacities and further exploration of the intricacies of these dynamics in specific contexts is recommended. The experience of witnessing and encountering death can vary from profession to profession, and anticipating or responding to overdose can generate feelings of stress, fear and anger depending on the quality of training received or its recognition as a psychological trauma (Wagner et al., 2014). Therefore, as this study succeeded in identifying a range of professions where targeted support options are required for drug-related client loss, future research should aim to focus on specific disciplines to account for differences in engagement and support access.

Given that those with a dual diagnosis (i.e., substance use disorders comorbid with a mental health diagnosis) struggle with service access

(Karapareddy, 2019), services often run in parallel instead of integrated care. In these instances, people can fall between the cracks, leaving HCPs struggling to signpost their client to an appropriate recovery pathway. Future research should seek to investigate if this compounds workers' experiences of grief reactions.

Although not addressed in the current paper as an aspect of HCPs' grief experiences, throughout interviews, participants referred to their services as a community inclusive of the clients they work with. As a result, staff expressed concern for the clients who lose peers to drug-related deaths and raised questions about how this may affect the well-being of clients and bring their own morbidity to the forefront of their emotional regulation. Exploring the bereavement experience of people who use drug and related services when a peer dies by overdose is important to understand to improve services for those who avail of them. Future research should also aim to examine the potential impact of alcohol-related deaths within such communities and services.

Overall, HCPs who support people experiencing addiction can exhibit profound grief reactions that are often masked by their professionalism. As O'Brien (2011), as cited by Urmann (2020) identified the concept of the 'wounded healer' having significant implications for best practice, it is of crucial importance that HCPs are supported and protected in their venture to support clients in their recovery. Ensuring their well-being will, then, ensure that practitioners are also positioned to support drug death bereaved persons as highlighted by Løseth et al. (2022), whether that be family members, other practitioners, or other clients. In conclusion, as evidenced by the manner in which some participants maintained continued relational bonds with their clients post-death, the grief associated with drug-related client loss has a clear impact on practitioners who support people experiencing addiction.

Submission declaration

With respect to the named paper submitted to Journal of Substance Use and Addiction Treatment, the authors wish to confirm that the publication has been approved by all co-authors, there are no conflicts of interest to report, and this paper is not under consideration for publication elsewhere. The study was approved by the University ethics committee and ethical guidelines were adhered to. The work is original, and no copyright has been breached by the inclusion of any content drawn from another source.

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CRediT authorship contribution statement

Daniel O'Callaghan: Conceptualization, Methodology, Investigation, Validation, Formal analysis, Writing – original draft, Project administration, Data curation. Sharon Lambert: Conceptualization, Methodology, Validation, Formal analysis, Writing – review & editing, Project administration, Resources.

Declaration of competing interest

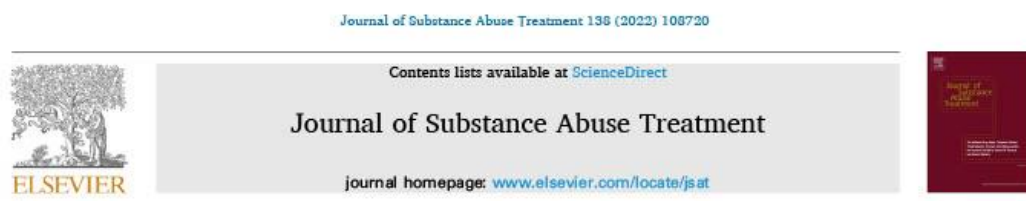
None.

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Appendix VII: Published Article from Chapter 8



The impact of COVID-19 on health care professionals who are exposed to drug-related deaths while supporting clients experiencing addiction

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ABSTRACT

Introduction: This paper explores the impact of the COVID-19 pandemic on health care professionals who support clients experiencing addiction. During the pandemic, addiction support became more challenging, as existing health care models had changed or been completely abolished. Clients continued to engage with social, justice, and health services in limited capacities, connecting with general practitioners, key workers, homelessness support workers, and other service providers. This marginalized population was among the most high-risk groups for adverse health outcomes during the pandemic and understanding the associated implications for practitioner well-being is crucial.

Methods: Fifteen health care professionals who work with active addiction in homelessness, public health, addiction, emergency medicine, and other areas participated in individual semi-structured interviews. Data analyses utilized reflexive thematic analysis.

Results: Four core themes emerged from the analysis: (i) Shift in Priority, (ii) Being Left Behind, (iii) Managing a Death, and (iv) Anxious Environment. Within each core theme, associated subthemes provide further context. The COVID-19 pandemic had a significant impact on the well-being of clinicians who work with people who use drugs, fostering a more anxious environment and compounding what can already be a high-stress occupation. Participants exhibited high levels of concern for the well-being of clients, and uncertainty permeated throughout conversations. Furthermore, staff expressed concern for their own well-being in the long term due to the inability to process adverse events, such as a service user's death, due to the chaotic nature of the pandemic.

Conclusions: This paper highlights some areas of concern to address for future service delivery and presents opportunities to future-proof services as the world moves toward hybrid models of working. The inflexibility of service provision during the pandemic and the digital divide due to public health measures pushed marginalized groups further into the margins, with significant implications for practitioner occupational well-being due to feelings of anxiety, powerlessness, and concern for mortality of clients. This study collects a broad scope of experiences across disciplines in health care and demonstrates how professionals navigated unprecedented circumstances.

1. Introduction

The declaration of the SARS-CoV2 virus outbreak as a pandemic in March 2020 created unprecedented challenges for health care professionals worldwide. For example, routine health care demands were exacerbated by the need for strict screening processes and social distancing requirements (Gavin et al., 2020). Turnover rates worldwide during the pandemic were at comparatively high levels (McConnell, 2020), leaving many health care settings substantially understaffed during a time in which services in the mental health sector were at an

increased demand (Xiang et al., 2020). Global research efforts have documented how the pandemic affected staff in many front-line disciplines, such as nursing (Labrague & de Los Santos, 2020), fire departments (Presant et al., 2020), and emergency medicine (Gavin et al., 2020). To date, literature is lacking that specifically addresses how the pandemic affected the well-being of health care professionals working in the addiction field.

One of the most high-risk groups for adverse health outcomes during the COVID-19 pandemic was individuals experiencing addiction (Dubey et al., 2020). Due to a high prevalence of medical comorbidities and

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environmental factors, many drug-dependent individuals navigate a range of health, social, and justice services. At each touchpoint, they connect with general practitioners, key workers, homelessness support workers, and other service providers (Perri et al., 2020). Addiction support and recovery became a significant challenge during the pandemic, as existing health care models changed or were completely abolished. The associated implications of these changes for practitioners have yet to be investigated.

The COVID-19 pandemic was not conducive to addiction recovery, and the implications for drug-related mortality were significant. Social support is a well-documented protective factor against relapse (Nikmanesh et al., 2017), and addiction recovery services often rely on group-based therapies (Columb et al., 2020; Liese & Monley, 2021). Evidently, social distancing requirements limited peer support options. Shared living spaces placed individuals at risk for coronavirus transmission and, to mitigate against the spread of the disease, residential services operated at largely reduced capacities (Perri et al., 2020). Marginalized groups experienced further social isolation, increasing the risk of overdoses occurring without observers who could provide medical intervention to counteract adverse drug reactions, e.g., naloxone (Volkow, 2020). Physiologically, comorbid cardiovascular and respiratory challenges are highly prevalent among drug-dependent individuals (Columb et al., 2020), which places them at higher risk for adverse COVID-19-related health outcomes with significant implications for mortality.

Current bereavement literature has identified grief-related and countertransference reactions in clinicians following the death of a client (Lakeman, 2011; McAuley & Forsyth, 2011; Yule & Levin, 2019). These studies highlight service providers as a vulnerable group in the aftermath of a service user death, calling for targeted support to address a high risk of complicated grief. The deaths of elderly patients often have generally normative healing trajectories, but a death by suicide, which is sudden and traumatic, may require targeted bereavement support (Murphy et al., 2019). Predictors for complicated grief, as such, include the nature of the death and closeness to the deceased. Recent literature has identified intense and complicated grief reactions associated with drug-related deaths, where deaths occur due to substances, but the cause of death may also be violence, accidental overdose, infectious disease, or suicide (Lambert et al., 2021; Titlestad et al., 2019).

Given that global drug-related deaths are increasing in prevalence (European Monitoring Centre for Drugs and Drug Addiction, 2020), and COVID-19 inhibited available supports while indirectly increasing mortality risks, considering the well-being of professionals who are exposed to drug-related deaths while supporting clients is important. These deaths can be socially stigmatizing, and associated bereavement outcomes include guilt, self-blame, anxiety, and, conversely, relief (Titlestad et al., 2019). Research to date has primarily focused on families, but a study by McAuley and Forsyth (2011) in Scotland examined grief-related reactions in service providers who experience drug-related deaths as part of their caseload. The authors examined emotional responses to a client's drug death using a self-report questionnaire with 76 caretakers across social, health, and voluntary care sectors. The key finding of this research was that grief-related reactions were present in 90% of the sample, with the most common grief-related reactions including self-blame, helplessness, anger, and thoughts about their morbidity. No statistically significant difference occurred in mean grief-reaction scores between staff of different disciplines. Yule and Levin (2019) more recently addressed the identification of grief-related reactions in service providers specific to drug deaths in a literature review. The authors drew on literature from other stigmatizing deaths such as suicide and suggested that clinicians who experience the death of a patient by drug-related outcomes are at increased risk for higher stress levels and grief-related reactions.

The responsibility to provide a high standard of care during the pandemic was challenging for service providers, especially while maintaining their occupational health. Clients of professionals providing

addiction services face further risks to their mortality compared to other health care settings. The complicated nature of drug-related bereavement has significant implications for providers, who are placed at increased risk for prolonged grief outcomes such as self-blame, depression, and anxiety (McAuley & Forsyth, 2011; Titlestad et al., 2019). Furthermore, a decreased sense of job control and increased demands both in and out of work can lead to a rise in occupational stress (Jetha et al., 2017), which may be exacerbated by unprecedented circumstances. As such, the aim of this study is to examine how COVID-19 impacted the well-being of health care professionals who are exposed to drug-related deaths while supporting clients experiencing addiction. The paper examines this impact within a range of different health care professions, with considerations for future practice and evolving opportunities to support staff in the future.

2. Methods

The current study is explorative and takes a phenomenological approach to understanding how the COVID-19 pandemic impacted the well-being of Irish health care professionals who support clients experiencing addiction. The first author conducted 15 individual semi-structured interviews, employing reflexive thematic analysis (Braun & Clarke, 2019) as a framework to interpret the transcripts in a hermeneutic manner.

2.1. Participants and sampling

This study includes 15 participants, seven men and eight women, all classified as health care professionals working in areas such as homelessness, addiction, public health, and emergency medicine. Initial recruitment occurred through purposive sampling by emailing departmental leads of various organizations. The email contained an information sheet for circulation in the service if appropriate. Further recruitment transpired through a snowball effect.

This research took place as part of a larger qualitative study examining drug-related bereavement in Irish health care professionals. However, as data collection commenced, staff had been working under pandemic-related conditions for several months. Therefore, capturing their experience during these times was of significant importance. To reflect the objectives of this research, the inclusion criteria were as follows: participants had to be older than 18, in direct contact with clients who are actively using drugs, and to have experienced the drug-related death of a service user during their time of employment. As an additional inclusion criterion, all staff had to be in active health care roles throughout the pandemic, a requirement fulfilled by all participants. The study had no sex or gender restrictions. The recruitment process excluded recently bereaved staff (within the last 3 months) with

Table 1
Profile of participants.

Participant	Role	Participant	Role
Participant 1	General Practitioner	Participant 9	Community Detox
Participant 2	Inclusion Health Social Worker	Participant 10	Addiction Counsellor
Participant 3	Homelessness Project Manager	Participant 11	Emergency Medicine Consultant
Participant 4	General Practitioner	Participant 12	Community Drug-Alcohol Worker
Participant 5	Addiction Project Manager	Participant 13	Housing Support/Addiction After-Care
Participant 6	Clinical Nurse Manager	Participant 14	Counsellor in Addiction
Participant 7	Researcher in Social Services	Participant 15	General Practitioner
Participant 8	Paramedic		

consideration for their psychological state.

Table 1 lists the current roles of participants, but participants also spoke retrospectively of previous relevant occupations.

Participants worked throughout the Republic of Ireland, with staff based in the south, southeast, mid-west, west, and east of the country. This study has a wide geographical spread, but each participant's specific location remains anonymized.

2.2. Data collection

The first author collected data through 15 in-depth individual semi-structured interviews. Thirteen interviews took place online via Microsoft Teams and two by telephone. An external audio device recorded the interviews, which were then transcribed verbatim. The data collection process took place from October 2020 to December 2020. Interviews ranged from 30 min to 57 min in duration, and the average duration was 44 min.

The semi-structured interview schedule guided the interview process; the schedule contained a list of seven open-ended questions asked across all interviews to ensure consistency and to allow the exploration of unanticipated topics. Participants spoke about drug-related bereavement and any implications COVID-19 had on supporting people throughout their addiction and recovery. COVID-19 was a recurring and unprompted topic throughout interviews, but the interviewer also dedicated specific questions to understanding how COVID-19 affected participants. The interviewer encouraged participants to speak at their own pace, but in adherence to general interview protocol for qualitative research, interviewer prompts and relevant questions facilitated further conversation. A briefing process occurred at the beginning of each call, informing participants of the sensitive nature of the study and of their right to pass on questions or end the interview at any time. However, none of the participants chose to do so. Debriefing conversations occurred at the end of each interview, including a reminder of relevant support services available if required.

2.3. Data analysis

Data analyses utilized Braun and Clarke's (2019) updated reflexive thematic analysis framework for conducting thorough exploration and interpretation of data transcripts, with findings reported in adherence to the standards for reporting qualitative research outlined by O'Brien et al. (2014). Both authors are experienced researchers who work with marginalized populations and consider reflexive thematic analysis to be the most appropriate analytical framework for bringing their research values, skills, and training to the data as they generate patterns of latent meaning (Braun & Clarke, 2021). The stages in Braun and Clarke's process are sequential but allow for fluid movement between phases. The stages are as follows: (i) familiarization with the data, (ii) coding the transcripts, (iii) generating initial themes, (iv) reviewing emergent themes, (v) defining the themes, and (vi) writing up the findings.

Each author familiarized themselves with the data, and the first author carried out inductive coding using NVivo qualitative analysis software (QSR International Pty Ltd., 2020), adopting a ground-up approach and creating codes through direct examination of the data. Upon generation of the initial codes, the authors engaged in continuous dialogue about theme generation. Back-and-forth movement between phases was common when new codes and concepts emerged from conversations related to the data. Given the inherently subjective nature of the coding process, the first author engaged in reflective journaling at the start of the coding process, adhering to the updated reflexive thematic analysis framework by Braun and Clarke (2019). This journaling facilitated written reflections about how the first author's experience in the area and how preexisting assumptions may have influenced any potential biases emerging during the coding process. The journaling process, supported by ongoing conversations between both authors, ensured that the researchers approached the data in the most inductive

manner possible.

2.4. Reflexivity

When utilizing reflexive thematic analysis, researchers must address how their experience and preexisting assumptions may influence interpretations of the findings. The first author has prior experience working with socially excluded populations in addiction services through research-based practice. The second author has both practitioner and research experience in addiction services. The first author was the sole interviewer, but the authors met to debrief and discuss the data after each interview. In our efforts to ensure an inductive approach to analysis, sometimes evidence of deductive thematic analysis emerged in the data, bringing assumptions into our interpretation. However, our use of reflective practice ensured our efforts to address this were comprehensive and congruent with our responsibilities as qualitative researchers (Dodgson, 2019).

2.5. Ethical considerations

The departmental ethics committee at the authors' university granted ethical approval for this research. Furthermore, the research protocol followed the Code of Ethics outlined by the Psychological Society of Ireland. Recruitment emails contained a briefing sheet and consent form outlining the voluntary nature of the study, and ensuring that data gathered during the interview would remain confidential and anonymous. Prior to interviews, the participants returned electronically signed consent forms to the first author. For data management and protection purposes, the authors stored the interview recordings on an encrypted laptop with a password-protected Microsoft OneDrive provided by the university. Data will be stored for a minimum of 10 years in the university data repository. Upon completion of a transcript, both authors discussed any further identifying information requiring removal from the data.

3. Results

Four core themes emerged from the analysis: (1) shift in priority, (2) being left behind, (3) managing a death, and (4) anxious environment. Core themes are supported by subthemes to provide further information and context.

3.1. Shift in priority

The participants in this study acknowledged that despite their wealth of professional experience, they were not fully prepared for the unprecedented challenges that the pandemic created. Staff members experienced widespread anxiety and increased occupational stress in the workplace, and evidence existed of confusion among staff as sudden changes emerged in their roles. Safeguarding against the spread of COVID-19 took priority in environments that typically prioritize the service user. Themes of internal conflict surfaced as participants addressed how their new priorities challenged their values as health care workers: "In addiction you've got to be flexible. Especially with COVID, it can't just be about the client now. I have to consider all the people in the building, my colleagues, my staff. Myself, even my own family." The shift in prioritization that Participant 10 described represents cognitive dissonance as contradictions arise between duty to clients and duty to oneself and others. Many project workers who have dedicated their professional lives to improving education, training, and support outcomes for marginalized populations witnessed their work come to a halt due to new priorities, such as Participant 3: "For me [COVID] has changed literally everything. The project I've spent years building has been suspended and I'm redeployed." The repercussions of this change are two-fold; these changes have mental health implications associated with increased job stress and a reduction of training and support opportunities for

marginalized groups.

Participants acknowledged the timely importance of investing resources into pandemic-related research and protocols but feared that this prioritization retracted from some basic harm reduction techniques utilized in addiction. Participant 4 outlined the shift in priority within the health care system:

Basic harm reduction, naloxone, needle exchange. Even just hepatitis C treatment, it has stopped you know, and it was just about to get going. In the last six months, I don't know if I've had one patient who was treated. It just gives you an example that the focus and the funding is on COVID, and yes it has distracted from some of the basics.

Staff expressed concerns that the fundamentals keeping many people alive did not have the same reach during the pandemic, even though addiction remained a prevalent issue. Drug-dependent individuals were at a significantly higher risk of overdose without any observers present to provide pharmacological support such as naloxone.

3.1.1. High threshold

The reprioritization of organizational components within addiction support and recovery also affected service delivery, reducing ease of access for service users. The pandemic necessitated the introduction of new administrative protocols and abolished the low threshold environment, which participants feared might result in fewer clients following through with service engagement. Contact tracing individuals with chaotic lives is difficult, and Participant 1 explained that the pandemic circumstances were not conducive to ideal operations. In fact, COVID-19 protocols contradicted the very foundation on which addiction support is built: *"The ideal is to have specialist low threshold services, no appointments, the least amount of administrative barriers. And all of that is the total opposite of what we're told to do as a service provider to keep the service safe now [during the COVID-19 pandemic]."*

Numerous once-accessible services ceased operations with implications for social work, homelessness, and other residential services. Participant 3 demonstrated the impact of this new "high threshold": *"I can't bring someone from the streets or another project in because then it creates more potential exposure to COVID."* Concern for people who rough sleep permeated throughout the theme of reprioritization, where integrating new people into services and existing projects was almost an impossibility. The closure of drop-in services also had a significant impact on recovery progression, and for the participants in this study, the loss of control over critical responsibilities was extremely stressful. Participant 2 highlighted some of the emotions associated with this loss of control:

I'm qualified around 10 years now and it's more so just a feeling of sadness and frustration where I could either scream at someone or cry my eyes out...Whereas before COVID, you could discharge someone from a hospital, get them two weeks in a B&B with a guaranteed detox bed at the other end. That's not the case now. I can barely get a key worker to ring them once a week to see if they're alright.

3.2. Being left behind

Amid the changes resulting from the pandemic, addiction continued to exist as a public health concern. Participants emphasized the importance of recognizing that people experiencing addiction were significantly more vulnerable than they were before the pandemic. As described by Participant 1: *"Addiction doesn't go away, and the lockdown has pushed more people to risky behaviors...I feel [the pandemic] is going to leave more people behind than were being left behind before."* Health care professionals take pride in their responsibilities, as summarized by Participant 15, a health professional working with active addiction,

"what you're trying to do is hopefully keep people alive long enough for them to get enough chances to get better." A prevailing sense of uncertainty existed among staff about the effectiveness of support efforts in achieving this goal during the pandemic, and some participants, such as Participant 6, reflected on the loss of control:

That is my biggest fear right now. Mental health difficulties go unrecognized in the monotony of this. Outside of COVID, it's really hard to be in hostels for years. My biggest concern, those guys that are chronically homeless and taking tablets are such high risk and I don't feel empowered. I don't feel I can do anything for them right now, even as somebody with a lot of experience. I feel a little bit helpless in this situation.

Participants expressed deep concerns about how service engagement became more challenging for an already marginalized population. In the extract above, the participant exhibited a sense of helplessness in being unable to draw on their experience to reach those who had become further marginalized. With drug-related deaths continuing to be a major public health concern, participants feared that more clients would experience adverse health outcomes while being left behind due to the reduced reach of support services.

3.2.1. Lost in transition

Participants identified the transitional stage among phases of recovery as a critical period, and as clients experienced significant delays in their recovery, service providers had an increased responsibility to watch over, maintain contact with, and keep clients on course. A prevailing sense of insecurity existed due to prolonged wait times increasing the risk of service users experiencing "slips" in their recovery, dropping out of contact, and getting lost in the transition. Participant 3 illustrated her concerns when reflecting on the noticeable changes in service users' recovery since the onset of the pandemic:

The amount of people who have had serious slips in their recovery whether it be mental health, starting to self-harm, engaging in crime, the lack of routine and structure, increases in domestic violence, tenancies being lost. If you're in recovery and you were struggling beforehand, you know it's too much to handle for people on their own.

The lack of outreach and residential treatment options heavily impacted stabilization programs, and extended waiting lists needed to be considered within care plans. Participant 2 stated that COVID-19 made procedures more strenuous with the closure of so many services, concurrently affecting morale as staff scrambled to ensure their clients maintained their course. She solemnly described the demoralizing effect that COVID-19 had on her as a professional:

It's great when you see people want to change their behaviour, but now I have nowhere to get for them. You are trying so hard to stay in contact with people who have chaotic lifestyles over the phone to maybe keep them going with a little bit of motivation along the way just to keep them alive. Until something might come up, but you don't know when that's going to come up. I can't do that for six months...It's really disheartening as a worker to know that a service might not be available for someone, when you know they're ready now.

3.2.2. Digital divide

The shift to virtual communication was a prevalent topic of discussion in the interviews, and participants reported varying experiences with its implementation. Participant 1 demonstrated that marginalized populations were at risk of being further divided with the move to virtual communication for professional support: *"The front doors of services were shut, and not all my patients and clients have smartphones and can't do video counselling. There is a digital divide"*. Other participants, such as

Participant 6, echoed these concerns: *"I don't think for this population that virtual consultations work very well. Personally, I find it difficult, but that might just be because the infrastructure wasn't set up."* The mention of "infrastructure" acknowledges the potential for successful integration of virtual support. However, such support required heavy facilitation that was not always available due to prioritization changes and staff redeployments.

The difficulties with virtual consultations were rooted in their limited reach. Participants spoke of clients with intellectual disabilities, language barriers, or a lack of technological understanding who struggled to engage. However, participants openly acknowledged that even well facilitated virtual consultation systems had some insurmountable barriers. The pandemic exacerbated the challenge of keeping in touch with clients with chaotic lives, as stated by Participant 10: *"I have so many clients where having the internet, having smartphones or even having the same phone number is a challenge."* These difficulties resulted in valuable time lost with clients and, in other cases, service users were not comfortable discussing their lives online or over the phone. Participants prided themselves in creating a safe space for clients within their practice, and feelings of frustration and helplessness permeated throughout interviews as COVID-19 abolished the sense of safety and security staff had fostered over their years of experience:

A lot of people we work with are very self-conscious about asking for help. Some don't like speaking over the phone, because they might have a mental health fixation on the fact that someone is going to hear something about their business. On the phone, how are you supposed to make someone feel safe?

However, we should also acknowledge that participants reported positive experiences with virtual communication, especially when communicating with other professionals and when considering implications for future practice. Participant 14 outlined his experience of working with fellow support workers. This counsellor acknowledged similar difficulties but demonstrated how, with the correct infrastructure, professionals could learn from the pandemic circumstances to develop efficient virtual practice alongside in-person support:

We were brought together in this virtual team and we had a task to ensure that any social inclusion clients presenting with symptoms or were close contacts, we were able to configure self-isolation accommodation for them... I've actually learned to make the most of the functionality. I've been able to do workshops and use breakout rooms and other facilities to make the work very engaging. That's one positive thing we can bring into the future.

3.2.3. New relationship dynamics

All participants spoke compassionately about the relationships they had developed with their clients. In detailing these impressions and connections, staff recalled pleasant and positive memories while becoming invested in their recovery. Service users being left behind during the pandemic was a significant source of anxiety for workers, not only from a professional standpoint but also from an emotional one. Staff emphasized the deep personal fulfillment in maintaining these relationships, but the pandemic strained some of these connections. Some clients began to take the safety protocols personally and felt threatened by them. Participant 10 provided an example as to how she mediated this: *"I was very cautious about a mask not meaning 'you're dirty and I'm wearing a mask in case you have the disease'. I was clear that I was wearing a mask because I was instructed. I don't have a choice – it's my responsibility to keep them safe."*

Relationship-building plays a crucial role in keeping clients engaged with services. In recognizing the value of positive relationships with clients, staff acknowledged that new protocols, alongside the digital divide, added a further layer of complexity to the navigation and maintenance of these relationships. Participants were concerned that the sudden shift away from in-person contact and reduced proximity would offset these often-delicate relationships. They also considered

how this change might influence a client's service engagement and well-being. Many participants, such as Participant 4, expressed concerns that some of their clients felt left behind or abandoned due to their new responsibilities, especially in residential settings:

It has a huge impact on staff well-being. When we are in complete lockdown, you can't meet people. We have such an amazing relationship with the participants over the years and they've built such trusting professional relationships that you become a huge support person for them. But all our service users may not understand the fact that I've been redeployed and I'm unavailable. In lockdown, you can't even meet up for a coffee.

3.3. Managing a death

The strong emotional investment staff have in their clients' recovery means that, in the event of a death, the death must often be marked emotionally alongside the procedural requirements associated with being a health care professional. Managing a death in this manner was difficult due to the lack of "downtime" during the pandemic. The overwhelming consensus among participants was that when a death is associated with addiction, enmeshed feelings of self-questioning, blame, and guilt occur. Participant 15 detailed the range of emotions she experiences when a service user dies by overdose or other drug-related complications: *"There's an unbelievable guilt. I always feel it's my fault if one of my patients dies, as you always feel it's such a shame and so unnecessary and unfair and potentially preventable."* Describing the deaths as preventable implies a degree of responsibility or control over the circumstances.

The pandemic hindered efforts to keep people alive and when participants solemnly reflected on deaths that had occurred since March 2020, the increased loss of control and anxiety generated from working during this time exacerbated bereavement outcomes. Alongside increased guilt, self-questioning was also prevalent in this theme, as participants questioned if the deceased would still be alive under pre-pandemic circumstances. When speaking about a drug-related death that occurred during the pandemic, one participant stated: *"I've always found that bringing services to people where they are is much better and without the ability to do that you need a lot more coordination on site and I just find that I wasn't really there."*

The personal investment staff have in the well-being of their clients further illustrates the devastating impact COVID-19 had on addiction support. In the event of a service user's death during the pandemic, the strain and changes in proximity in some of these relationships made the grief process more complicated. Pre-pandemic, processing grief was difficult due to these well-built and trusting relationships. During the pandemic, it became even more difficult due to how fast service provision was required to move forward. Furthermore, funerals were difficult to attend due to public health restrictions. Participant 9 highlighted the importance of funerals for service users and staff:

Their peers have literally been their own family unit for years. And they're left with nowhere to process that emotion, or that grief. They can't attend the funeral. Now, in the pandemic it's easy for families to say [it's closed] due to COVID restrictions. The lads then struggle to emotionally regulate around this person's death. If I don't go to funerals, I always expect them to come back. It's me closing that relationship with them. And it's also an acknowledgement of the fact that they were part of the community we belong to.

Health care professionals played a crucial role in supporting marginalized groups but simultaneously placed themselves and their close contacts at risk for disease transmission when on site. Balancing the duty to protect themselves while maintaining a stable and healthy environment in the workplace and at home became a significant challenge. With little time to process adverse experiences, particularly after the death of a service user, Participant 4 pondered the long-term implications for his and his colleagues' mental health:

I'm conscious that COVID has brought this in, we are now fitting in more stuff into our days. So, they're a little bit more frantic, and that background noise number one. And [contracting COVID-19], number two. It impacts on how all of it affects us from... First of all, the background noise in one way doesn't allow us to stop and think about [service user deaths] as much as we might have and I suppose the background stress, the impact of this actually makes the stress worse.

3.3.1. Loosening of the guidelines

The sudden onset of the pandemic necessitated immediate regulatory changes within services. The creation of quick solutions to unique challenges resulted in abolishing existing operating procedures and altering others to cater to the emerging needs of service users. The supply of methadone was a recurring topic during interviews, especially among general practitioners. Participant 4 provided context to this:

There was a set of guidelines that you had to go by pre-COVID, but they actually were loosened because of COVID. We needed to see more people, so instead of seeing someone that we might have seen every two weeks you might now see them every three weeks. You might give them a little bit more takeaways so that they don't have to go to the chemist every day to get their methadone. Those sort of loosening of the guidelines means that everyone is a little bit more exposed.

These data emerged within a conversation about service provider protection following the drug-related death of a service user. Participant 4 mentioned colleagues that experienced legal issues while managing a drug death in a service, and the loosening of the guidelines created further anxiety surrounding decision-making processes and legal outcomes for professionals. COVID-19 guidelines also had implications for the homelessness sector. A reduction in beds and living spaces led to frustration among service providers who, again, questioned how events might have played out in other circumstances:

Our rooms in the shelter were shared rooms, and that would be strategic, because when people were intravenous drug using we tried to create a culture of a buddy system. So, if we had two intravenous drug users they'd share a room so that if one got into difficulty the other could raise the alarm. With COVID that system has been abolished. We've had 15-bed shelters reduced to 8, shelters with 70 beds reduced to around 44.

3.4. Anxious environment

The theme of anxiety was prevalent throughout interviews and, as it permeated throughout conversations, evidence suggests that COVID-19 fostered an anxious environment within the context of service provision. Many service users live with comorbid health difficulties that placed them at high risk for adverse health outcomes during the pandemic, and the fear of outbreak within residential services was a perpetual concern for both staff and service users. Participants spoke about how fortunate they were not having experienced this in their own workplace but acknowledged other services where a single COVID-19 case had crippling effects on service provision. Participant 3 detailed the anxiety and constant monitoring that occurred within a shelter for people experiencing homelessness:

The anxiety of some of the residents and staff with regards to COVID like... We are doing temp checks twice a day, assessments every time someone comes and goes. Even with that, the masks obviously in place, social distancing in place, reducing numbers in and out of kitchens. You can still see how much people are nervous and anxious about it.

The anxiety surrounding the implications for their profession extended across all disciplines represented in this study. During interviews, participants questioned the quality of their own mental health, given the increased level of consideration they needed to maintain for others. For Participant 8, a paramedic, house calls could have had significant implications if not carried out with due care: "There's a bit of a suspicion or fear there within paramedics as well for [our safety], like 'Does this person have COVID?'" The increased health risks, demands, and anxiety surrounding the consequences of their work for their loved ones contributed to a concurrent rise in occupational stress. Participant 3, who worked in homelessness shelters throughout the pandemic, spoke about the difficulty in separating oneself from the anxiety: "It is so impactful at all levels... Never, ever, ever have I found it so difficult to separate work from home." Navigating the working day while considering the welfare of their colleagues and family added an extra layer of complexity to the work-life balance, which was typically crucial to maintaining positive mental health routines.

4. Discussion

The current study examined how COVID-19 impacted the well-being of health care professionals who are exposed to drug-related deaths while supporting clients experiencing addiction. The findings identified many obstacles unique to the pandemic and highlighted how lockdown restrictions compounded existing challenges in service provision. Staff experienced increased anxiety and occupational stress due to the chaotic nature of operating during these circumstances. With little opportunity to address this, concerns about the long-term impact of the pandemic were prevalent, particularly in relation to service users being left behind by new protocols and the subsequent impact on mortality rates in addition. Participants reflected on potential long-term effects on their well-being as they worked at a frantic pace with little time to process adverse events.

Sudden role changes and the reprioritization of responsibilities prompted internal conflict within staff who had adhered to personal and professional values throughout their careers. Staff with more than 20 years of experience in addiction support expressed feelings of increased occupational stress due to unfamiliar barriers and the inflexibility of the "high threshold." Jetha et al. (2017) developed a system dynamics model of workplace stress among nurses and acknowledged that workplace stress is constantly evolving. The key findings of the study stated that job control, social support, workplace safety, and demands outside of work are strong predictors of poor mental health outcomes in health care professionals (Jetha et al., 2017). Similarly, as the pandemic evolved, key occupational stressors included increased out-of-work demands when trying to keep their loved ones safe, a loss of control over their core responsibilities to keep clients alive, and decreased workplace safety due to the fear of disease transmission. A continuous cycle of stressors resulted in intensified feelings of frustration, fear, and helplessness. In moving to a new model of service provision following the reopening of services, much can be learned from service providers' experience during this pandemic in how they adapted both professionally and emotionally. Furthermore, we can identify their needs in the face of intensified stress. Organizations can examine these experiences retrospectively to inform policies to optimize their staff's occupational health in times of unprecedented distress while also optimizing support provision to marginalized groups.

The direct health implications of COVID-19 for people experiencing addiction are widely understood within the literature (Dubey et al., 2020), but participants urged health care systems to recognize the indirect effects of the pandemic on marginalized populations. Staff highlighted that some clients were being left behind and experiencing "slips" in their recovery due to delays, issues with virtual support, and increased social isolation. As a result, service providers experienced further anxiety while trying to support their clients in line with public health restrictions. Research suggests that self-efficacy beliefs and social

support play important roles in preventing relapse, as examined by Nikmanesh et al. (2017) through a quantitative self-efficacy scale and a multidimensional scale of perceived social support. The current study reflects these findings, but the pandemic made it difficult for staff to reinforce these values through limited face-to-face contact when relying solely on virtual support methods.

However, as the world moved forward into more hybrid service provision with increased vaccination levels and services re-opening worldwide, opportunities existed to develop safer, multi-faceted service provision systems that incorporate the strengths of both virtual and in-person support to provide a wider reach. The pandemic resulted in a pivot to hybrid working models with an increase in telehealth utilized in a range of health services. Research on new working practices emerged at the time of this study, so it is difficult to draw conclusions about how different cohorts adjusted. Similar to the participants in the current study, some have argued that telehealth provision has facilitated easier access to services (Molfenter et al., 2021), and others are concerned that particular cohorts have struggled with access to technology and isolation (Moore et al., 2021). Limited data exist from the service users' perspective. More research on this topic will likely emerge from which informed conclusions could be drawn. The use of telehealth may have had positives for some groups and negatives for others. Many frontline service providers have expressed concerns that drug-related deaths increased during the pandemic. If this is the case, we need to understand if the lack of face-to-face service provision played a role in these deaths. Until research fully establishes this, we cannot draw conclusions or make recommendations.

Managing a client's drug death became significantly more challenging for staff during the pandemic, particularly with increased uncertainty surrounding the quality of their health care provision in unprecedented circumstances. Practitioners typically followed a set of principles when caring for their clients, but the pandemic circumstances altered many of these guidelines. This change left health care workers feeling less protected in their decision-making processes (e.g., methadone prescribing) as regulations around their responsibilities were loosely defined. This insecurity subsequently fostered further anxiety in staff surrounding their efforts to keep clients alive, intensifying their sense of self-blame following a drug-related death. These sentiments provided by Irish health care practitioners echo changes in international regulations, such as in the United States, where the Substance Abuse and Mental Health Services Administration directed treatment providers to prescribe take-home medication more flexibly during the pandemic (Substance Abuse and Mental Health Services Administration (SAMHSA), 2020, as cited by Volkow, 2020). To protect workers' well-being, they must feel supported in their decision-making in times of high stress.

Similar to the current study, McAuley and Forsyth (2011) examined grief-related reactions in health care workers who work with people who use drugs. Many bereavement outcomes emerging from the 2011 study's surveys were prevalent in the current study's interviews. The extenuating circumstances emerging from the pandemic intensified bereavement outcomes such as self-blame. The findings of this study coincide with existing bereavement literature in recognizing the drug death of a service user as a harrowing experience for health professionals (Lake-man, 2011; McAuley & Forsyth, 2011; Yule & Levin, 2019), but findings also highlighted that the pandemic compounded the grief process.

Given the long-term impact of complicated grief (Lambert et al., 2021; Titiestad et al., 2019), more rigorous welfare policies must be implemented to protect employees' well-being. More specifically, policies should aim to decrease anxiety around decision-making and provide targeted bereavement recovery programs that address complicated grief. From an organizational perspective, the procedural acknowledgement of a client's death involves the completion of the appropriate documents and contacting relevant people. However, this study highlighted clear emotional connections between the service provider and client, and organizations must not fail to address the emotional

component of marking a death. Funerals play a significant role in closing the relationship from an emotional perspective, and the pandemic resulted in reduced access to these ceremonies. The authors recommend creating a space to mark these deaths for staff (and service users) within an organization's framework.

4.1. Conclusion and implications

Leading epidemiologists and climate scientists argue that pandemics are likely to become more common, and this COVID crisis provided an opportunity to learn and reflect on future-proofing services. This study collected a broad scope of experiences across disciplines in health care and demonstrates how professionals navigated unprecedented circumstances. The in-depth methodology (Braun & Clarke, 2019) allowed for an intricate understanding of the internal conflict within participants and the difficulties they encountered in caring for their clients. All participants had a concern for the mortality of those left behind by the system. While the number of those who have died due to drug-related deaths during the pandemic were unknown at the time of writing, the anecdotal evidence from front-line providers in Ireland is that a significant increase occurred (O'Carroll, 2020).

Excessive occupational stress in health care workers has well-documented implications for well-being and is associated with elevated levels of employee burnout (Meng et al., 2015). This paper highlights some areas that are cause for concern and should be addressed for future service delivery. The inflexibility of service provision and the digital divide due to public health measures pushed marginalized groups further into the margins. Services should pivot to the provision of intensive individual care working within public health guidelines and aim for daily communication with people who live chaotic lives. The impacts of drug-related deaths on staff and service users are profound and require appropriate policies and support, with heavy investments in making services available with as few obstacles as possible.

This study provided an overview of different professions that shared many common difficulties. However, the first author conducted each interview with a single participant. This area of study would benefit from increased insight from the various health care roles represented in this study. Future studies could benefit from focus groups to gain further professional insight into how the pandemic influenced operations. Furthermore, highlighting any potential differences between disciplines would support the development of a measure to explore possible health outcome differences among occupations, with the aim of providing targeted support to addiction counselors, general practitioners, and other health care workers as required. Finally, while the participants in this study provided a comprehensive overview of clients' experience, subsequent studies should aim to examine the impact of the pandemic on service users themselves.

Overall, the COVID-19 pandemic had a significant impact on the well-being of clinicians who work with people who use drugs, fostering an anxious environment and compounding what can already be a high-stress occupation. However, service providers admirably continued to support marginalized populations in the face of unprecedented circumstances.

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CRedit authorship contribution statement

Daniel O'Callaghan: Conceptualization, Methodology, Investigation, Validation, Formal analysis, Writing – original draft, Project administration, Data curation. Sharon Lambert: Conceptualization, Methodology, Validation, Formal analysis, Writing – review & editing, Project administration, Resources.

Declaration of competing interest

With respect to the named paper submitted to Journal of Substance Abuse Treatment, the authors wish to confirm that the publication has been approved by all co-authors, there are no conflicts of interest to report, and this paper is not under consideration for publication elsewhere. The study was approved by the University ethics committee and ethical guidelines were adhered to. The work is original, and no copyright has been breached by the inclusion of any content drawn from another source.

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'Special death': Living with bereavement by drug-related death in Ireland

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ABSTRACT

This paper explores the impact of complicated grief on the family system following the drug-related death of a family member. Drug-related deaths are rife with moral stigmas, and those left behind often carry an emotional burden laden with shame and guilt. 17 bereaved family members were interviewed using semi-structured interviews and transcripts were analyzed using reflexive thematic analysis. Three core themes were generated: Renegotiation of Relationships; Experiencing Complex Emotions; and Adjusting to a New Reality. The findings demonstrate that this population experience great difficulty in processing their grief as they struggle with family breakdown, navigating supports and stigma.

The World Health Organization has described drug dependence as a growing major disease burden and current trends indicate that associated mortality is increasing (EMCDDA, 2020). While most countries record these deaths statistically, there is limited research regarding the impact and lived experience of the families affected. Drug-related deaths (DRDs) are often sudden losses with negative societal connotations that challenge the normative grieving process of the bereaved. In this context, DRDs are deaths from the intake of narcotics where cause of death may be due to violence, accident, infectious disease, or suicide (Titlestad et al., 2019). While there is recent literature surrounding the impact on the family of living with problematic substance misuse, and physical and mental health effects have been reported, the bereaved who have lost a loved one to drug-related complications are an understudied social group (Titlestad et al., 2019; Titlestad et al., 2021). The dual process model of grief by Stroebe and Schut (2010) has recently been applied to this phenomenon as a theoretical framework, and the unique difficulties in healthy oscillation between loss-oriented and restoration-oriented processes are evident in how the bereaved experience their grief.

In Ireland, and internationally, there is no formal bereavement measure that estimates the number of people bereaved due to a DRD. However, current research estimates that for every DRD, there will be at

least 10 individuals who are impacted by the loss (Dyregrov et al., 2018 as cited by Titlestad et al., 2019). Despite the potential for widespread impact, historically the area of drug-related death had failed to generate interest amongst researchers in the social sciences with most reported studies emerging from other disciplines (Feigelman et al., 2011). A systematic review by Titlestad et al. (2019) synthesized the experiences of drug death bereaved family members across eight studies (two from the UK, three from the USA, and one each from Brazil, Norway, and Denmark). Although the review demonstrates a wide geographical spread, the review recommended increased qualitative and quantitative inquiry in future research efforts (Titlestad et al., 2019).

In discussing the phenomenology of grief as it relates to DRD bereavement, Dyregrov et al. (2020) explored the experience of this population from contextual, relational, and public health perspectives in the literature. Families bereaved due to a DRD experience many social, physical, and psychological health outcomes unique to the context of a "special" death, coinciding with the findings of Titlestad et al. (2019), including stigmatization, complex emotions, the lack of help when in crisis and the importance of help from peers. Furthermore, difficulties unique to living with active drug use prior to the death were also highlighted as risk factors for complicated grief, including stigma, relationship strain, and anticipatory grief. da

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Silva et al. (2007) identified six individuals in Brazil who had died by overdose and interviewed one associated family member. The concept of anticipatory grief, shame and stigma were prevalent findings in the Brazilian context and suggested targeted support for the unique nature of DRD bereavement.

Although there are currently no existing studies of strong methodological quality in Ireland, Templeton et al. (2017) explored the specific needs of this population through interviews with 32 adults who had been bereaved by fatal drug overdose in England and Scotland. Conducted as part of a larger study on bereavement, drug death bereaved individuals were a prominent cohort. The study included parents, siblings, and partners, but also included friends of the deceased, three of which were active drug users at the time of death. Interviewees detailed challenges in justice system interactions, stigma, complex emotions such as guilt and self-blame, and found themselves questioning their right to grieve. Furthermore, some interviewees were directly involved in responding to fatal overdoses, which may have led to thoughts about what could have been done to prevent the death. The authors stated that support for these individuals should consider the complex emotions and the difficulty experienced when thinking about culpability. Earlier studies conducted in the UK reflect these difficulties, as a pilot study by Guy (2004) revealed the complicated nature of bereavement, where family members report that the image of the deceased has been tarnished by their involvement with illicit substances, and that they are not entitled to grieve because the person who has died is blameworthy.

Christiansen et al. (2020) investigated parental mortality following the drug-related death of a child in Norway. Using cox regression analysis on parents with at least one child aged 15 or over (sourced from the population register and cause of death register), drug death bereaved parents were compared with those bereaved by other causes of death and non-bereaved parents. Parents bereaved by a drug-related death generally had a higher natural cause mortality, with a significantly high external cause mortality in the first two years post-death. Parents bereaved by a DRD had a high external mortality in the short term, where the grief is felt most intensely, increasing the possibility of accidental deaths, death by suicide, or substance use. However, this study did not explore the life experience associated with living with active substance use or the intensity of complicated grief.

Complicated grief prevents a person from accommodating their bereavement and does not naturally

lessen over time (Tobin et al., 2020). Disenfranchised grief is defined as “a loss that cannot be socially sanctioned, openly acknowledged or publicly mourned” (Doka, 2002, p. 4) because of the characteristics of the death or of the bereaved. To examine the experiences and needs of parents following the DRD of their child, Titlestad et al. (2021) conducted interviews with 14 drug-death bereaved parents in Norway. Using reflexive thematic analysis, themes related to preparedness, stigma, complex emotions, and relationships emerged in the data. These findings demonstrate the complexity of drug-death bereavement, where the paper highlighted the silence from helpers while living with active substance use, and silence from public services after death. The lack of tailored help during their child’s life led to parents experiencing a need for extended parental involvement in their loved one’s addiction.

Based on the evidence, there is a clear requirement for targeted interventions to address the complex grief experienced by this population. Templeton (2020) aimed to test an adapted version of the 5-Step Method as a psychometric tool within addiction services. Four practitioners utilized the adapted tool with six bereaved adults. All participants highlighted the value of a structured intervention that was tailored to the nature of their grief. In general, families valued the chance to talk through their loss, to have it understood and validated, and the compassionate response from practitioners was a clear facilitator in understanding their grief. However, this study also addressed substance-related issues including alcohol. The current paper deals specifically with drug deaths but the findings by Templeton (2020) may be pertinent to this population. It was concluded that supporting this cohort requires specialist knowledge.

The current study examines the impact of DRDs on the family system. However, while previous studies interviewed family members individually, we explore DRDs in the context of family dynamics by interviewing multiple family members at once. The paper is the first of its kind to explore the issue of DRDs in an Irish context, where the total DRDs are above the European average (EMCDDA, 2020). As a significant national (and global) issue, this paper aims to add to the current literature in understanding the nature of DRDs and associated challenges.

Methods

We aimed to provide a hermeneutic understanding of how families bereaved by a DRD in Ireland experience

Table 1. Profile of participant families.

Family and relationship to the deceased	Deceased	Cause of death	Time since death
Family 1: Mother, Sister, Niece	Male aged 21	Hanging	21 years
Family 2: Father, Mother	Male aged 27	Overdose	13 years
	Male aged 38	Liver failure	5 years
Family 3: Mother, Brother	Male aged 37	Overdose	1 year and 1 month
Family 4: Father, Mother, Sister	Male aged 40	Overdose	8 years
Family 5: Father, Daughter	Male aged 19	Hanging	9 years
Family 6: Mother, Sister, Sister, Niece	Female aged 46	Hanging	9 years
Family 7: Mother	Male aged 23	Overdose	9 years

complicated grief. The findings reflect the narratives, stories and experiences provided by the participant sample. To gather these stories, the first author conducted seven interviews, each with multiple members from a single family.

Recruitment and participant profile

All participants in this study were bereaved by a DRD, which was a primary inclusion requirement. Seven families comprising 17 affected family members discussed the impact of the early deaths in semi-structured interviews (Table 1). The relationships of the participants to the deceased were: three fathers; six mothers; one brother; five sisters; and two nieces. Interviews covered the early deaths of one female and seven males between the ages of 19–46 years old. Two of the deceased were brothers. The causes of death included four deaths by overdose and three by suicide. The time between the death and the interview ranged from 1 to 21 years.

For the purposes of providing a theoretical structure to the recruitment strategy, we considered Koerner and Fitzpatrick's definition of the family when preparing the sample, specifically "groups of intimates who through their behavior generate a sense of family identity with emotional ties and an experience of a history" (p. 177). Families were recruited through the National Family Support Network (NFSN) in Dublin, Ireland so that support services could be offered if requested following participation. The NFSN currently has 70 family support groups nationwide, and purposive sampling was used by the researcher via these connections to recruit suitable participants via recruitment leaflets. The recruitment leaflets indicated that participation would require a minimum of two family members, and members of the same family were interviewed together as the impact of a death can be particularly evident when viewed within the context of family dynamics. Individuals who conveyed their interest in participation were sent an information pack outlining the nature of the study. After the interviews, the

participants were provided with follow-up support from the NFSN if required.

To participate, families had to meet the study's definition of family and be active members of an NFSN support group. Persons under 18 years of age, people who had been bereaved within the last 12 months, and persons who disclosed an active addiction or mental health issue were excluded.

Data collection

Data was collected through six focus group interviews and one in-depth interview with a single mother using a semi-structured interview schedule. During initial contact with the researcher the mother explained that her reason for wishing to participate was to highlight the impact on her family. Her son's death was never discussed amongst her family and this story of silence was of considerable relevance to this study. At this point, it was considered ethically important to include her data.

The semi-structured interview schedule contained five core questions that acted as topic guides while simultaneously allowing the interviewees to address unanticipated topics of interest. After introductory and briefing conversations were held in the location of the interview, the five topics acted as thematic anchors for the purposes of consistency across the data: about the family, the impact of experiencing a drug-related death, challenges, support options and recommendations for supporting families, and the final question was a discussion about the value of the interview. In all interviews, some time was spent with the family viewing photographs of the deceased family member. Photos were voluntarily shared by the families and as such were not used as data, but rather to further discussion. Questions were open ended and allowed the interviewees to speak at their own pace. General qualitative interview practice was employed to further facilitate the conversations, such as the use of prompts, follow-up questions and paraphrasing.

One interview was conducted in the south of Ireland two in the south-east and four in the east. Six

interviews took place in the family home, and one interview was conducted in the office of the NFSN in Dublin. Interviews were digitally recorded and transcribed verbatim. Participants requested to conduct interviews in their own homes, and this safe and familiar space facilitated open discussion about a difficult topic. Interviews were carried out between August and December 2019 and lengths were dictated by the participants, ranging from 1 hour and 11 minutes to 2 hours and 40 minutes, not inclusive of any breaks that were requested. The average duration was 93 minutes.

Data analysis

Data was transcribed and analyzed using inductive reflexive thematic analysis. Using Braun and Clarke (2019) six-step process, the interview transcripts were analyzed in a sequential process with fluidity between phases in the interest of best practice. The phases involved familiarization with the data, coding, generating initial themes, reviewing themes, defining and naming themes, and writing up. All authors familiarized themselves with the data, and this was a recurring process due to recurring meetings after each interview was conducted. The second author, using NVivo software, generated the initial codes. However, before initial themes were generated, a rigorous process was carried out in which all authors examined, and suggested changes, exclusions, and edits to, the emergent codes. Deciding on the information included in each theme was a group effort carried out by all coauthors on this paper. Throughout the analytic process, the coauthors engaged in reflective practice as per the updated framework by Braun and Clarke (2019). The scope and naming of themes were agreed between coauthors.

Researchers and the subject of reflexivity

We adopted a reflexive approach throughout the entire research process as a form of quality control, as per Dodgson's (2019) recommendations on reflexivity in qualitative research. The nature of the topic and the qualitative methodology present a high risk of bias due to pre-formulated assumptions, and through reflective practice we aimed to reduce the risk of being influenced by our own interpretations. Each coauthor has previous experience in conducting qualitative research in addiction and with vulnerable populations, and all interviews in this study were conducted by the first author. With prior experience

of working with families in an addiction service and in therapy, this individual was the best fit to conduct sensitive, impartial interviews while being cognizant of their own prior assumptions or potential over-emphasis on certain topics. This researcher was the only one present at the time of interviews and had no previous experience in working with any of the participants.

After an interview was completed, all researchers met to listen to, and discuss, the recording. With the input from fellow researchers, this open dialogue allowed the interviewer to reflect on any emerging biases, and to be aware of how this may have influenced the interviews. Consideration was also given to appropriate and permissible terminology within interviews. For example, drug use is often associated with criminality and reprisals and consideration was given to how this would be addressed within interviews. Due to previous experience working with families in an addiction services, the researcher was able to utilize transferable skills to ensure the appropriate consideration for how they may have been perceived and responded to by the participants. All coauthors of this paper were involved in ongoing discussions about data interpretation. This was preceded by agreements about the analytic process, more specifically the coding framework and how to address emerging themes. In employing an inductive approach, deductive thematic analysis occurred in places, thus there was evidence of some questions and assumptions brought to the data. However, the efforts in reflective practice and open dialogue ensured we addressed this where possible, in line with our responsibilities as qualitative researchers (Dodgson, 2019).

Ethics

Ethical approval was granted by the ethics committee associated with the university in which the authors are employed, and the research was conducted in line with the Code of Ethics by the Psychological Society of Ireland. The families were carefully selected by coordinators of various support groups. Participation was voluntary, and participants were free to withdraw at any stage. Should participants have experienced distress due to participation they were offered the full support of their relevant network group. Upon showing interest in participation, interviewees were provided with an information pack by their support group leader, briefing them on the nature of the study. This pack included screening tools for complicated grief, general health, and trauma. The purpose

of this was to ensure that inappropriate recruitment did not occur, but no participants were deemed ineligible for an interview. When a family member agreed to participate, contact was made between the researchers and the interviewee. Prior to all interviews, participants were once again briefed on the nature of the study and signed an informed consent sheet. This was done to provide written confirmation that participants understood the ethical considerations involved in this study, including confidentiality and the purpose/future uses of the data. After the interviews, participants were debriefed. Data was stored on an encrypted drive provided by the university.

Results

Three main themes were extracted from the reflexive thematic analysis: Renegotiation of Relationships, Experiencing Complex Emotions, and Adjusting to a New Reality. All themes feature the impact of drug dependence on the family within various contexts, and associated subthemes that underpin each theme are outlined.

Renegotiation of relationships

Familial and social relationships were recurring topics of discussion in the data, and relationships represented a shared value for the bereaved. All participants noted that living with active drug use resulted in complex interactions with family members, friends, and other members of the community. The loss of a child due to drug-related complications was described as a hugely traumatic experience, often forcing families to transition from chaos to a new reality of loss. In entering this new reality, however, some participants found that previously existing relationships had become strained, or terminated, following the death. At times relationships had broken down, but there was also a more subtle "pulling apart"—where the family continue to co-exist but a silence surrounding the death was an invisible breakdown in relationships.

Family dynamics

The chaotic nature of living with active drug use added a significant challenge to the maintenance of familial relationships. The lifestyle of the deceased had already created a division within the family structure in some cases, and following the death, some connections were further complicated while others were severed. Due to the circumstances surrounding the DRD, the role family members played in supporting

the deceased during life was called into question. One participant describes the now fragmented relationships with his siblings following the death of their brother:

All my sisters had no time for [brothers' addiction to heroin] to be honest with ya, and now we're feeling guilty. Now we are feeling guilty. Too late now so it is, he's gone now. *sniffs* And I had murder with them there, a couple of weeks ago, told them all a few home truths.

Some family members reflected on how they found themselves withdrawing from their family system following the loss. Many of the bereaved struggled to integrate their grief into existing family dynamics, and their shock and trauma inhibited their ability to remain connected. One mother recalled how she feared to love as the idea of potential future loss was too difficult to bear:

I had three grandchildren when [son] died and he left a letter saying you know you done your best and all that sort of stuff, make sure the kids don't go on drugs, help them, but I find now that instead of helping them *pause* I kinda neglected "em."

This mother's concept of love had been shattered by the loss, and prevailing feelings of future loss resulted in a change in how she approached her relationship with her grandchildren. In her efforts to repair this relationship, she understood that it would take time and acknowledges it is a work in progress. The impact of such withdrawal was evident throughout the data, as another mother describes how she is struggling to maintain a positive relationship with the partner of her lost son, the mother to her grandchildren: "ah coming up to his anniversary she always gets really distant, or she might go away, or she might cause trouble or she's always doing something." This participant, who is instead experiencing the withdrawal of another family member, fears that the connection may be severed due to prevailing feelings of condemnation, blame, and anger:

Now his children unfortunately haven't spoken to us since and we would love to have them back into our lives you know, we tried to reclaim the family but it's not to be because the mother has blocked it.

How family dynamics are impacted by the loss of a loved one illustrates how a DRD can create additional losses within the context of family relationships and can limit support options as family members distance themselves from one another. This is often due to unresolved, or unspoken, conflicts being exacerbated by the death. There was a sense of condemnation within families when individual family members

began to process their grief before others. One parent felt castigated for addressing her grief and moving toward a sense of healing, demonstrating that even though grief may permeate through the family structure, it is still an individual experience:

Now his girlfriend is as bitter as the day he died, she never went for counselling, she never looked after herself, never did anything, and she thinks because I have moved on that I don't give a fuck about [my son], she thinks because I have had counselling that I have worked on myself, so there can be a lot of arguing.

Fractured sense of community

Due to the stigma surrounding drug-related deaths, many participants found themselves questioning their value within a community context. A bereaved father spoke about attending two funerals of young men who had died, one by overdose and one in a traffic accident. He noted that there was difference in the level of attendance at the funerals, which were held on the same day in the same community. He believed the lack of attendance at the drug-related funeral was due to a silent condemnation. As someone whose son was an active drug user at the time, he was consumed with sadness for the grieving family. Following the drug-related death of his own son, the bereavement brought this memory to the fore and he, too, felt condemned as a parent who had also lost a child to overdose:

And all the people from the area judged his parents because their son [was in addiction]. Sometimes I feel like I deserve to be punished but it's very hard to come out the other end, that's very hard when you don't understand that you didn't do anything do ya know what I mean? We didn't do, I didn't do anything.

The loss of grandchildren was also mediated by agents outside of the family system when children were placed in state care. The grandparents in these cases felt punished and condemned by social services within the community:

The children that he had, there's two of them, there's one of them in care now, I'm not good. *cries* There's one of them in care, we were condemned, and your grandchildren are going [into care]. It's like this, you'll do what we tell you, you don't deserve those children.

The need to isolate oneself after the death also extended into other social spaces as highlighted by this interviewee who withdrew from her peers following the death of her brother:

You know even looking back like I separated myself from my friends in school, I didn't want to be part of it cos I felt different. Like I should be ashamed, or that I was being judged for what happened in my family.

Experiencing complex emotions

Participants spoke at length about their feelings both before and after the death. From the narratives, the range of emotions was extensive, ranging from relief, to guilt, anxiety, and self-blame. The stigma surrounding drug-related deaths permeated throughout this entire theme and played a significant role in inhibiting normative grieving processes. In experiencing complicated grief, participants struggled to find meaning in the loss and were often confused by their own emotions. At the time of interview, many participants stated they still had not come to terms with the loss even years later.

Lack of help during life intensifies complicated grief

In the interviews, families spoke at length about the value of support during life, and how the lack of support exacerbated their feelings following the death. Families reported that some of these experiences compounded what was already a very difficult situation. This lack of help during life complicated the grief process even further:

Well [my son] was seeing a psychologist and she washed her hands of him when he wasn't playing ball, the juvenile liaison officer washed her hands of him, you know there is something wrong in a system that can adopt that attitude.

There is an anger that the death may have been preventable had the help been more accessible. The preventable nature of the death resulted in feelings of self-blame for families, as they questioned if they had done everything in their power to support their loved one. While acknowledging that professionals are better suited to provide the targeted support that their loved one may need, the lack of compassion in some situations developed feelings of isolation that shifted the "blame" back to the parents. Many families reported that they felt disenfranchised by hurtful social encounters where support was envisaged but not received. This amplified feelings of isolation and shame as even those who were expected to be non-judgmental viewed the death in a negative light: "but even the priest nearly destroyed my mother, even the priest, because the priest did say to her 'you know he'll never be in heaven'."

The social ineptitude assumed by those in supportive roles affected family members emotionally as they

felt further delegitimization of their grief after the death. When a DRD occurs in Ireland, families must navigate a range of different services such as health, justice, and social services. At each of these touch-points, the bereaved will encounter numerous professionals and the participants in this study outlined incidents where they felt their grief was further delegitimized, reinforcing their insecurities about their entitlement to grieve the loss of their loved one. This sense of abandonment was an isolating, and frustrating, experience and led to increased feelings of anger after the passing of her loved one:

I rang Dr (name), and I spoke to her and [brother] was facing me in the little hall, and he said, "tell her that I'm coming off drugs." [Doctor] asked "Is he coming off drugs?" and I said "he's off heroin three weeks, that's not the problem, he's suicidal. *imitates doctor* 'Oh we don't deal with drug cases' and I'm like, 'but he's suicidal.' *imitates doctor* 'Yeah but, no, you'll have to get him to go to a drugs place.' A couple of days after, I rang and I said, 'I rang you the other day about my brother.' She said, 'oh how's he getting on?' and I said 'he's fucking dead' and I just hung up the phone, that was the end of it then, but I was very very angry at her, really angry."

The perception of the deceased by others both in life and in death further compounded the perception that the death was a "bad" death unworthy of public support. The narratives of the families detail a complex tension between the health needs of their loved ones and the fact that much of their addiction behavior led to criminal activity and, ultimately, contact with the justice system. Drug taking is an illegal behavior that is responded to as such, however the criminal justice system has neither the capacity nor the remit to consider the health issues of drug dependence. Many families reported that their loved ones had been exposed to traumatic events which had adversely impacted their well-being and felt that drug use was linked to mental health. Four of the families complained that their young people had a very negative relationship with the police and that there was a failure to see their children as struggling due to poor mental health: "[my brother was] trying to get his life back on track but the police wouldn't let him alone remember?" Others described police judging their children: "some would just write him off, 'he's a scumbag, that's it,' and would treat him accordingly."

The right to grieve

Families highlighted how stigma surrounded the circumstances of the death and was evident in how they were supported in the aftermath. Incidents where

others perceived their loss in stigmatizing ways were prevalent occurrences in the experience of participants, where DRDs were perceived as "bad." Feeling disenfranchised, inner conflict emerged due to how families were supported in the aftermath of the death. One mother detailed her difficulty in making sense of her emotions, questioning whether her thoughts were valid:

He deserved nothing better because he was a drug addict, this is the way it was coming over me. A poor child there died of leukemia God bless him and save him, but don't talk about this scumbag that deserved to die. I don't know whether that was just in my head or not.

This mother detailed her experience in questioning her right to grieve for her son given the circumstances of his death and compared it to another death, one by illness. This extract further brings to light a common theme throughout the literature; the stark contrast between drug-related bereavement and that of other deaths. In questioning their right to grieve, participants also spoke about feelings of self-blame that often consumed them in the years following the death. The opportunity to grieve publicly about the death of their loved one being stripped away further facilitates feelings of isolation as families are unsure of who they can turn to for help:

There was nobody for me to talk to now the first time, the shame that is forced on ya because your son you know, you didn't deserve any of your feelings you know you didn't deserve to talk about him, you didn't deserve anything because he was a heroin addict or a junky.

As some participants explored their negative experiences that led them to question their right to grieve, there were also positive stories of validation, support, and reinforcement of the value of life. Evidence of this emerged when speaking about support groups that were tailored specifically to DRD bereavement. Families valued the opportunity to feel understood and acknowledged that their grief is unique and "not understood" by wider society. Peer support groups provided opportunities to share knowledge and validate experiences. Participants spoke about how this assisted decision making, navigating relationships and self-compassion: "we found a group here and we started getting involved, our journey, this crossroads took us on the right road." Perhaps the biggest impact of peer support was on an individual's grief process, often helping people to move from shock and anger to peace and acceptance. Complicated grief saw family members frozen in time, caught in stages of anger or

disbelief. Having a safe space to process and move through the natural stages of grief, to oscillate between loss-oriented and restoration-oriented processes, provided an immense feeling of release and healing:

I only dealt with my pain about *pauses* four years ago, which, three or four years ago, when they set up this bereavement group, and I swear to God, I cried, and cried, and cried for weeks.

Relief

A sample of the families in this study acknowledged feelings of relief following the death of their loved one. This relief stemmed from a compassionate place in the hearts of participants. Living with active drug use is chaotic and stressful, but some parents were relieved for their child that they would no longer have to suffer. They were constantly worried for the welfare of their child, but death brought a form of reassurance of safety comforted by a belief in an afterlife:

Now when [my son] died it did break me heart but thanks be to God I knew where he was gone and maybe taken before he's worse. I knew where he went, I was very happy. I didn't like him to be gone but I knew where he had went.

There was initial guilt associated with feelings of relief, as many participants questioned if they were "wrong" to feel that way: "you have guilt you know and these things are all normal but when you are going through these things it doesn't feel normal, the guilt you know." This, again, highlights the need for tailored responses that validate the grief of this population. For many, the pain of their loved one's active addiction ceased with death:

He wanted to die I think because his life was just destroyed, he had lost his family he had no life at t'all, he had no legs, his arm was gone, he was angry, he just couldn't get himself together at all do you know what I mean, it was a blessing for him you know.

Adjusting to a new reality

All those who died in this study were adults, but to the parents they will always be their children, as poignantly described by this mother: "I would drive out to the grave, it was like I was making his bed, I would pat the whole thing down and fix it and everything." DRDs are often abrupt losses despite the veiled preparation many families experience as reported in the literature. Families in this study reported their adjustments to this "new reality," where they struggled

to find meaning in the loss, or came upon a new-found purpose in life. This theme highlights some of the changes in life experienced by the bereaved following the death. The concept of financial hardship also emerged in most interviews, albeit briefly in some cases as participants spoke about outstanding drug debts following the loss of their loved one.

The missing piece

Difficulties in coming to terms with the loss were prevalent points of discussion in interviews and all families highlighted unique and significant challenges when trying to reach acceptance. Participants explained the void left in their lives following the death, like a piece was missing from the family structure. Adjusting to this took some time, and the time since death varied among participants in this study. In the following extract a father recounted those early years trying to bring himself "back to reality":

The worst thing that can happen is wishful thinking, cos that's not reality and that will hit you like a brick wall, I went to J's grave every day for three years to remind myself that he was dead, cos every night I would sit here and wish that he would walk through that door and I went to bed like that so when I woke in the morning it was the worst rawest pain in my stomach.

The loss of a child is profound for a parent, and the loss of an adult child in traumatic circumstances is not less significant. There is also a grieving for lost potential and a sadness surrounding future life events:

There's always been something missing at Christmas time, any family event [my brother] was always missing, if I am ever going to get married [my only brother] is going to be missing, there's a lot of things where we look to the future you know ... a part of you is gone and you are never going to regain that back.

Families must also reconstruct the memory of their loved one as they will have experienced positive times with their child but also very negative times. They have the memories of the child who was in addiction, and memories of life before addiction. These two versions of their loved one need to be aligned for emotional balance within this new reality:

I suppose there's two sides to it, there's love and there's heartache raring a child, so the love and the heartache, the heartache was stopped automatically, suddenly stopped, so then you have to go back and pick out the bits you loved about him and knock out the other bits, that was very confusing.

Illness

Disenfranchized grief is more likely to give rise to inter-generational trauma experiences as unprocessed grief permeates through the family system. There is a heavy emotional cost for all involved, but every family had at least one person who attributed the onset of a serious physical illness to their grief experience, a new reality for them post-death. One mother collapsed within weeks of her son's death: "I had a brain haemorrhage after [my son] dying they said it was the stress that caused it."

New purpose in life

Some participants detailed positive experiences in adjusting to their new reality, demonstrating a healthy oscillation between loss-oriented and restoration-oriented processes. Living with active drug use consumed the lives of family members, but the death of their loved one provided a new perspective in which to view life:

For 20 years, more, for 25 years, we were trying to juggle things around in life you know trying to hide things trying to control their addiction and we didn't really achieve anything you know but when M died it changed our view on things.

There was complicated juxtaposition for families after losing a loved one to a DRD, with an internal conflict in trying to balance emotions between the pain of loss and a relief that their loved one is now safe in death: Healing through activism was identified as a method of alleviating feelings of helplessness. Parents in the current study described how they used their experiences to advocate at political, social, and personal levels: "We were marching for nearly a year, taking to the streets, lobbying government ministers." The activism enabled parents to push for socio-political change and, at a more personal level, it facilitated peer support. Engagement with peers gave huge hope for families as there is potential to influence change and this ultimately facilitated healing: "say helping others, when we go to a meeting it grounds us, it reminds us of how important it is to stay well and maybe our story might help people and we might be able to encourage people."

Discussion

The current study outlines the impact of DRDs on families and identifies many challenges that are intensified by the nature of the death. There are harrowing accounts of grief and trauma, and a clear sense of a neglected and overlooked pain. Family members in

this study reported disenfranchized grief, where their loved ones' death is not acknowledged or is devalued, and the stigma and shame associated with addiction leaves people feeling marginalized and powerless. Families understood their loved one's struggle with addiction to be laden with moral judgements; with little effort to understand the behavior as a response to trauma, mental health, and/or economic deprivation.

In general, the concept of complex and the range of feelings experienced by drug-death bereaved families in Ireland were consistent with the literature elsewhere in the field (Titlestad et al., 2019). DRDs being perceived as "bad" deaths created a range of difficulties for families, including condemnation from others (both silent and explicit), internalized feelings of shame facilitated by stigma, and a general lack of support from friends, family, and services during and after the life of the deceased. All families expressed confusion, distress, loss, and anger at their bereavement being treated this way and this is perhaps the key finding of this study. Coinciding with Guy's (2004) pilot study on bereavement due to a drug-related death, family members in the current study spoke about how the image of the deceased was tarnished in the eyes of the public due to their association with illicit substances. At times, participants felt their grief was invalidated as if they, or their loved one, were directly at fault for the drug-related death.

Examining the trajectory of bereavement from this population using Stroebe and Schut's (2010) dual process model, there were numerous instances where the ability for restoration-oriented coping was inhibited throughout the data, or where participants found themselves trapped in loss-oriented cycles. This was evident through the renegotiation of family relationships as participants detailed the loss of various familial connections, with repeated efforts to try and reconnect. The ability to engage in restoration-oriented processes was also impacted by the fractured sense of community, where identity struggles were prevalent and family members struggled to try new things due to shame and isolation. However, there were individual differences apparent here as some family members provided examples of restoration-oriented coping through a new purpose in life, forming new relationships through activism, and engaging in peer support groups. Indeed, the grief associated with a DRD is inherently complex and individual differences must be accounted for. However, it must also be noted that the time since death varied greatly in this

study and may have influenced the balance between dual processes.

Templeton (2020) explored the possible benefits of a structured and flexible framework in supporting those bereaved by a DRD. The primary benefits outlined by participants related to understanding the loss. The current study finds evidence to support the value in validating and understanding the experiences of the bereaved, as many families reported significant challenges with self-blame, many of which were triggered by the way in which they were supported by their social contacts and the wider community. It appears from this research that the appropriate and most useful services were bereavement supports specific to DRDs. This is not unexpected considering the beliefs of blame, shame and stigma that have been referenced in the literature and the interviews. The isolating nature of a special death requires supports that aim to cultivate greater self-compassion and strengthen resiliency in the face of being burdened with feelings of shame and helplessness. These findings are echoed throughout the literature that state the importance of targeted responses to drug (and alcohol) related bereavement (Turnbull & Standing, 2016). The literature recognizes that “special deaths” require specialized services to mitigate against the impacts of disenfranchised grief.

However, it is also important to note that the requirement for targeted support does not solely apply to the period after death—many families reported that their sense of self-blame and isolation were exacerbated by a lack of support while their loved one was alive. In the early days of managing addiction many families did not seek support, as one of the biggest factors that prevents people accessing psychotherapy is fear of stigmatization (Vogel et al., 2007). This is exacerbated when substance dependence is the presenting issue (Myers et al., 2009). The reflections of families are linked with current reports that state that these barriers can be mitigated by acts of kindness and compassion from professionals (Titlestad et al., 2021; Templeton, 2020).

Christiansen et al. (2020) explored parental mortality following a DRD and found that drug-death bereaved parents exhibited a higher mortality rate than other causes of death. However, life experience associated with living with active substance use, or the intensity of complicated grief, were not controlled for. The current paper coincides with these findings and finds evidence of physical illness linked to the combined stress of living with active drug

use and the loss of a loved one. Family members reported an intense strain on their wellbeing during a tumultuous time caring for their adult child during this period, which also corresponds with the findings by Titlestad et al. (2021) about extended parental involvement. A mother who participated in this study has died since the data was collected. She was undergoing chemotherapy at the time of the research project and during that interview her daughter made the following statement when addressing her mother: “and this is your third time since [daughter] died, this is her third time with cancer.” To support these families, services should direct efforts at mitigating the impact from not only a psychological approach, but also from a psychosocial and psychosomatic standpoint.

There is a requirement for robust policies to shift drug use from a criminal justice issue to a health issue, and a public campaign that challenges stigma would assist families to access early intervention. Many families found healing and purpose through activism, where they sought to use their experience to encourage social change with respect to stigma and support.

This study is the first of its kind in an Irish context. The total number of DRDs in Ireland is above the European average (EMCDDA, 2020), and given the potential for widespread impact per each death, this study is important. Through the in-depth methodology (Braun & Clarke, 2019) findings provide an insight into the unique and traumatic grief experienced by these families and provides a voice to a population that are rarely acknowledged in academia, with findings applicable to other international contexts. This study also interviewed multiple family members together, providing a unique insight into family dynamics. Participants themselves noted that this was a constructive feature of the study design, however the researcher considered that the presence of other family members may have resulted in the inclusion of enhanced or inhibited discourses throughout the data.

This study utilized a purposive sampling strategy that, although recruiting enough participants, may have benefited from a more nationwide application. This also brings into question potential differences between rural and urban areas, and potential differences in areas of differing socioeconomic status. Future studies could also build on a considerable limitation to this study as it relates to time since death. Many family members were at different

stages of their grief process and this may have been attributable to the many years that had passed since the death occurred, in contrast to more recent deaths in this same study.

Disclosure statement

With respect to the above-named paper submitted to Social Science and Medicine, the authors wish to confirm that the publication has been approved by all coauthors, and authors have no conflicts of interest.

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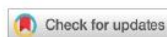
Data availability statement

The data cannot adhere to the FAIR principles as the sample size was too small and the participants would be identifiable from the rich qualitative interviews.

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Appendix IX: Published Article from Chapter 9



Original Manuscript

The Internalization of Stigma and the Shaping of the Grief Experience for Peers Bereaved by a Drug-Related Death

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Abstract

People who use drugs form a significant part of the community who are impacted by drug-related deaths, but their stigmatized positioning in society yields implications for their access to support and the social recognition of their grief. This project explores how the internalization of drug-related stigmas shapes the grief experience for peers bereaved by a DRD. Six individuals who experienced the drug death of a peer during their own time in active addiction participated in semi-structured interviews, analyzed by interpretative phenomenological analysis. Three superordinate themes are reported in this paper: (i) Forged Connections; (ii) The Condemnation Script; and (iii) Nowhere Left to Turn. Participants reported grief responses such as survivor’s guilt, shame, and increased drug use against the wider social invalidation of their close peer bonds. This paper appeals for a more health-based approach to supporting people in active addiction that recognizes and validates their grief experiences.

Keywords

drug-related death, addiction, overdose, peer loss, complicated grief

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Introduction

Drug-related deaths (DRDs) are a global public health concern, and bereavement for those socially connected to people who use drugs frequently results in a complicated grief with significant social and health implications (Bottomley et al., 2022; Titlestad et al., 2021). DRDs are deaths that occur directly due to the intake of narcotics but may also be a result of drug-related violence, suicide, or infectious disease (HRB, 2019; Titlestad et al., 2019). These characteristics, and the societal stigmas associated with drug use, often lead DRD bereaved individuals to contend with shame, isolation, and a lack of social support while grieving (Bottomley et al., 2023; Lambert et al., 2021; O'Callaghan et al., 2022). In approximation, 10–15 people experience bereavement from a single drug death (Dyregrov & Selseng, 2022), with research identifying complex and disenfranchised grief reactions in several family, community, and service provision contexts (Lambert et al., 2021; Meen et al., 2024; O'Callaghan & Lambert, 2023; Titlestad et al., 2021). Total deaths are increasing worldwide, such as in Europe (EMCDDA, 2024) and North America (CDC, 2022 as cited by Reime et al., 2022), identifying a critical and prompt requirement for targeted bereavement intervention protocols.

Research efforts in Ireland (Lambert et al., 2021), Norway (Titlestad et al., 2022), Britain (Templeton et al., 2017) and the United States (Feigelman et al., 2020; Sterling et al., 2022) continue to highlight the profound and complex impact of DRDs for bereaved family members. Collectively, the literature underscores diverse pre-, peri-, and post-loss experiences, with psychological affect stemming from anticipatory grief (Feigelman et al., 2023), the negative characterization of their loved one (Dyregrov & Selseng, 2022), and feelings of self-blame, shame, and disenfranchisement (Lambert et al., 2021; Valentine et al., 2016). The socially constructed narratives and moral stigmas associated with drug use compound grief processes to the extent that families often grieve in isolation, with prolonged exposure to complicated grief as a significant risk-factor for long-term health disorders (Doka, 2020). Family members are at increased risk for the development of depressive symptoms, prolonged grief disorder, post-traumatic stress disorder, generalized anxiety disorder (Bottomley et al., 2022), and a higher risk of natural cause mortality (Christiansen et al., 2020).

In accordance with Dyregrov and Selseng's (2022) position that DRDs have a broad psychosocial impact radius, people in active addiction navigate a multi-disciplinary network of social, health, and justice systems. Consequently, healthcare professionals (HCPs) are also at risk for complicated grief outcomes (Sperandio et al., 2023; Yule et al., 2023). In contending with internalized expectations of professional durability, HCPs reported grief-related reactions inclusive of severe stress (Yule et al., 2023), guilt, self-blame (Sperandio et al., 2023), fears of litigation, anxiety, and traumatic flashbacks (O'Callaghan & Lambert, 2023). Negative social norms, sometimes integrated within organizational structures, heavily influenced the support available to HCPs, who reported difficulties with openly discussing the impact of DRDs (O'Callaghan & Lambert, 2023; Yule et al., 2023). Barriers to help-seeking can be further

compounded by a complex amalgamation of internalized self-stigma and their societal positioning as experts in their profession (O'Callaghan & Lambert, 2023).

Evidently, the inhibiting properties of DRD stigma extend to the wider social context of drug use, and HCPs appealed for broader societal acknowledgement that people in active addiction form a vital constituent of the community directly impacted by DRDs (O'Callaghan & Lambert, 2023). People may witness multiple overdoses when in active addiction (Nolte et al., 2023) and, thus, are frequently positioned as first responders to overdoses among peers (Schneider et al., 2021). Overdose trauma has been associated with PTSD symptoms and, anecdotally, participants within the literature base reported that overdose deaths are increasing (Nolte et al., 2023; Schneider et al., 2021). Nolte et al. (2023) surveyed people who use drugs in New England ($n = 578$), where 83.6% of the sample had witnessed an overdose, and 85.8% knew someone who had died by overdose within the previous 6 months. In Toronto, Kenny et al. (2022) surveyed 249 people who inject drugs, and in the 6 months prior to participation, 79.5% witnessed 2 or more overdoses, and 41.4% witnessed 2 or more deaths.

Few studies have investigated the grief experiences of people who use drugs, yet the existing evidence highlights the prevalence of complicated grief reactions. Wojtkowiak et al. (2019) interviewed 10 bereaved men who use drugs, using grounded theory to explore their meaning systems within the social context of drug use. The participants' stigmatized societal position inhibited their grieving opportunities, with many describing shared social spaces of meaning making, such as funerals, as "uncomfortable." These experiences align with findings by O'Callaghan & Lambert (2022), who reported that some clients were forbidden from attending funerals. Denied of their right to engage in normative socioemotional grieving practices, social exclusion fostered a disenfranchised grief for participants, sometimes leading to increased drug use as a coping strategy (Wojtkowiak et al., 2019). This study presents a crucial insight into the lived experience of a critically under-researched population, but the exclusive focus on male participants may overlook potential gender-related variations.

Selseng and colleagues interviewed 13 drug death bereaved individuals to explore bereavement in the context of their own drug use (Selseng et al., 2023), and their experiences of support (Selseng et al., 2024). Both studies highlight the prevalence of complicated grief and a profound lack of social and professional support. Prompt and actionable supports are crucial (Selseng et al., 2024), as many participants reported using drugs to emotionally suppress their grief and avoid actualizing the loss (Selseng et al., 2023). However, while seven of participants in these studies were using drugs at the time of death (Selseng et al., 2024), others were not actively using drugs or were in treatment. Some participants reported returning to drug use post-bereavement, highlighting implications for recovery while underscoring a requirement for a nuanced understanding of the varying stages of drug use at the time of death. The importance of understanding grief at different stages is reinforced by Bethune Scroggs et al. (2022), who suggest that the bereaved may not begin to process losses until entering recovery; the death potentially including secondary losses such as companionship or safety.

Macmadu et al. (2022) utilized thematic analysis to characterize drug use behaviors in people following the overdose of a peer, identifying grief-related symptoms associated with fatal overdoses and increased overdose risks particularly evident when losing someone emotionally close to them (Macmadu et al., 2022). While this study included participants referring to both fatal and non-fatal overdoses, the work reinforces the scarce evidence base by highlighting grief-related symptoms in people who experience the fatal overdose of a social network member. The authors recommend future research to develop a more robust understanding, and identification, of mediators of these outcomes, including the effect of peer overdoses on individual overdose risk (Macmadu et al., 2022).

The lack of support for the bereaved reported by Selseng et al. (2024) may be further augmented by their limited social capital (Neale & Brown, 2016), with grief symptoms exacerbated by structural and socioeconomic inequalities such as poverty and criminalization (Pettersen et al., 2019). Legislative policies may yield inadvertent consequences as they reinforce dominant social norms that devalue the bereaved person's position in society, leading to poor health outcomes attributable to diminished help-seeking behaviors (Muncan et al., 2020). Thus, people who use drugs experience a double stigma, their experience of a stigmatized loss integrating with their socially stigmatized position as people who engage in behaviors perceived as unlawful (Selseng et al., 2023).

The current study aims to provide a phenomenologically rich exploration of how the internalization of drug-related stigma shapes the grief experience for peers bereaved by a DRD while in active addiction. Although scarce, existing literature highlights unique challenges faced by this population in being recognized as bereaved (Selseng et al., 2023; Wojtkowiak et al., 2019), and the current paper seeks to contribute to the establishment of a more robust evidence base for a significantly under-researched population. Building on previous research that focused solely on men (Wojtkowiak et al., 2019) or included people not actively using drugs (Selseng et al., 2023, 2024), this study specifically addresses people in active addiction, a subgroup highlighted for their grief-related reactions by Selseng et al. (2023, 2024). Addressing how stigma affects grieving processes in the context of ongoing addiction, this study aims to provide a holistic understanding of personally nuanced and complex lived experiences, offering a deeper insight into the intersectionality of grief, addiction, and stigma. Overall, it seeks to inform the development of culturally competent practice frameworks that are responsive to the influence of individual circumstances and experiences of trauma.

Methods

The current study adopts a phenomenological approach to exploring the experiential impact of DRD bereavement for 6 individuals who were bereaved while in active addiction, utilizing interpretative phenomenological analysis (IPA) to present idiographic narratives and convergent themes across cases.

Methodological Approach

The suitability of IPA as the chosen methodology is reflected in its hermeneutic capacity to explore individualized lived experiences, eliciting convergent perspectives which construct patterns of meaning across the sample (Bush et al., 2019). Emotional experiences of drug related bereavement carried a deep significance in the participants' lives, with peer loss representing a major transition within the stigmatized sociocultural context of their addiction. IPA provided a phenomenological lens through which the psychosocial variability within the group could be interpreted, exploring how grief takes on a significance within the wider experience of active addiction (Larkin et al., 2021; Smith et al., 2009).

Participants and Sampling

This study includes 6 participants (4 men and 2 women) who are now in recovery but were previously in active addiction and engaged with drug-related healthcare services. Utilizing purposive sampling, the authors sent emails containing information sheets to relevant organizations and other contacts within established professional networks. The email introduced the nature of the study and outlined the inclusion criteria, and the organizational leads circulated the information. Thus, participants could self-select to contact the first author by email or phone at their convenience.

After an initial distribution of the recruitment criteria that specified participants should be in recovery for at least 2 years, several people in recovery approached the first author expressing their desire to participate and share their stories. However, they did not fall within the specified timeframe for recovery. Thus, to minimize exclusionary criteria while ensuring emotional safety, experts in the field of addiction were subsequently consulted to determine a definition for recovery. These consultants reported that recovery is self-defined, wherein participants would have the right to self-determine. Thus, the inclusion criteria were finalized as follows: participants must have been over the age of 18, to have experienced the loss of a peer through a DRD during their own active addiction, to have completed a treatment program, and now be in recovery. Participants were also required to be actively linked with a support group, with access to support structures post-interview if necessary. There were no specific sex or gender requirements. However, efforts were made to secure an equal gender distribution in the sample where possible. Table 1 lists the pseudonymized name, gender identification, and the duration each participant self-determined their recovery at the time of interview:

Data Collection

The first author conducted 6 one-to-one semi-structured interviews between December 2022-June 2023. All interviews occurred in person, their duration ranging from 40-65 minutes, with an average of 46 minutes. Interviews adopted a semi-structured format

Table 1. Profile of Participants.

Participant	Gender	Time in recovery
Levi	Male	8 years
Kenny	Male	6 months
Marco	Male	1 year
Annie	Female	6 months
John	Male	10 years
Sasha	Female	13 years

via six open-ended questions designed to facilitate a participant-directed conversation about the experience of loss while in active addiction. Questions focused on their journey through addiction, the dynamics of their social relationships during this period, their experience with loss, the effects of stigma, and their sense of self. Participants were briefed at the beginning of each interview and debriefed at its conclusion, including the signposting of relevant supports.

Interviews were recorded by an audio device, from which the data file was transferred to an encrypted drive. Once each interview was transcribed verbatim with all identifying information removed, the original audio file was permanently deleted.

Data Analysis

Data analyses utilized [Smith and colleagues' \(2009; Larkin et al., 2021\)](#) case-within-theme approach to interpretative phenomenological analysis (IPA), with findings outlined in adherence to the standards for reporting qualitative research as reported by [O'Brien et al. \(2014\)](#). Both authors are proficient in working with qualitative data that details the lived experience of socially excluded populations, and IPA presents as a double hermeneutic yet systematic approach to deconstructing the experiential transcripts and synthesizing meaning within cases and across the dataset ([Smith et al., 2009](#)).

The first step involved familiarization with the data, where the transcripts were read and re-read. This was followed by the development of initial non-hierarchical notes, with an exploratory focus on explicit meaning and semantic content. A subsequent mapping of these notes by their interrelated concepts resulted in emergent themes ([Smith et al., 2009](#)). In this process, some notes were merged or discarded in thoughtful consideration about how to reduce the size of the data while preserving its complexity. Lastly, in searching for connections across emergent themes, the authors made decisions about how to contextualize the data within each case, resulting in the development of superordinate themes ([Smith et al., 2009](#)). In repeating this rigorous analytic process for each transcript, a cross-case analysis produced superordinate themes of higher-order concepts that best represented participants' experiences of drug-related peer loss ([Larkin et al., 2021; Smith et al., 2009](#)).

Roles, Reflexivity & Research Integrity

To faithfully represent the participants who kindly shared their stories for this project, the authors wished to ensure the highest methodological integrity. The first author has prior experience working with socially excluded populations through research-based practice, and the second author has both practitioner and research experience in addiction services. As the sole interviewer, the first author wrote post-interview memos and engaged in reflective journaling to diarize an audit trail from the beginning of the analytical process. These notes were generated to facilitate transparent discussions in peer debriefing sessions between the authors. Debriefing sessions adopted a reflexive bracketing framework (Smith et al., 2009), with consideration for emerging feelings, potential biases, and pre-existing assumptions. Addressing the risk of bias through reflective practice and peer debriefing established an iterative dialogue that coincided with our responsibilities as qualitative researchers (Dodgson, 2019).

Ethical Considerations

This study's design was not preregistered, and thus received entire ethical approval from the authors' home university through its social research ethics committee. All pre-interview materials ensured participants were fully informed of the study's nature, the details of participation, and the potential uses of their data. Participants provided informed consent via signed consent forms before their interview. Any identifiable data was anonymized and confidential, and participants were informed of their right to withdraw their materials from the study up to 2 weeks post-interview. Upon completion of the anonymized transcripts, the original interview recording was deleted, and data was stored in written format (Microsoft Word) on an encrypted Microsoft OneDrive provided by the authors' home institution.

Results

Presented herein are three superordinate themes (Table 2) demonstrated through a case-in-theme approach to idiographic narratives: Forged Connections; The Condemnation Script; and Nowhere Left to Turn. Each superordinate theme contains three subthemes, which categorize narratives of particular focus under the broader superordinate theme. Collectively, these themes illustrate complex journeys of grief as participants navigated the loss of companionship amidst social invalidation of their peer bonds. Through discriminatory societal practices and belief systems that frame addiction as a criminal activity, grief-related reactions were inarguably shaped by how addiction is situated as a taboo within the social domain.

All participants spoke solemnly about multiple peer losses throughout interviews, but each referenced close friends whose deaths were significantly impactful for them. To provide additional context to the individual lived experience of each participant,

Table 2. Superordinate Themes With Descriptive Context and Associated Subthemes.

Superordinate theme	Subthemes	Description
Theme 1: Forged connections	• Filling a void • Social resonance • Cost of belonging	Explores how grief takes on a particular significance in the context of the intensity of peer relationships, where the shared experience of social exclusion enhances the peer bond.
Theme 2: The condemnation script	• Shattered reflection • Social fracture • Inhibited grief	Illustrates how participants conceptualize their grief, disenfranchised by stigmatized societal belief systems that criminalize addiction and invalidate their grief.
Theme 3: Nowhere left to turn	• Drug dependency • Death as an escape • Survivor's guilt	Demonstrates how participants respond to their grief in contention with stigma while bereft of social support.

Table 3. Participants' Relationships to Deceased and Circumstances of Drug-Related Death.

Participant	Social context of death
Levi	Levi's best friend and godfather to Levi's child.
Kenny	Close friend died by overdose and was found in a public bathroom by authorities.
Marco	Childhood best friend, Cody, who died while both were using together in Cody's home.
Annie	Close friend who Annie had met during an early treatment effort died when both left the treatment center prematurely.
John	Best friend Ben, whose drug-related death caused significant pain as John still grieves his potential.
Sasha	Two closest friends, Henry and Ava, who died 3 weeks apart.

Table 3 contains a brief overview of these relationships and the circumstances of their deaths.

Forged Connections

Societally ingrained stereotypes about participants' place in the world created social barriers between themselves and the wider community. Accordingly, they constructed their social world within the margins that they felt socially relegated to. Adopting and internalizing dominant social perceptions, addiction became a defining feature of their identity, pushing participants further to the periphery of society and increasing their sense of isolation. As poignantly stated by John, the public fails to recognize just how

pervasive such deeply prejudicial attitudes can be, severing the connection between people who use drugs and the wider community: *"When you're using [drugs], you feel every bit of [the stigma]. So, you just feel like you're outside of society and you're eh... You know, it's just very isolating."* For all participants, however, existing on the fringes of society forged connections with others who were similarly alienated, serving as an acute juxtaposition to the hugely isolating nature of addiction. As highlighted by Sasha, the shared trauma histories and social exclusion pushed peers closer together, carving out an interdependent, non-judgmental social space:

I just feel that those relationships at the time, they did form something, they did provide some form of connection. And when you're in a lonely place like addiction, you know... Any connection is better than none.

An often-unspoken interdependency, the shared nature of their socially assigned position on the outskirts of society constructed bonds that kept peers alive during severely chaotic life situations. As a result, drug-related stigmas yield the dual-outcome of exacerbating the social isolation of people in active addiction while concurrently enhancing peer bonds within this community. The critical role these connections played in the lives of participants, bolstered by stigma, often resulted in intensified grief reactions when a peer passed away.

Filling a Void. Many family figures in Levi's life were unable to fulfill designated roles, and he positioned his peers as surrogate role models in place of absent caregivers: *"I was diagnosed with all sorts of stuff from a very young age. Dad was in and out of jail, so I turned to the streets for that friendship. For that male role model."* As his peers came to personify these roles in his life, Levi described a sense of kinship and familial bonding among a *"community of people"* that were situated on the margins of society; a conceptualization of peer bonding that was reflected in the narratives of all participants. The concept of 'family' was a value of central importance for Levi who, in demonstrating how his personal values augmented the importance of his peer bonds, shared that many of his peers acted as a proxy for his biological family: *"The friendships I formed were basically my family...I knew then, I wasn't the only one in this situation."* In a similar manner, communal acceptance acted as a core cultural value for Kenny, and the disempowering effects of social exclusion were magnified due to how his personal self-worth was intrinsically linked to how he was perceived by those around him: *"For me, I always felt that I was 'less than'...and I had that even before I started taking drugs."* However, Kenny's peers in active addiction afforded him a sense of belonging he had yearned for, forging bonds that replenished his sense of place with an implicit sense of acceptance:

It's a cutthroat lifestyle. You have to be street wise, and you have to watch your back but there is kind of a community there as well, like you know? I think it's like, "we all know we're f**ked." But we're okay with each other like, we're okay with each other...

Levi and Kenny's narratives demonstrate how such relationships can become deeply meaningful as they represent the personal fulfilment of human connection that social exclusion deprived them of. Comparably, friendship and connection epitomized the core of Marco's character, and despite underlying insecurities about his self-worth, his morale was largely fortified by his attachment to his childhood best friend: *"My best friend Cody, he felt like a brother to me. Basically, I would have taken a bullet for him. We'd travel the world together."* In contrast to other participants, Marco's relationship with Cody existed before engaging with drugs, but drug use ultimately became a distinctive feature of their brotherhood as they traversed the threshold from recreational drug use into active addiction.

As the essence of Marco and Cody's connection changed, the value remained. Marco cherished this friendship, with his reliance on their bond becoming more intense due to increasing levels of social isolation stemming from their drug use. This bond acted as an anchor to Marco's sense of psychological safety, demonstrated by how Cody's death took on such significance in Marco's world as it began a sequential process of loss: *"You feel invincible, bulletproof. Little did I know I was made of f**king eggshells... Lost my job, banned off the road, apartment gone. I literally went off the edge."* While Marco's narrative highlights how existing relationships can change within the bounds of addiction, it further demonstrates how stigma and isolation can forge powerful and meaningful bonds among peers.

Levi longed for the wider societal recognition of these connections as authentic and meaningful; that the terms 'family' and 'friend' carry the same merit regardless of your social situation. Levi's best friend died from a DRD, and he shared how he honored this man's humanity both in life and death: *"I've a tattoo on my arm of him, he's the godfather to my child. I didn't make him that, or get tattooed, if it wasn't a significant relationship in my life."* While many of these relationships were predicated on a need's basis, particularly around drug distribution, such principles did not negate the development of meaningful friendships.

Social Resonance. The community of people who use drugs are regularly impacted by cycles of death, incarceration, and grief. The constancy of change emerging from the cyclical loop of trauma and crisis impedes opportunities to process and make sense of these experiences, but one constant for participants was the homogeneity of shared experience which often brought people closer together. Shared experience acted as a synergetic social mechanism by which the depth of peer connections authenticated, and within these friendships, participants were identified by the qualities of their person and not by the characteristics of addiction. Sasha found solace in the escape that drug use provided as a shared experience amongst peers and noted that deeply traumatic circumstances engendered a collective emotional understanding: *"There's a lot of emotion around the pain we share. I look back on those times and I see those friendships as inevitable...If there is no safe adult, peers will lead peers."*

Mutual understanding was particularly pertinent for Annie, whose close social contacts failed to understand that her addiction was a health issue, perceiving her as

making poor 'lifestyle choices' and influencing her social and familial detachment. Among her peers, including those within various treatment centers, Annie felt "seen" in a way that contrasted how she felt socially imperceptible by wider society. She acknowledged that an unspoken communal essence among peers eventually manifested into the formation of strong connections, cultivating the sense of belonging and understanding that Annie had lost:

All those girls, I'm still in contact with a good few of them. There's just such a connection there, you know? Because you're so lost and you're so alone when you go into a treatment center, and finally you have somebody that is experiencing the exact same things you're experiencing.

Participants did note that peer groups in this context were not in the best position to be supporting one another, but as they were marginalized by society and in deep crisis, the concepts of shared experience and mutual understanding played a significant role in buffering against the stigma from an intra-community perspective. With drug use interwoven into the fabric of their attachment, Levi acknowledged an underlying transactional element to these relationships, but he inherently sought to satisfy the intrinsic human desire for connection. Thus, shared experiences created solidarity amongst disenfranchised peers:

[We had] really close bonded friendships, even though it was around substances. But [my peers] were all coming from traumatic experiences as well. And they were on the streets too, so who better to support one another? You know, through substances, but also through friendship.

Sasha echoed these sentiments, acknowledging that many of these relationships were predicated on behaviors, actions, and principles that can be considered dangerous, but they bonded through the desire for belonging and the underlying sense of mutual understanding:

[The connections] weren't necessarily healthy, but people will peer up because we're social animals. And we gravitate, we're wired for connection, even if those connections are toxic...So my peers at the time would have been all young people like me who were equally strung out and distressed for multiple reasons. And I would have had a couple of close friends... Everybody was dead by the time I hit 25.

Cost of Belonging. Such belongingness and intense peer bonds were costly, and the mortality risks of active addiction presented a perpetual threat to this socially constructed safety net. With stigma concealing their support needs from mainstream society, participants were left to grieve significant losses as they remained encircled within their own temporality without external intervention. Cycles of loss depicted the fragility in which each participant's sense of belonging was predicated on, and Kenny

noted the challenges of dealing with the death of a peer that represented so much during a time of ongoing crisis: *"There is a community. The people do kind of look out for each other. It is community and a death does hit people as well, and it does hit people who are, everyone's in crisis as well."* As John stated, the lack of societal acknowledgement of the rupture caused by DRDs means that the grief and impact is often contained within the community *"the community is left with it."*

John spoke fondly of a close friend Ben, and to him, their closeness was as profound as any relationship in his life. However, when Ben died, he experienced a profound grief that he was left to contend with in isolation. John deeply connected with the loss of life and the loss of potential, grieving the humanity, kindness, character, and potential of Ben that would never reach beyond the limits of his social status:

He was a very close friend now. He was very funny as well. And he was a great singer. And he's from a nice family as well, he was good natured...When I think of when we do functions and social gatherings, stuff like that, I think of what Ben is missing out on.

The concept of 'potential' embodied a recurring thread within these narratives of grief. Participants paid respect to the peers they had lost by conceptualizing their lives in terms of their humanity, remembering the human qualities which they never had the opportunity to actualize in wider society. Participants learned that such connections came at a high price; they provided psychological warmth during a time of crisis, which then resulted in a profound grief when a peer died by drug-related circumstances. Annie analogized such grief to the loss of a family member: *"You're just so close to those people and I... I mean I grieved now like it was a parent."* Drug-related peer loss detached the anchor of belongingness that Annie had fervently clench, and she longed for the recognition that such connections carry authenticity.

Marco cited the loss of Cody as the driving force for what *"really got [him] on heroin,"* accelerating his drug dependence and shattering his worldview as he transitioned from smoking to intravenous dependency. The psychosocial implications of the loss were amplified by the traumatic conditions in which it occurred, as Marco was not only forced to contend with the loss of his best friend, being the first to discern that he was in difficulty, but furthermore, to bear witness to the ensuing panic:

We were smoking in his house, and we goofed off, could have been hours, six or seven in the morning at this stage. I woke up, and he was blue on the floor. After not breathing. I tried to give him CPR, his dad came up then and was like "he's fu**ing dead!" I was ringing the ambulance, they came and had the machine over him, a chest pumping machine and all his ribs were breaking. This was unbelievably traumatic. Because he was my best friend, and he was dead next to me in the bed.

The Condemnation Script

Drug-related peer deaths represented the loss of a key sustaining factor that provided solace from the pervading sense of loneliness that participants experienced while pushed to society's margins, but also the loss of familial connection, friendship, and human potential. Articulated by Levi, outside of their community participants witnessed their peers reduced to dehumanized statistics in death, fostering a sense of futility about their own existence: "*It's not acknowledged or they're 'just another one'...We're just another statistic.*" As peer deaths caused a significant rupture in the social world of participants, this was not the case at a broader societal level. The divergence between the personal and societal reactions to the death created a psychological incongruity for participants whose meaning-making processes were subsequently impeded by the social nullification of their peer bonds.

The invalidation of these relationships caused harmful introspection about the value of participants' own lives and affected their ability to sustain other relationships. They were condemned for their association with drug use before they were recognized as human beings grieving their loved ones. Furthermore, all participants were disheartened to witness the same labels their peers had grappled with in life remain attached to them in death, prompting a reflection on the value of their own existence. As stated by Kenny, such condemnation perpetuated a fear that their own lives were meaningless, with labels indoctrinating the false notion that one's life can carry less meaning based on social currency:

That was a big fear of mine then. That I'd be found dead in a toilet and labelled as a junkie. I'm a person too. No one wants to be like that, it's a brutal way to die as well.

Shattered Reflection. The psychological dissonance following the death of a close friend presented significant challenges for participants, as the value they placed on the lives of their peers ran contrary to society's incognizance of the loss of human life. Given the significance of shared experience, participants often saw themselves reflected in the lives, and deaths, of their peers. Contradictory belief systems convoluted their efforts to make sense of the loss, particularly as it instigated introspective processes of self-evaluation. Stigmatized reactions to the deaths forced them to contend with the double stigma of grieving a societally condemned death while also attributing these social attitudes to their own person. The ingrained belief system that drug use devalues an individual's place in the world was reflected in Annie's immediate familial context with little consideration for how this may prompt harmful introspection:

I see it in my own family. If I tell them someone has died [by natural causes], or someone has died from a drug related death their reaction is so different. It kills me. And sometimes I don't even talk about it. Because I'd get so angry, I'd internalize it and I'd feel it inside. I'd be frustrated, and so angry with them for their reaction to it. So, I don't talk about it.

Internalizing these reactions led to a marred self-concept, but also inhibited Annie's help seeking behaviors due to substantiated fears that her grief would not be taken seriously. Furthermore, normative grief-related reactions such as anger and sadness intensified as they emerged from both the grief itself and the indifference of those around her. When grieving, Annie was starkly reminded that despite the love she held for the deceased, such compassion was not universally conveyed. Through tainted self-reflection, Annie made sense of the loss in the context of her own drug use as she became concerned that her own death might bring shame to her family amidst a backdrop of societal apathy:

I kind of worried, am I going to die from, is it going to be a drug-related death? Will it be shameful on the family, will people even care as much because it's a drug related death and not natural cause? And it's mad that I'm even thinking about, 'how am I gonna die?'

Kenny experienced similar challenges about his place in the world, consequently questioning the value of his own life. With no symbolic representation for a life outside of addiction, he acknowledged his grief through sorrowful compliance that his societal footprint would be minimal, shrouded by the socially defined undesirable characteristics of drug use. Seeing himself reflected in the faces of those who died, each death set in motion an internal grieving process as he questioned if he would be mourned:

I knew there was a potential that I could die any time and I just accepted it like, you know? Would anyone care? Part of you, then, wants to die, man. Part of you is okay with dying. Life is so s**t anyway.

The internalization of dominant social norms stripped Kenny of both his humanity and individuality. Social condemnation and societal disregard for the death of their peers further diminished self-worth for all participants, as their already diminished sense of self was shattered by the perception of their peer community as meaningless. John spoke at length about his own self-worth during this time, his sense of self eroded as he internalized the socially perceived traits of the community as individual characteristics. However, he implored society to recognize that each person in this community is left with a complex and individualized grief: *"There's a lot of grief left through the people that are using [drugs] and they're not f**ing robots; you know what I mean?"*

This deindividuation resulted in the formation of a dual identity for participants, where the human beyond the addiction was not socially acknowledged. When John's best friend Ben died, society failed to align the dual identities that John carried, and in the wake of societal inattention towards his bereavement, his personal efforts to align both identities became more challenging. Ben was an individual who had boundless potential, and in grieving the loss of his close friend he also grieved for his future and his humanity. Despite John recognizing his potential, Ben could not detach from the

stigmatizing labels imposed on him, resulting in self-questioning about what this suggests about his own prospects:

What he would have brought to life, and the potential he had, because when somebody dies... Not Ben the 30-year-old heroin addict. It's not just him that died. It's the father he could have been, it's the psychologist he could have been, or the care worker, or whatever he wanted to do with his life. The contribution he could have made to society.

Social Fracture. The indifference of society towards the shared grief of the community impacted many existing relationships that participants held, exacerbating their sense of isolation following a death. Sasha recounted a lack of support, struggling to receive any help at all, so much so it impacted on her existing relationships. Following the deaths of her two close friends, Henry and Ava, Sasha's health deteriorated, and she retreated from her remaining social circles who did not recognize the depth of her grief. However, the attitudes by those around her, even those who would be able to provide support, exacerbated her grief:

After that, I hit rock bottom. And at this point no doctor would touch me. It was just "look, she's going to die anyway," d'you know? 'Cause I was just so, so using at that point. There was grief at the time, but then I realized how much trouble I was in myself and I kind of shut down around the relationships I had developed.

For Marco, grief-related reactions by those around him impelled Marco to internalize the perception he was complicit in Cody's death and permeating his own grief with socially reinforced self-blame. Marco recounted his desperation as he made vehement efforts to wake Cody and save his life, his best friend unresponsive in his arms as distress reverberated throughout the household. His efforts to revive him fostered feelings of intense futility and self-blame which were exacerbated by Marco's vilification in the aftermath, his friendship with Cody now socially recognized as a blameworthy causal factor in his untimely death:

There was an inquest. When I went down, I felt like I was being attacked. All his family were after coming, and they were like "what the f**k..." Obviously, they were channeling their anger, their son was after dying and I understand that now. But at the time I was like "what the f**k, I'm his best friend, I wouldn't do anything to hurt him."

As vilification from people connected to Cody augmented Marco's sense of failure and culpability, descent into such a belief system fueled his crisis of self as he subscribed to the epithets imposed on him: "*It was the absolute worst...All the demons came back tenfold, telling me I'm useless...Waster, a failure your whole life. Heroin was a big escape for me, and tablets.*" In his efforts to find meaning in the loss of a cherished friendship, the intersectionality of complicated grief, existing traumas, and condemnation trapped him in perpetual rumination over his perceived role in the death. Their

friendship transcended addiction, but the qualities of Marco and Cody's relationship were disregarded as addiction became its key identity marker. Drug use altered the social perception of their bond and overrode Marco's permission to grieve. After the breakdown of his connection to Cody's family, in reflecting on how they were forced to contend with their own stigma Marco recognized that he now embodied the circumstances of their son's death: *"He [Cody's father] probably still blames me to this day; I'd never spoken to him again and I used to be up with that family every Christmas."*

Inhibited Grief. The psychological retention of stigmatized labels impeded all participant's engagement with culturally normative grieving rituals, and these challenges manifested differently depending on circumstances personal to each participant. Layered with underlying stigma and given his positioning as complicit in his peer's death, Marco's interactions with others throughout the grieving process acted as further inhibitors to engagement with grieving rituals. Drug-related stigma and blame socially resituated him from 'brother' to 'unwelcome guest' at the funeral: *"You get those eyes watching you like, 'oh he was with him when he died.'"*

Annie's relationship with her family also became strained throughout the grieving process. In losing a close friend to drug use, Annie's expression of normative cultural grieving practices suddenly took on a new meaning due to stigmatization associated with drug use. Publicly grieving the loss of her peer became a subject of question as the validity of her connection was disregarded, contributing further to Annie's sense of disenfranchisement:

I watched it online, the funeral. Jesus, I was just heartbroken. My family then looked at me saying "she hardly even knew her," you know? "She was only in treatment with her." But that connection you make with people in a treatment center, it's just unbelievable.

Kenny's engagement with culturally normative grieving rituals such as funerals, as routine social practices to honor his friend's life became veiled in uncertainty and apprehension: *"You don't fit in...I tried to pay my respects, though I find it hard going to funerals. I feel less than, I don't even know if the family wants me there. I still went because he was a friend!"* Such feelings of apprehension were reflected in the narratives of all participants; John reported similar psychological difficulties when attending funerals: *"I remember going to the funeral. I didn't want to go. I just barely went to show my face and legged it again... Just felt really awkward about it, you know?"* Participants' inability to comfortably pay their respects due their association with drugs severed their sense of belonging, further contributing to their sense of disenfranchisement as drug-related stigmas obstructed their perceived right to grieve meaningful relationships. However, their proclivity to attend funerals despite prejudice and while actively in crisis illustrates the high regard to which participants hold these connections.

Nowhere Left to Turn

The reactions of others to the deaths of their peers confirmed participants' fears that the wider public considered their lives and deaths as inconsequential. Left to cope with complicated grief on their own while their sense of belonging dissipated, this gradually bore significant repercussions for their social network, adversely affecting their intrinsic sense of community and access to support. With limited options for support, Levi described his social world as "*absolute chaos*" following the death of his best friend as the bereavement inflated an excessive emotional load already saturated by a myriad of social, justice, and health complications:

You had all the life situations as well that were going down, with social workers, kids, courts. Family members, dependency, money. All that stuff that you couldn't deal with anyway. So, then you throw this loss on top of it. You're just scattered.

The overwhelming combination of grief, trauma, and fear with no social support to assist in the process of overcoming this immense suffering left participants with little option but to remain trapped in cycles of suppression. Sasha recounted similarly chaotic experiences as she could not regulate around the death of her friends: "*We learned to shove down grief and just keep surviving ourselves.*" With depleted capacities for emotional regulation and no external intervention, herself and her peers were forced to rely on each other as they had nowhere left to turn. However, as most members of the community had inhibited coping skills, they were often not in the best position to support one another. Their community was in crisis and existence within this domain exacerbated her sense of grief and trauma:

Suicide attempts, overdoses. It was a lot of chaos, and there was very genuine reasons for all of it. And the help certainly wasn't there. But I think in our peer mix we just could not help one another. Because we were all in that boat. And I think our efforts to help one another were probably more harmful and more toxic.

Society could not recognize the psychological turmoil that Sasha and her peers were experiencing. She highlighted the complexity of emotions that, upon reflection and therapeutic intervention, are now discernable but created a cascade of disarray during a time of crisis:

Yeah, drug use increased. I think when Henry died, I would have been particularly close to him and I had just been to Ava's funeral 3 weeks earlier, and we were all kind of in a circle... We were very close. I just felt at the time, there was guilt. There was shame. There was a lot of things. Fear. And definitely, I suppose, in lucid moments, just a reflection on how we were living our lives, but also a deep frustration about not knowing why the circle was continuing and nobody was asking 'why,' or looking to help.

Drug Dependency. With a limited emotional bandwidth to engage in loss-oriented practices, and a scarcity of professional resources to assist with psychological restoration, participants' existing drug dependency continued to function as their core coping mechanism. Overwhelmed by grief, the duality of mourning a stigmatized loss in a stigmatized community initiated a causal sequence of increased drug use, where all six participants reported a rise in drug intake following peer loss. For John, with a lack of targeted supports and his life socially governed by stigma, the grief compelled him to rely on drug use as a numbing agent:

Because I didn't want to feel what I was feeling. It didn't scare me away from using drugs. In fact, it just spurred me on to use more. Because the grief, the upset, the hurt, the pain. You don't want to feel that, and you just want to take more tablets.

Following the DRD of a peer, Kenny's fear center became considerably over-activated as he faced the reality of grief and, subconsciously, what that loss represented for his own mortality. Entrapped within the boundaries of social stigma with little options for support, he entered a phase of psychological paralysis, compelled to draw on his existing coping strategies to quell the emotional noise in his head:

It could happen to me tomorrow... It didn't stop me using [drugs]... If anything, I'd have used more. Just to kind of push down the feelings, and now that you're in danger yourself. It's a reality, but if you're using [drugs], you're not worrying about it.

Increased levels of drug use placed participants at a further risk of fatal overdose, and this grief response involved the very behavior that participants were socially condemned for. Levi acknowledged that masking the grief with substances may be societally misconstrued as indifference towards the loss of his close friend, however, this was not the case: *"They weren't understanding the different situations that I was after going through. That led me to picking up that substance."* The unseen reality was, as Levi articulated, that drugs acted as a suppressing agent for participants as there was no capacity to manage more emotional pain:

I didn't know how to manage [the death], and the only way I knew how, by every other situation in my life, was to use drugs. So, the drug use increased. Because I just wanted to numb all of the feelings. I didn't want to feel anything. And that's what drugs do.

The presence of drugs as a causal circumstance in Cody's death had an inverse effect on Marco's opportunities to grieve and isolated him in the aftermath. Internalized feelings of blame and shame through stigmatized vilification negated his propensity to engage in help-seeking behaviors as his drug use escalated. A relationship that had once provided him psychological warmth shifted to a source of psychological trauma; the conceptual reorientation of a cherished bond resulting in increased drug use and long-term psychological outcomes:

I was diagnosed with PTSD from that, from all the stigma. When I was at the inquest the dad was shouting and roaring at me...Heroin and tablets went just through the roof. I mean, bad. It was just downward, a proper "forget everything" type of thing. 30 Xanax a day, and a bag of heroin. I'm lucky to be alive like, I swear to God.

Death as an Escape. The concatenation of events following the death ruptured Marco's ideological interpretation of the world and he struggled to find meaning within the remnants of his social domain. Ultimately, a sense of hopelessness prevailed as Marco expressed his difficulties living in a world without a place for him. His world had become psychologically cold, and a very dark place: *"If anything, I wanted to be in [Cody's] position. At that time, I wanted to die like. My whole world was after falling apart."* Sasha disclosed similar expressions of envy, struggling to exist in a world where she felt so isolated and could not attribute meaning to her own life: *"I can almost remember being envious of young people that were part of my peer group because their pain was over, and I couldn't understand."* For Annie, the ceaseless condemnation of her peer group over years of social exclusion and apathy towards their deaths eroded her self-worth as she projected society's indifference on to herself, she was envious of the fact that her peers were no longer suffering while she was left behind without a place to belong, and to endure continuous denunciation:

When I heard about somebody who died from drugs, I was jealous. Which is awful, but I wasn't in a good place myself and I felt I was never going to get out of this, and I just wanted to die myself. And I was like "why can't that happen to me?"

Given what such meaningful connections represented for participants during times of severe crisis, such as kinship and mutual understanding, the impact of the deaths of individuals representing these intrinsic human values became far more complex. All participants spoke about their relationship with death during their time in active addiction, with Annie disclosing that, trapped in a cycle of trauma but longing for peace, she attempted death by suicide:

It started to impact on every area of my life. Friends, financial, and mental health was very, very bad...I was taking drugs quite a lot. It really did take over so I started stealing money from everywhere I could. I would try pay for things and everything, so my family started to find out. And work, everything. And so, then I tried to take my own life twice.

Annie's drug use permeated multiple facets of her life as existing relationships became strained over time and some, including her marriage, deteriorated entirely. Expressions of suicidal ideation or attempts to die by suicide emerged throughout interviews as participants felt that they had nowhere else to turn. Kenny's primary coping resources centered around repressing extant traumas, and the reinforced sense of disenfranchisement emerging from the bereavement necessitated more urgent coping strategies. However, Kenny was so emotionally overwhelmed that he could not permit

himself to grieve, nor could he allocate the psychological resources to make sense of the loss in the context of broader society. As a result, he became enmeshed in a cycle of emotional suppression and suicidal ideation:

I made the decision to kill myself... I was very badly strung out, I was like, "so I'm stoned today, but tomorrow is coming. I'm going to have to come down sometime and I just can't do any more sicknesses." And I just was like "alright then, it's okay, you're going to kill yourself, you don't have to do it anymore."

Survivor's Guilt. Many of the participants explicitly stated that, to this day, they live with survivor's guilt that manifests in personally individualized ways. Marco, who felt blameworthy for Cody's death and has not reconnected with Cody's family, questioned the sanctity of his own life as he dwelled on his survivor's guilt. Even in his recovery, the internalized shame of his past remains very much alive:

I was driving, his mother walked past me, and I put my head down. To hide. Because I was ashamed. Over that stigma being put into me, I used to use [drugs] with her son. And now he's dead and I'm alive, and here I am driving a car. I just felt awkward and guilty, and I know this woman since I was 10 years old. That's the madness of it.

John wished for more conscious efforts to recognize the potential and humanity of people in active addiction; to create visibility for life outside of addiction and to break the cycle of psychosocial entrapment within a continuum of trauma and social neglect. However, following Ben's death, John experienced profound survivor's guilt as he considered his own life in comparison to how he viewed Ben as a beacon of potential. Contending with survivor's guilt alongside the social conceptualization of his grief as unsanctioned hindered his efforts to make sense of the loss:

I'm feeling like, "how the f*** did he die?" He's only using [drugs] about the last 12 months, and he's innocent. I'm using about the last 10 years, heavily, and I'm here and he's not, you know?

Discussion

The current study shared the voices of six bereaved individuals who experienced a DRD while in active addiction, using IPA to center on their narratives and explore how their grief experience and identities as bereaved were shaped by stigma. For participants, their peer bonds represented mutual understanding, companionship, and familial connection, where drug-related peer loss resulted in profound grief-related reactions. Influenced by the twofold stigma of grieving a DRD while positioned within a stigmatized community, participants reported a diminished self-concept, survivor's guilt, self-blame, shame, and increased drug use against the societal invalidation of their bereavement. The findings highlighted an urgency for targeted bereavement

intervention protocols that acknowledge an increased risk of fatal overdose and disenfranchised grief for a community in crisis. The firsthand stories of grief portrayed by the bereaved in this paper corroborate healthcare professionals' implorations that people who use drugs are critically underacknowledged as a group who are impacted by DRDs (O'Callaghan & Lambert, 2023).

Discussion of Empirical Findings

This study further reinforces the conceptualization of drug-related bereavement as a complex area with no uniform approach to support. In providing an in-depth phenomenological insight into individual mediators of grief for people in active addiction, and the convergence of bereavement experiences across this group, this paper demonstrates that grief outcomes are influenced by a nuanced interplay between personal experience, systemic belief systems, and legislative structures. However, while the participants in this study reported many similar complexities in their grief responses to other social groups such as families (Lambert et al., 2021; Titlestad et al., 2019) and HCPs (O'Callaghan & Lambert, 2023; Sperandio et al., 2023), there are significant contextual differences. The narratives provided by participants provide a crucial insight into the complex mental processes involved in grieving a stigmatized loss while socially situated within a stigmatized community.

To this end, the current study supports the identification of a unique double stigma highlighted by the work of Selseng et al. (2023, 2024), and comprehensively explores the health implications of grieving while experiencing marginalization and compromised wellbeing. Most crucially, this study underscores the immediate aftermath of a peer's DRD as a critical period for crisis intervention as participants expressed suicidal ideation, attempts to die by suicide, and increased drug use with a further risk of overdose. With systemic stigmas generating both internal and external barriers to help-seeking and support, the psychological integration of these experiences stretches beyond the individual capacity of those who are already in crisis. With difficulties regulating around the loss of their peers, the findings reinforce a growing evidence base that identifies increased drug use as a persistent grief response for people who use drugs (Macmadu et al., 2022; Selseng et al., 2023), necessitating urgent community-based strategic interventions to prevent further loss of life.

This paper advocates for drug-related policies and procedures in addiction, health, and homelessness that recognize and employ actionable responses to the increased risk of further deaths by overdose and/or suicide within communities after a DRD. Furthermore, this study provides in-depth contextual and relational information about barriers to help seeking through an exploration of socioemotional intricacies, which services can utilize to mitigate these barriers and increase the efficiency of crisis support provision. Broadly, participants noted that their grief was unrecognized by the wider public, echoing the findings by Selseng et al. (2023, 2024) who reported that, with their humanity and grief neglected, the bereaved remain solely positioned as people who use drugs and not as people who grieving a profound loss.

While participants acknowledged the risk factors of forming attachments while in crisis, this study provides additional in-depth context to the evidence base regarding the function and importance of peer relationships in active addiction. All six participants analogized many relationships to various roles within a family structure, with their peers representing social intimacy, belongingness, and potential, adding further credence to [Bethune Scroggs and colleagues' \(2022\)](#) reporting of drug-related peer loss invoking secondary losses. [Macmadu et al. \(2022\)](#) noted that increased overdose risks were evident when the DRD of an emotionally close peer occurred, and in the current study, all six participants acknowledged the loss of at least one close relationship that had profound implications on their wellbeing. However, drug-related stigmas eroded the social validity of these peer bonds.

Their peer bonds delegitimized during life, and their grief disregarded during death, this report highlights a unique disenfranchisement for people who use drugs as their connection to the deceased is not formally defined. Although participants used heartfelt familial terms to describe their peers, the personal meaning of such connections may not be socially acknowledged in the same way as more universally recognized relationships, such as a parent's connection to their child. [Wojtkowiak and colleagues' \(2019\)](#) work demonstrated a fragmented and delayed grief for this population, and [Bethune Scroggs et al. \(2022\)](#) stated that the individual may not begin to fully process the loss until entering recovery. These findings are reflected in the current study, as participants struggled to find meaning in the loss of their peers, which had further psychological implications for their self-concept.

Given the prevalence of loss in the lived experience of each participant, and the broader context of active addiction, urgent action is required on behalf of addiction and recovery services to provide information on delayed or disenfranchised grief. Currently, there is a societal failure to look beyond addiction to recognize the individual who is grieving in crisis, and the professional acknowledgement of grief within services would serve to validate and support those who have been bereaved by a DRD, including recognizing 'survivors' guilt' experienced by peers. Furthermore, strengths-based therapeutic interventions that assist the bereaved in making sense of the loss are recommended, especially given the profound impact on participants' self-concept reported in the findings.

Validating the peer bonds for this population may yield implications for post-traumatic growth as, amidst the stigma, both families ([O'Callaghan et al., 2022](#)) and HCPs ([O'Callaghan & Lambert, 2023](#)) identified role constancy as a pathway to healing. Parents maintaining continuing bonds with their children through symbolic means and HCPs utilizing their professional responsibilities as practical coping mechanisms functioned as both loss-oriented and restoration-oriented methods of healing ([O'Callaghan et al., 2022](#); [Stroebe & Schut, 2010](#)). By internalizing the social undermining of their peer bonds, participants' roles in the lives of their contemporaries became unclear and, in some cases, nullified. Coinciding with the findings of [Wojtkowiak et al. \(2019\)](#), opportunities to honor the lives of their peers were severely

inhibited, as participants felt unwelcome at funerals and shared spaces of mourning evolved into areas of judgement and condemnation despite their efforts to pay respects.

Dominant social norms construct attributional beliefs at a societal level that frame drug use as a behavior that is morally wrong, neglecting to recognize addiction's association with trauma. These norms, reinforced by inequitable societal and legislative structures, can perpetuate stigma and hinder support practices through a justice led reaction to a mental health problem (Muncan et al., 2020). Service providers in health and social care settings, particularly those who regularly work with people who use drugs should work towards the implementation of the recommendations outlined in this paper; this has the potential to decrease service user death and reduce psychological distress associated with complicated bereavements.

Recommendations for Policy and Practice

Policies and procedures in addiction must recognize and respond to drug-related complicated grief outcomes as significant public health risks, and it is crucial that responses employ case-sensitive and evidence-based models of practice. The concept of a double stigma acts as an under-acknowledged and hidden harm within the community of people who use drugs, with severe implications for psychological health and mortality. The development of specialized training and education opportunities for staff in social and healthcare settings that cultivate a greater professional understanding of such unique grief experiences would serve to enhance the capabilities of services to address an individualized and complicated grief.

As acknowledged above, given the increasing instances of DRDs, the implementation of therapeutic interventions that integrate both grief and addiction support within service frameworks is crucial. Furthermore, this paper recommends public health campaigns to address the stigma but also raise awareness about the impact of DRDs for the community of people who use drugs. Current research has appealed for the recognition of overdose as a severe psychological trauma (Nolte et al., 2023; Schneider et al., 2021), which finds further credence in the current study as at least one participant disclosed a diagnosis of post-traumatic stress disorder (PTSD) following the DRD of his best friend, but all six participants witnessed fatal and non-fatal overdoses while in active addiction.

Strengths, Limitations, and Directions for Future Research

From the individual perspectives of six drug death bereaved individuals, this study presents further evidence that people in active addiction grieve for the loss of their peers within their community. However, recruitment from this project took place in an area where all participants' experiences reflect active addiction, grief, and recovery within urban settings. Literature suggests that people who use drugs in rural areas are often exposed to more isolation, so future research should aim to understand the experiences of those who may not be routinely connected to communal spaces. Furthermore, there

are avenues to explore cultural differences, such as the experiences of ethnic minority groups.

Conclusion

The findings of this paper contribute to the understanding of disenfranchised grief within a community that is already marginalized due to systemic stigmas associated with addiction. Individual grief correlates emerge based on group characteristics, but also from distinct within-group individualized factors such as connection to the deceased, allostatic load, and social positioning. The findings contribute to a broader understanding of the social context of drug-related bereavement, and how the intricacies of social positioning can exacerbate grief outcomes in different ways. As a critically under-researched area of inquiry, understanding variability in experience and support needs is crucial to the development of functional and adaptive practice frameworks that address specific psychological harms.

Author Contributions

Daniel O'Callaghan: Conceptualization, Methodology, Investigation, Validation, Formal analysis, Writing – original draft, Project administration, Data curation.

Sharon Lambert: Conceptualization, Validation, Formal analysis, Writing – review & editing, Project administration, Resources.

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Ethical Statement

Ethical Approval

With respect to the named paper submitted to OMEGA – Journal of Death and Dying, the authors wish to confirm that the publication has been approved by all co-authors. The study was approved by the University ethics committee and ethical guidelines were adhered to. The work is original, and no copyright has been breached by the inclusion of any content drawn from another source.

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Dr Sharon Lambert is a senior lecturer in applied psychology who is experienced in working within community based settings that provide supports to marginalised groups. Sharon's research interests revolve primarily around the impact of trauma on development, its link with substance dependence and mental health and consequent considerations for service design and delivery.