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‘Special Death’: Living with Bereavement by Drug-Related Death in Ireland

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.

Keywords: Drug-related death; bereavement; family; complicated grief; special death

Introduction

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, Lindeman, Lund, & Dyregrov, 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, Mellingen, Stroebe, & Dyregrov, 2020). The dual process model of grief by Stroebe & 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, Jordan & Gorman, 2011). A systematic review by Titlestad et al., examining family drug death bereavement literature, was published in 2019. The review synthesised the experiences of drug death bereaved family members across 8 studies based on the inclusion criteria (2 from the UK, 3 from the USA, 1 from Brazil, 1 from Norway and 1 from Denmark). Although the review demonstrates a wide geographical spread, the review addresses a requirement for 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, Møgster, Løseth, Lorås, & Titlestad (2019) 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 stigmatisation, 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 Silva, Noto & Formiggoni (2007) identified 6 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.

While 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 state 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, Reneflot, Stene-Larsen, & Johan Hauge (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 2 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, Lambert & McCarthy, 2020). Disenfranchised grief is defined as 'a loss that cannot be socially sanctioned, openly acknowledged or publicly mourned' (Doka, 1989, p4) 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., (2020) 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 utilised 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 finding by Templeton (2020) may be pertinent to this population. It was concluded that supporting this cohort requires specialist knowledge.

The current study looks at the impact of DRDs on the family system. However, while previous studies interviewed family members individually, this paper will explore DRDs in the context of family dynamics by interviewing multiple family members at once. Seven families comprising of seventeen affected family members discussed the impact of the early deaths of seven men and one woman in semi-structured interviews. The paper is the first of its kind to explore the issue of DRD's 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

This is an explorative study that aims to provide a hermeneutic understanding of how families bereaved by a DRD in Ireland experience complicated grief. The findings presented in this paper 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. To interpret and understand these narratives, we employed reflexive thematic analysis (Braun & Clarke, 2019) as an analytical framework.

Recruitment & Participant Profile

All participants in this study were bereaved by a DRD, which was a primary inclusion requirement. Seventeen bereaved family members were interviewed across seven interviews,

with four males and thirteen females (Table 1). The relationships of the participants to the deceased included the following: 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 one year to twenty-one years.

[Table 1 here]

For the purposes of providing a theoretical structure to the recruitment strategy, Koerner and Fitzpatrick's (2004, p177) definition of the family was considered 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." 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 also 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 with a stated 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 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 and were as follows: (1) 'about the family', (2) 'the impact of experiencing a drug-related death', (3) 'challenges', (4) '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 produced 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-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 & Clarke's (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: (1) familiarization with the data, (2) coding, (3) generating initial themes, (4) reviewing themes, (5) defining and naming themes, and (6) 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 co-authors on this paper. Throughout the analytic process, the co-authors engaged in reflective practice as per the updated framework by Braun & Clarke (2019). The scope and naming of themes were agreed between co-authors.

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 co-author 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 co-authors 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 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 emerged from the conduction of reflexive thematic analysis: (1) Renegotiation of Relationships, (2) Experiencing Complex Emotions, and (3) 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

The renegotiation of family dynamics was not the only prevalent subtheme within the theme of relationships. 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 the 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 touchpoints, 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 lead 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 details her experience in questioning her right to grieve for her son given the circumstances of his death and compares 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 newfound 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 recounts 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 3 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

Disenfranchised 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

disenfranchised 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. The data generated three bereavement themes: (1) Renegotiation of Relationships, (2) Experiencing Complex Emotions, and (3) Adjusting to a New Reality.

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 & 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 this 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, Fakier & Louw, 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., 2020; 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., (2020) 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.

Strengths & Limitations

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 (Dyregrov et al., 2018 as cited by Titlestad et al., 2019), this study is of considerable importance. 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, while recruiting enough participants, may have benefitted 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.

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Tables with Captions

Table 1

Profile of Participant Families

Participants per family & 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 Male aged 38	Overdose Liver failure	13 years 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