Grieving the Living and the Lost: Sibling Experiences With Drug-Related Deaths

by

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To my parents, thank you for always making me feel loved, never doubting my abilities, and constantly inflating my confidence. I wouldn't be here without your unwavering belief in me. To Jess and James, it has been an honour, a privilege, and probably fate to have been on this journey with you both. To my husband and the *many* (seriously, so many) incredible people in my life: the ones who checked in constantly throughout this program, the ones who don't get upset when it takes me seven business days to reply to a text, the ones who tell me how proud they are, and especially those who've seen potential in me when I couldn't see it myself. I appreciate and love you all more than you'll ever know.

Dedication

For my sister: It has been nearly five years, but not a day goes by that I haven't thought about you. Although I grieve your life and your death, you continue to motivate me. This capstone is both for you and in memory of you.

> You become. It takes a long time. That's why it doesn't happen often to people who break easily, or have sharp edges, or who have to be carefully kept. Generally, by the time you are Real, most of your hair has been loved off, and your eyes drop out and you get loose in the joints and very shabby. But these things don't matter at all, because once you are Real you can't be ugly, except to people who don't understand (Williams, 2017, p. 7).

Abstract

Drug-related deaths (DRDs) continue to be at an all-time high. The increase in these deaths leaves many family members bereaved. Although research in the field of death studies may explore these losses, the bereavement experiences of siblings following a DRD remain under-researched in comparison to other areas of bereavement research. This capstone project aims to explore what shapes siblings' experiences following a DRD by exploring the intersection of ambiguous loss, anticipatory grief, stigma, and disenfranchised grief through a thematic literature review.

Keywords: drug-related death, substance use disorder, ambiguous loss theory, disenfranchised grief, anticipatory grief, addiction, sibling bereavement, stigma, meaning-making

List of Acronyms

AG – Anticipatory grief

AL – Ambiguous loss

DRD – Drug-related death

SUD – Substance use disorder

IDU – Intravenous drug use

IE – Infective endocarditis

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Chapter 1: Grieving the Living and the Lost

Drug-related deaths (DRDs) are a continuing public health crisis. It is difficult to obtain a comprehensive picture of the extent of this crisis in Canada, as the data reported by Statistics Canada relies on the collection and reporting of each province and territory. Some provinces only deem a death to be drug-related if a substance is listed on a death certificate; others do not report DRDs if individuals are under the age of 19, and medical consequences of substance use are not included in the statistics in Canada (Public Health Agency of Canada [PHAC], 2024). These reported numbers represent only a small percentage of the complications and consequences of substance use, which could lead to death. For example, occurrences of infective endocarditis (IE), an infection of the heart valves, which can occur as a result of intravenous drug use (IDU), continue to increase (Geirsson, et al., 2020). Geirsson et al. (2020) found that in the United States, hospitalization and heart valve surgeries related to IDU-IE have increased as much as 1100%, with 30% of surgeries being repeat surgeries, demonstrating the recurrence of endocarditis within this population.

Endocarditis is only one example of the negative health consequences of substance use. Other complications include infections such as HIV and hepatitis, respiratory problems, cardiovascular problems, gastrointestinal issues, liver problems, kidney damage, and neurological issues (National Institute on Drug Abuse [NIDA], 2020). These complications significantly increase the likelihood of death, which demonstrates that DRDs extend far beyond the reported cases of poisoning and overdose. This illustrates how DRDs are underreported and that statistics are not providing the full picture. Statistics in Canada are failing to account for deaths related to the long-term consequences of substance use and other drug-related medical concerns. Without proper reporting on this data, we cannot see the full picture of the far-reaching

impact and implications of substance use. The importance of understanding the scope of the ongoing public health crisis is to recognize that with DRDs rising, so too do the hidden consequences of the number of family members and loved ones left behind, which is the primary purpose of this capstone.

The increase in the number of bereaved family members highlights the need for more research and education surrounding grief and loss related to DRDs so that bereaved individuals can have support better tailored to their needs. Grief, loss, and bereavement support cannot adopt a one-size-fits-all approach. Throughout the literature, the focus remains on parents, spouses, or children of individuals lost to substance use, with siblings continuing to be the forgotten mourners, as with other types of bereavement research (Tenhulzen, et al., 2024). Although this area of bereavement is under-researched, the loss of a sibling needs to be acknowledged as being as impactful and life-changing as any other type of loss. Further, the experience of ambiguous loss (AL) is a particularly complex and related consideration that needs to be made with respect to DRD bereavement. AL can begin long before death occurs, making it more difficult to understand what bereaved siblings may experience both before and after death. Initially, this capstone was going to focus more heavily on how AL shapes the grieving process; however, upon investigating this topic, it became evident that a broader exploration of sibling loss in the context of DRDs was necessary. This shift was made so that other factors, such as disenfranchised grief, anticipatory grief (AG), and stigma, could be included in this capstone's study and fully reflect the experience of a loss of a sibling to DRD. Additionally, the research in this capstone aims to examine the experiences of DRD-bereaved siblings to better inform mental health professionals, grief support organizations, and policymakers to appropriately address the needs of this population.

Purpose Statement

The purpose of this capstone is to shed light on the experiences of siblings bereaved by DRDs. This research aims to address the impact of AL and AG before death and disenfranchised grief after death, providing a better understanding of how these unique experiences shape sibling bereavement. The ultimate goal is to provide insights into the needs of grieving siblings so that counsellors and support systems can better serve this population both before and after a DRD. The secondary goal of this research is to reduce the stigma associated with DRDs and individuals experiencing addiction.

The primary research question guiding this capstone asks: What psychological factors shape the bereavement experiences of siblings after a DRD? Secondary research questions include:

- How do AL and AG influence sibling bereavement experiences?
- What role does stigma play in shaping sibling grief?

Theoretical Frameworks

The research has been grounded in two theoretical frameworks: AL theory and social constructionism. Combining these two lenses captures both the internal and external factors that shape the bereavement experience. AL theory can help explain the internal processes of the pre-death experiences of siblings. At the same time, social constructionism explains both pre- and post-death experiences by highlighting how external factors such as stigma and societal narratives shape grief. Using both frameworks allows for a more in-depth and comprehensive examination of the emotional and social complexities of bereavement in the context of DRDs.

AL Theory

Boss (1999) describes AL as grief that lacks clarity or resolution, often when a loved one is physically present yet psychologically absent. This type of loss is traumatic for those experiencing the loss because it is not visible to others, often going unrecognized or misunderstood, although lasting for many years or even a lifetime without resolution (Boss, 2010). AL is relevant in the context of addiction because individuals experiencing substance use disorders (SUDs) may become unrecognizable to their loved ones due to psychological and behavioural changes and the unpredictability of recovery from SUDs. This creates a sense of loss before death, which could go on for several years, often but not always ending with death. As such, AL theory is necessary to help understand the pre-death experience of those who are DRD-bereaved.

Social Constructionism

Social constructionism (Berger & Luckmann, 2011) posits that our individual reality is not an objective truth, but rather it is shaped by social interactions and societal influences. Therefore, the reality for those who are DRD-bereaved is shaped by concepts such as norms, beliefs, and values, which are not fixed facts; rather, they are continuously shaped and reinforced by the cultural and historical contexts of the time. This framework is relevant to this topic because stigma, societal attitudes, and language can all influence the bereavement experiences of DRD-bereaved siblings and help to understand how these external factors impact and even exacerbate their experience.

Methodology

This capstone project explores the under-researched experiences of DRD-bereaved siblings. The focus of these experiences is on AL, AG, and disenfranchised grief. There is

limited research available on this topic, so trial and error were needed to find the appropriate combination of search terms that encompasses as much of the applicable literature as possible. Throughout the review process, my approach remained flexible to ensure that a comprehensive review was completed while also paying attention to literature in adjacent areas of research. The following sections detail the search parameters used, inclusion and exclusion criteria, data management strategies, and review processes.

Search Parameters

The search began with using the CityU online library. The initial search used the following parameters:

- ((sibling loss) OR (sibling death) OR (sibling bereavement) OR (sibling grief)) AND ((ambiguous) OR (ambiguity) OR (disenfranchised) OR (disenfranchisement)) AND ((drug death) OR (drug-related death))

Using the CityU online library, this search yielded three results. Due to the limited results, search terms were gradually removed to broaden the range of articles. The second search removed ambiguity and disenfranchisement to focus on sibling bereavement and DRD:

- ((sibling loss) OR (sibling death) OR (sibling bereavement) OR (sibling grief)) AND ((drug death) OR (drug-related death))

This search yielded 145 results and was changed to:

- ((sibling loss) OR (sibling death) OR (sibling bereavement) OR (sibling grief)) AND ((ambiguous) OR (ambiguity) OR (disenfranchised) OR (disenfranchisement))

This search yielded 31 results. Due to the limited results, the search was broadened to encapsulate a wider range of results to:

- ((sibling loss) OR (sibling death) OR (sibling bereavement) OR (sibling grief))

Given the limited research available on DRDs and sibling bereavement, flexibility was required for inclusion, allowing more general articles to be included in the research. These results included peer-reviewed articles published within the last 10 years. However, these filters were sometimes removed to see if any older articles of seminal value or grey literature would be relevant to include in the research.

Inclusion and Exclusion Criteria

Articles were reviewed throughout the process to determine their relevance. The intention was to find articles that addressed sibling bereavement, AL, or disenfranchised grief in the context of DRDs. However, few articles encompassed all themes. At times, Google Scholar was used to determine if any additional literature was available that was not accessible via the CityU library. However, it was used sparingly due to its being less user-friendly and more challenging to refine results specifically to peer-reviewed articles. The result after filtering the research on the above-mentioned inclusion criteria yielded 3,174 articles and reviews for this capstone. Any articles that were found to include alcohol use disorder in their definition of SUD were excluded. Through this initial process, 51 articles were deemed to be relevant.

Data Management and Review Process

The beginning of the research process included downloading all articles that appeared relevant at first glance. These articles were then organized using the reference management tool, Zotero. Once all seemingly relevant articles were collected, each article was systematically reviewed. First, by reading the abstract, then moving on to the results section if the abstract was determined to be relevant. Articles deemed irrelevant to the topic were immediately removed. Annotations and related notes were documented within Zotero for the remaining articles. Throughout this exploratory process, new insights ultimately changed the research focus. In

some instances, additional sources were found via references within articles, and reverse research was completed to access information that had been obtained in a previous research strategy.

Expanded Glossary

Defining terminology in the context of addiction and bereavement is essential because language shapes perceptions, and certain terms carry stigma, as alluded to in the previous section. Many terms in grief literature are used interchangeably, making it necessary to distinguish the difference between the terms. Additionally, clarity, accuracy, and sensitivity are required throughout this capstone, and by defining these terms, we acknowledge the weight and stigma that these terms may carry. The majority of these terms are defined using both a dictionary definition of the term with additional supporting definitions and information from academic literature or organizations specializing in addiction, grief, or bereavement. The decision to use dictionary definitions is to provide a more standardized and recognized definition, whereas the literature-based definitions provide more context.

Addict

The term addict is commonly used to describe a person with an addiction (see below for the definition of addiction). However, this term is often considered derogatory in nature when pejorative. It contributes to stigma because it reduces a person to their substance use, disregarding other parts of their identity. The literature discusses how labelling individuals as addicts can lead to authoritative attitudes, which means society will respond with control and punishment, rather than support and compassion (Baker et al., 2022). The Canadian Centre on Substance Use and Addiction (CCSA, 2017) suggests using person-first language or postmodified nouns (e.g., a person experiencing addiction or preferably a person with a SUD) to

reduce stigma. In this capstone, the term addict will be used only when citing sources that include it or when emphasizing a stigmatizing narrative.

Addiction

Addiction is the "state of being addicted," (Merriam-Webster, n.d.-a) or an action or behaviour where individuals are no longer in control of themselves (Centre for Addiction and Mental Health [CAMH], n.d.). The definition differs from that of an addict because addiction describes the symptoms that come with being an addict. Merriam-Webster (n.d.-a) defines addiction as *"*a compulsive, chronic, physiological or psychological need for a habit-forming substance, behaviour, or activity having harmful physical, psychological, or social effects and typically causing well-defined symptoms (such as anxiety, irritability, tremors, or nausea) upon withdrawal or abstinence." It is important to note that the definition of addiction, specifically the hows and whys, may vary depending on the proposed theory or model of addiction. For example, the widely known and accepted biopsychosocial model recognizes addiction as an interplay between biological, social, and psychological factors versus the disease model, which posits that addiction is a brain disease, or the moral model of addiction, which is rooted in the belief that addiction is the result of a personal failure. Often, the word addiction is used to describe the most severe presentations of SUD or problematic use (CAMH, n.d.). However, due to the negative connotations associated with the term, it is not used in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; DSM-5-TR; American Psychiatric Association [APA], 2022). Throughout this capstone, the term addiction may be used for ease of communication and to align with how it is commonly used in the literature and reporting. The use of this term is not intended to reinforce stigma, but rather to maintain accessibility for the reader and consistency throughout.

Bereavement

Bereavement is the state of being bereaved of something or someone, and for the purpose of this capstone, it will encompass the state after the death of a loved one, specifically a sibling (Hilberdink et al., 2023; Merriam-Webster, n.d.-b). During this state, one can experience both grief and mourning. The term bereavement, along with the word "bereaved," is frequently used throughout this capstone to encompass the experience of loss, including grief and mourning. The reason why this term is used frequently is because it encompasses a multitude of experiences versus grief, which describes only the various reactions to loss. See the definition of grief for further clarification.

Drug-Related Death

As discussed earlier in this chapter, how a DRD is defined varies from province to province (PHAC, 2024); however, for the purpose of this capstone, a DRD encompasses all deaths that are caused by or are a consequence or complication of drug use. Suicide, although it may be a consequence of drug use, is excluded from the definition of a DRD for the purpose of this capstone. This is due to the potential of additional stigma associated with suicide, which could further complicate any bereavement experiences of the DRD-bereaved.

Grief

Grief is the cognitive, emotional, and behavioural responses caused by bereavement (Hilberdink et al., 2023). The term grief is used frequently in this capstone. Bereavement encompasses grief. However, the terms are not interchangeable because bereavement describes the state of having lost a loved one, whereas grief refers to the reaction to that loss. In other words, bereavement includes grief, but grief does not always include bereavement and can be associated with non-death-related losses.

Mourning

Mourning is the public and outward display of grief (Merriam-Webster, n.d.-c). Mourning allows individuals to process the loss, often with cultural or religious displays of grief, such as funerals, as well as any symbols of grief, such as wearing black (Hilberdink et al., 2023).

Substance Use Disorder

SUD is the diagnostic term used in the DSM-5-TR (APA, 2022), which encompasses 10 separate classes of drugs and is characterized by continuous substance use despite harmful consequences. In the context of this capstone, the term SUD will be used to describe primarily opioid and stimulant use disorders as they are the leading contributors to DRDs in Canada. It is important to note that although alcohol use disorder is classified as a SUD, it has been excluded for the purpose of this capstone. The stigma associated with alcohol is less, and because of this, the experience of bereavement may differ in alcohol-related deaths. Although the term SUD is used infrequently in this capstone, the term substance use or user may be used. For clarity, it refers to individuals who use substances regardless of an official diagnosis. This is done to avoid pathologizing those who use substances.

Positionality

This research is, first and foremost, a passion project sparked by my personal experience after the loss of my sister. The lack of support and acknowledgement of my sister's death was surprising. At times, the discomfort that arises when I mention my sister can be palpable. I have spent many years wondering why I perceive my experiences, along with the responses I receive about my sister's death, as different from those of others who have experienced loss. I knew that if I were going to spend upwards of a year researching and writing about a topic, it needed to be personal and important to me, while at the same time, contributing to the literature. Not only

does my personal experience and the gap in the literature support this capstone, but so does the increasing number of DRDs, making this research timely and necessary. With my deep personal connection to the topic, it has been crucial for me to acknowledge how my experiences and life up to this point have shaped my perspectives and contributed to my biases. I know how difficult it is to lose a sibling, and my research is driven by sadness, not just for myself but for others like me. However, I feel that I often assume that those who have similar experiences feel the same way as I do, and I find myself projecting my sadness onto them, perhaps unintentionally creating confirmation bias. To minimize this, I must first acknowledge that grief is an entirely unique experience and then search for evidence of other perspectives. While my loss was challenging and devastating, this experience is not everyone's truth. Biases aside, I still selfishly wish to shed light on this population because I want to understand my experience better and validate it through research. However, in recognizing my own desire to understand my experience better, I know how important it is to help other siblings who are grieving, especially those who feel as unseen and isolated as I did.

Social Location

It is important to consider my social location as this too shapes my experiences and my worldview. I am a Caucasian Canadian woman currently pursuing and finalizing my Master of Counselling, with plans to become a Registered Psychologist. I grew up in a small local service district in New Brunswick, graduating from high school with 27 of my peers, whom I had known since kindergarten. My upbringing was one of shared experiences, where everyone came from a similar background, limiting my exposure to diverse perspectives, such as the factors that influence addiction. Although drug use was not unheard of, it remained mostly unseen, far removed, and irrelevant to my life.

When my sister began using substances, I had already left for university and, therefore, I was removed from the daily reality that my sister and parents faced. Looking back, this distance made it easier to avoid confronting what was happening, perhaps an "out of sight, out of mind" mentality. To this day, I still find it difficult to understand that something that felt so foreign to me had become a reality within my family. Although I understand the biopsychosocial factors behind addiction, my lack of exposure still makes it difficult to comprehend how or why someone would decide to experiment with substances that are known to have such severe consequences. However, no amount of academic knowledge can answer my questions about my sister's choices, and most importantly, I must recognize that this capstone project will not provide these answers either. Instead, I must interpret this research as simply research, an exploration of research relevant to my experience and many others.

Mitigating Bias and Objectivity

It is likely as obvious to you, the reader, as it is to me that my largest bias is my personal experience. While this experience fuels my motivation and passion, it also makes it easy to see my perspective as the most important or even the most valid one. As much as this capstone is a way for me to process my own loss, I want to ensure that if other siblings choose to read this capstone, they feel seen and understood. The research needs to go far beyond my experience and my story and reflect the incredibly complex and diverse experience of all who have experienced the loss of a sibling due to a DRD. Throughout the research and writing process, I must continuously check my biases, making space for diverse experiences outside of my own. Again, to mitigate bias, I will ensure that multiple perspectives are represented in my research, as the goal is not to provide a singular account of DRD sibling bereavement but rather to document an experience that, while in its entirety, may not resonate with all, however, perhaps parts of it will.

Outline of Chapters

This capstone is organized into three chapters. This chapter has introduced the topic and its significance and has discussed the purpose of the capstone, along with the research questions and theoretical frameworks guiding the research. Next, an overview of the methodology used to gather and analyze the literature occurred. My self-positioning statement, which articulates my motivation and biases, was also outlined. Chapter 2 begins with a thematic literature review, structured around two themes: (1) The Experience of Loss, and (2) Stigmatization. To provide an in-depth exploration into each theme, multiple subthemes will be explored throughout. These themes will be examined through one or both chosen frameworks: AL theory and social constructionism. The final chapter, Chapter 3, synthesizes the findings from the literature review and explores practical applications of this knowledge. It includes proposals for future action, including improved support services, stigma reduction initiatives, tailored counselling approaches, and policy changes. Additionally, it critiques the DSM-5-TR criteria for prolonged grief disorder. Finally, this capstone concludes with a reflexive statement in which I will revisit and reflect on the entirety of this experience.

Chapter 2: Literature Review

The Experience of Loss

With addiction, loss often begins long before death. This means that DRD-bereaved siblings begin grieving the loss of their sibling before their death, when they witness physical or behavioural changes in their siblings, or when they begin to see them less because of their addiction (Mechling et al., 2018). Family members live in constant fear of receiving the dreaded phone call that their loved one has died, and this anticipation and uncertainty compound the ambiguity of their loss (Meen, Reime, Lindeman, et al., 2024). Family members and friends who live with someone experiencing substance addiction report it as stressful, chaotic, unpredictable, and tumultuous due to a constant fear of safety for themselves and their loved ones, further adding stress to their experience of loss (O'Callaghan et al., 2023; Sampson et al., 2023). These feelings physically and emotionally exhaust siblings and can persist long after death (Dyregrov et al., 2019; Titlestad, Lindeman, et al., 2021). Those who are DRD-bereaved experience a continuum of loss that begins with the ambiguity of having a sibling experiencing addiction and continues with the anticipation of their death (Templeton et al., 2017). The research on this complex form of loss identifies how AL, AG, and prolonged grief shape the bereavement experiences of siblings following a DRD. This will be investigated further below.

AL

Pauline Boss coined the term AL in the 1970s to describe a type of loss that remains unclear (Boss, 2007). With AL, a loved one may be physically or psychologically absent, although still alive (Boss, 2007; Boss & Carnes, 2012). Unlike traditional losses, such as death, where the absence is definitive, AL is defined as an intangible or uncertain absence (Betz & Thorngreen, 2006). Examples include missing persons or unknown whereabouts, an airplane

crash, but your loved one's body has never been found, dementia, autism, or other cognitive impairments, and addiction, which is the primary focus of this capstone (Boss, 1999; Boss & Carnes, 2012).

The impact of addiction disrupts family dynamics. It leaves siblings grappling with the ambiguity of unresolved grief and helplessness while they attempt to make sense of how their relationships and roles are changing within the family, while their sibling is changing in front of them (Boss, 2007; Meen, Lindeman, et al., 2024; Titlestad, Lindeman, et al., 2021). Although their losses may already be evident, AL makes it challenging to move forward with life as usual because the course that addictions may take in one's life is unpredictable (Betz & Thorngreen, 2006; Boss, 1999; Boss, 2004). The framework of AL posits that those experiencing this form of loss go through chronic uncertainty due to a "here and not here" experience; this can be profoundly traumatic as death continually looms in the background (Boss, 2006; Boss, 2010). Siblings and families face a lack of closure, which can be incredibly stressful within the family system because role clarity is required for equilibrium in the family and without closure, it is difficult to know who is "in or out" and who is in what role in the family (Boss, 1999; Løberg et al., 2022). In the literature, addiction and AL are commonly described by participants and researchers alike as a rollercoaster ride (Boss, 1999; Titlestad, Mellingen, et al., 2021). The rollercoaster ride is characterized by conflicting emotions, instability in family life, and unpredictability, where hope for change is repeatedly met with disappointment (Betz & Thorngreen, 2006; Lindeman, Selseng et al., 2023). This cycle of addiction and ambiguity leaves siblings and family members feeling trapped in the uncertainty of addiction, emotionally drained, and unable to move forward with their lives (Boss, 2007).

Boss' (1999) work on AL defines the rollercoaster ride as a model of family stress on which families continuously ride the rollercoaster through the ups of hope and the downs of hopelessness. The only way to get off the emotional rollercoaster of AL is to take a gamble and make a definitive decision about the status of their loved one, thereby restoring balance in the family. In the context of addiction, perhaps this might mean deciding that the individual experiencing addiction will never return to the family in the same capacity and considering them lost to their addiction, rather than living in a state of not knowing. Boss' foundational research is based on years of extensive interviews with families experiencing various forms of AL. While her framework of AL is widely applicable to various circumstances, this broad application across so many contexts may overlook some of the nuances of different types of AL, such as with addiction.

Titlestad, Mellingen, et al. (2021) conducted a qualitative study using semistructured interviews with DRD-bereaved parents. Through a reflexive thematic analysis, they found that participants (n = 14) described their experience of having a child experiencing addiction indeed like a rollercoaster ride. Again, it was described this way because of its ups and downs and ongoing turbulent emotions. However, Titlestad, Mellingen, et al.'s findings are based on the Norwegian population, which may limit their generalizability. For example, in 2023, Canada reported 39.5 drug-related deaths per 100,000 people, more than five times Norway's rate of 7.1 per 100,000 (Gjersing, 2024; PHAC, 2024). While Norway remains among the top 10 countries globally for overdose rates, its numbers are significantly lower than those of Canada. This discrepancy raises questions about whether culture and prevalence impact the generalizability of the study's findings to other populations.

Boss (2007) distinguishes a difference between ambiguity and uncertainty or ambivalence. The difference is that ambiguity is external and situational, whereas ambivalence arises from internal emotional conflict. However, often, ambivalence leads to ambiguity. For example, this experience can be demonstrated in parents of children using drugs who can feel both helpless and yet at the same time hopeful for recovery (Titlestad, Mellingen, et al., 2021). An example of ambivalence is when siblings or family members struggle with conflicting feelings, such as love and care for their loved one, while simultaneously feeling frustrated or angry about their loved one's choices. This internal conflict can lead to ambiguity due to the uncertain and unresolved nature of the experiences of their loved one experiencing addiction.

Sibling relationships also differ from those of parents, as the relationship does not often consist of caregiving roles. Instead, sibling relationships are characterized by equality and the expectation of a lifelong connection (Towers, 2023). The shared equal bond of siblings is also characterized by the future splitting of caregiving responsibilities for aging parents and knowing that this will not happen can feel like a burden and a loss to siblings (Towers, 2023). When a sibling is experiencing addiction, this sense of equality is toppled. Siblings may feel responsible for protecting and supporting their equals, caring for their parents in the future, and perhaps even attempting to take on a parental role with their sibling.

Towers (2023) conducted a qualitative study using interviews with 36 bereaved siblings to explore their experiences following a sibling's death. The data from the interviews were analyzed using a thematic analysis. The study emphasized the shared, equal bond between siblings and how this equality often includes an expectation of caregiving responsibilities for aging parents, which will be divided equally in the future. When this shared responsibility becomes no longer possible due to addiction or death, it is a dual loss for the sibling (i.e., a loss

of the sibling and the imagined future they would have shared). However, the researchers did not describe whether data saturation was achieved, which made it difficult to determine if they interviewed enough participants.

Towers (2023) also allowed participants to bring artefacts to their interviews, which were related to their deceased siblings, potentially adding a layer of connection to their sibling, and thereby enriching the richness of the data collected. However, less than half of the participants brought an object with them. Towers (2023) acknowledged that the artefacts contributed to deeper insights, but did not elaborate on how a lack of an artefact may have contributed to how deeply those participants shared. Understanding how the artefacts contributed to the richness of the data gained from participants could have benefited the reader and further contributed to the validity of the results.

Løberg et al. (2022) completed a qualitative study using semistructured interviews with 14 DRD-bereaved siblings. Through a reflexive thematic analysis, they found that siblings felt the need to compensate for the actions of their sibling experiencing addiction and would conceal aspects of their life from their parents to appear to be a perfect child. Siblings were also found to provide support similar to parental support, rather than burdening their parents. The literature suggested that taking on this burden may have made siblings experience similar feelings of helplessness and hopelessness when compared to parents of children experiencing addiction (Titlestad, Mellingen, et al., 2021). As mentioned earlier, sibling relationships come with certain expectations for the future, and this imagined future changes or no longer exists when one sibling is experiencing addiction. AL is exacerbated by the need to reconcile expectations with a harsh new reality, which may be that their sibling will succumb to a DRD (Tower, 2023). AL represents the loss of a future. A future where achievements and milestones were celebrated

together, along with familial responsibilities. Therefore, DRD-bereaved siblings would not only be navigating their sibling's death but also their life and all other future losses. The loss of these normative and expected experiences can understandably have a profound impact on siblings (Towers, 2023).

Although limited literature exists that addresses the intersection of addiction and AL in sibling relationships, related research provides some context to this experience. A narrative synthesis of the literature by Mechling et al. (2018) utilized the lens of AL theory, where they examined children whose parent was diagnosed with an opioid use disorder (OUD). This review did not specify how many articles were used, nor did it discuss inclusion or exclusion criteria. Instead, the findings were presented in a narrative synthesis, allowing for the exploration of numerous areas of the literature. However, the selection process was not systematic, which means there is a possibility of selection bias. The review found that children experienced ambiguity when their parents were experiencing an OUD, which disrupted their sense of stability, creating emotional conflict and uncertainty about family roles. While this study was focused on parent-child relationships, it might not be unreasonable to apply these findings to sibling dynamics. Considering the perceived equality of the sibling's relationship, it is possible that addiction can cause disruption and disorganization for children and siblings alike. For example, siblings may be expected to take on more of a caregiving role with the sibling struggling with OUD, or they may need to provide emotional support to their parents, thereby creating role confusion similar to how children of parents with an OUD may become parentified (Mechling et al., 2018).

Confusion occurs when people are misinformed about the nature of addiction. In the context of sibling relationships, this confusion makes it difficult to understand the behaviours of

siblings experiencing addiction, which means actions can be interpreted as deliberate or intentional rather than a symptom of a medical condition (Mechling et al., 2018). Without accurate information, understanding a loved one's actions in this way can make the relationship more frustrating and challenging, in turn making coping with AL more difficult. It is important that siblings have a better understanding of addiction because recognizing the reasons behind their loved one's actions and behaviours can improve their ability to cope with AL (Mechling et al., 2018).

Additionally, many DRD-bereaved siblings position themselves as different from others who are grieving (Meen, Reime, & Selseng, 2024). Siblings interpret this perceived positioning as the interruption of a storyline that was supposed to continue into adulthood, where the loss was not due to death but addiction. Similarly, the qualitative subset from the mixed methods study completed by Sampson et al. (2023) demonstrated that those affected by friends and family members who were experiencing crystal methamphetamine addiction said they "lost" their loved one before their death. This study had a sample size of 17, and the researchers believed they reached data saturation; however, over half (nine) of the participants were mothers, perhaps skewing the perspective more towards the parental as opposed to the sibling experience. Although questions about loss were not included in the questions asked of participants, loss was found to be all-encompassing, permeating throughout the entirety of the results beginning with a loss or change in identity, the loss of someone they once knew, and even loss of self, due to the change in participants' lives.

AG

AL and AG intersect because they are both pre-death experiences that profoundly affect family members. In essence, AL acts as an umbrella term that also encompasses AG. In other

words, death is not always inevitable in the case of AL for those individuals with siblings/family members struggling with addictions, and yet AG may occur because death is perceived as the only or the most likely outcome (Fjær & Dyregrov, 2021; Meen, Lindeman, et al., 2024; Titlestad, Lindeman, et al. 2021). Lindemann (1944) first described AG to explain premature mourning that prolongs the grieving process. In a qualitative study consisting of 32 adults completed by Templeton et al. (2017), they found that AL began the grieving process before death, first occuring with the loss of aspects of their loved ones, such as their health, identity, and relationships. Participants in this study were recruited via convenience, purposive, and snowball sampling and explored pre and post-death as well as the death itself. This sample, like many others, consisted primarily of parents (19 of 32 participants), and the sample was predominantly female. Although these experiences were discussed as part of AL, they also apply to AG because experiencing these ambiguous losses adds to the anticipation of death. This study described a state of constant vigilance, where individuals continually feared the potential for loss, which aligns notionally with AG and could also apply to siblings as well as parents.

In a phenomenological study conducted by Hicks et al. (2024), several of the 12 participants, which consisted of six siblings, during their in-depth one-on-one interviews described AG as an integral part of their emotional experience. Participants noted that their experience of AG began before their family member died, and often, they were unsurprised when the death occurred. Further complicating this experience for the DRD-bereaved was that many of their siblings experiencing addiction recognized death as the only outcome of their life, further solidifying the stronghold that the substances had on their loved ones lives, making it feel as though no matter what they did, they could not prevent death and could only continue to anticipate their sibling dying (Hicks et al., 2024; Meen, Lindeman, et al., 2024). Ambiguity and

anticipation, though distinct, come together to describe what participants in Templeton et al. (2017) called “living bereavement.” This is an all-encompassing way to describe how families grieve what they have already lost from addiction and what they may lose in the future from death.

The study completed by Fjær and Dyregrov (2021) as part of the Norwegian Drug Death Related Bereavement and Recovery (END) project examined the bereavement experiences and the support received after DRDs. This particular study was a subset of the overall project’s data, which was qualitative in nature, from written responses in which the participants were asked, “Is there any advice that you want to give to politicians? If so, please describe.” The survey received responses from 255 bereaved individuals, and 83 of these responses were identified as specifically addressing bereavement services and were thematically analyzed to identify the trends within the responses. A noted strength of this study was the addition of written responses, which may have allowed for more honest and reflective answers, as participants could take their time formulating a thoughtful response without being under pressure in an in-person interview. Allowing participants to voice their opinions on policy recommendations was an appreciated and meaningful feature of the study. Bereaved individuals are often excluded from policy discussions, and providing them with this space is an opportunity for them to feel heard and valued in the path toward potential systemic change. However, since the information was intended to be used to address policymakers, participants may have responded with what policymakers wanted to hear rather than deeply reflecting on their own needs and bereavement experiences. This may have resulted in an incomplete representation of their personal bereavement experiences. A participant in Fjær and Dyregrov’s study described their experience as follows: “There is no sure help for those who are faced with death as a possible outcome every

single day, 365 days a year, for years" (p. 623). As previously highlighted, family members view death as the only possible outcome; thus, the daily anticipation of this death can become distressing, with feelings of helplessness, apathy, and ambivalence all affecting one's relationship with oneself, their family, and their sibling (Meen, Lindeman, et al., 2024).

Not only is AG mourning a death that you anticipate is coming, but it can also include the anticipation of losing all the things that could have been. This demonstrates how AL and AG are not mutually exclusive and are related, as the ambiguity of addiction amplifies the anticipation of death and all the losses that may come with it. Towers' (2023) participants demonstrated this overlap of AL and AG when they spoke of their losses before and after death. The losses described included absences when their sibling was alive and those that never existed, such as future relationships with nieces and nephews who would never be born. The difficulty in this loss was that siblings would never know what could have happened in the future and instead had to create their own narratives based on societal expectations of what they think would have happened if their sibling had not died (Towers, 2023). The need to craft imagined futures that will never be realized reflects the immense pressure on siblings to rationalize and make sense of their loss, and to experience it in a socially acceptable way.

The meta-analysis by Titlestad, Lindeman, et al. (2021) highlighted an enduring strain in their review. The articles in this analysis were both quantitative and qualitative in nature and were thematically organized. All eight articles found that the families experienced an enduring strain defined by years of uncertainty, fear, hopelessness, and chaos both before and after the death of a family member. The review also revealed that the constant oscillation between hope when improvement was seen and sadness when their loved one relapses added more strain to the families studied. This experience highlighted both ambiguity and anticipation in the experience

of the DRD-bereaved. However, it is necessary to note that the eligibility criteria for the classification of a DRD were vast, including deaths that were caused by violence or suicide. Although these deaths are still drug-related, the expanded criteria reflected the lack of research in this area, as the meta-analysis only consisted of eight articles, even with the broad inclusion criteria. Although all deaths are important, relevant, and necessary to explore, suicide, violence, or homicide may introduce additional complexities as they each carry their own unique experiences and stigma and may unintentionally inflate results. While it is critical to understand all causes of DRDs, differentiating the type of death experienced may better capture the dynamics at play. AG has been studied in other contexts, especially in dementia and Alzheimer's research, and again is related to AL but remains underexplored concerning addiction. The experience of AG in the context of addiction versus terminal illnesses could potentially be seen as similar. However, some noticeable and unique differences exist due to its nature. For example, with some terminal illnesses, the progression toward death may be evident, and it is known for certain that the outcome will indeed be death. In contrast, with addiction, death is not certain, and instead, there may be a recurring cycle of relapse and recovery, making it difficult to find closure or stability.

Stigmatization

Disenfranchised grief occurs because society marginalizes and invalidates the lived experiences of the deceased, reducing their worth, and in turn, places stigma on the deceased and later perpetuates it and extends it to the families and further isolates them (Lambert et al., 2022; Stout & Fleury-Steiner, 2023; Valentine et al., 2016). This extension of stigma, or stigma by association, is known as courtesy stigma (Stout & Fleury-Steiner, 2023). Courtesy stigma can isolate families and imply that families are complicit or even responsible for their loved one's

addiction, further complicating the stigmatization that families experience (Stout & Fleury-Steiner, 2023). This contributes to a lack of support and discourages families from expressing their grief, which contributes further to their disenfranchisement. Not only is stigma applied to drug use, but it extends to the associated lifestyle, which may include mental health issues, behavioural problems, and conflict with the law (Templeton et al., 2017). Even from the systems that should be there to support families, such as police or funeral directors, families receive little compassion or understanding. Stigma is the primary motivator for the lack of compassion and underscores the systemic barriers families face in accessing support (Lambert et al., 2022; Titlestad, Mellingen, et al., 2021).

Siblings often choose to protect their parents from their grief and will grieve in silence at the expense of their emotions and needs (Dyregrov et al., 2022). Meen, Reime, and Selseng (2024) note that during active addiction, siblings lack the care that they need, and when help is offered after death, it is not tailored to their needs. Instead, the priorities may be on other familial relationships. When one is unable to access the care they need, individuals feel isolated, unsupported, and stigmatized. This will be examined next, and in particular, will examine how stigma and the barriers that come with it shape the disenfranchised grief of DRD-bereaved siblings and how this further adds to their isolation.

Societal and Internalized Stigma

Stigma is both an internal and external experience. The externalized stigma and criticisms surrounding addiction that families may hear about their loved ones can be absorbed by them, leading to self-stigmatizing feelings of guilt, shame, and blame (Dyregrov & Selseng, 2022; Meen, Lindeman, et al., 2024; Sampson et al., 2023). These feelings make the bereavement process difficult because one does not want to grieve publicly and will instead grieve in isolation

(Sampson et al., 2023). Research also highlights that not only does stigma contribute to grieving in isolation, but it also contributes to families not seeking out support (Dyregrov & Selseng, 2022; Hicks et al., 2024; Titlestad, Lindeman, et al., 2021).

The societal stigma surrounding addiction is thought to be in response to individual, social, and cultural responses to death (Valentine et al., 2016). Frequently, DRD-bereaved are subject to a lack of understanding and being treated as "second-class citizens" (Templeton et al., 2017) due to society viewing the deceased as "just a drug addict" with moral failings and minimizing their struggles (Dyregrov & Selseng, 2022; Fjær & Dyregrov, 2021). Additionally, the stigma applied to family members is an experience similar to the direct stigma applied to their loved ones, with family members continuously misunderstood, unsupported, judged, and alienated before and after the death of their loved one (Fjær & Dyregrov, 2021; Meen, Lindeman, et al., 2024; Stout & Fleury-Steiner, 2023; Valentine et al., 2016). Stout and Fleury-Steiner (2023) completed a qualitative study using semistructured interviews with 35 participants who had friends or family members who died from a drug overdose. The experience with stigma was the focus, which was examined by discussing participants' interactions with others, including interactions with law enforcement and other societal responses to death. Examining these interactions identified how they reinforced stigma and how this stigma was then applied to the family. Understandably, courtesy stigma can further discourage families from seeking support fearing that they might be judged, where the research suggests that this courtesy stigma may contribute to how siblings perceive themselves, how others perceive them and then, in turn, how they interact with their social networks due to the exclusion and alienation experienced (Stout & Fleury-Steiner, 2023). A notable strength of this study was the statements of reflexivity detailed by Stout and Fleury-Steiner. Unlike other qualitative research included in this capstone,

the authors provided the reader with an account of their personal experiences and preconceptions throughout the research process, as well as how they attempted to mitigate bias, thereby further strengthening the validity of the study.

Stigma is pervasive throughout society and has even been perpetuated in media portrayals of addiction (Templeton et al., 2017). The use of stigmatizing language, such as referring to people experiencing addiction as "junkies," has perpetuated stigmatizing narratives and reinforced misconceptions and misinformation (Botticelli & Koh, 2016). Research indicates that stigmatizing language can contribute to punitive responses rather than supporting helpful responses such as interventions (Baker et al., 2022). As a result, the fear of judgment discourages families from seeking support. In a quantitative study that compared the stigma surrounding suicide versus that of unintentional overdose, it was found that far more negative language was used to describe how people perceived overdoses as opposed to the perception of those who suicided (Kheibari et al., 2022). The sample size was large (n = 503) and demonstrated statistically significant differences in attitude. However, the study adapted the Stigma of Suicide scale to measure the stigma associated with overdose, raising concerns about construct validity. Because this scale was originally designed to assess attitudes towards suicide, the adaptation of the questions for the context of overdose may not accurately capture the stigma surrounding overdose. Descriptors such as "pathetic, irresponsible, stupid, and an embarrassment" were more likely to be associated with overdose, whereas suicide was described as "brave and dedicated." These different perceptions reflect broader societal attitudes and highlight an attitude that is unhelpful in contributing to the help-seeking behaviours of family members, as it reinforces the notion that substance users are worthy of blame (Kheibari et al., 2022).

Kheibari et al. (2022) found that drug use was perceived as a social activity, an activity one does to socialize with friends, rather than an activity done out of necessity. In contrast, they found that it was perceived that those who suicided did so because of social isolation, or in other words, lack of social activity, the opposite of the perceived experience of those using drugs. However, their research demonstrated that feelings of social isolation were common with both suicide and drug use, which differs from the perceived experience. This perception continues to reinforce stigma and the preexisting negative image associated with drug users, which even reduces the likelihood that individuals will intervene with life-saving measures when they observe someone experiencing an overdose (Kheibari et al., 2022). With these harsh negative images and perceptions, it suggests how and why it might be challenging for siblings not to be influenced by societal attitudes and illuminates how societal stigmatization might be internalized. If siblings come to believe these stigmatizing societal perceptions about their siblings struggling with addiction, they may subsequently find it difficult to obtain the support they need, due to the internalization of stigmatization contributing to the expectations that they will be misunderstood or dismissed by professionals and others alike.

As surviving siblings are expected to internalize societal stigmatization, they find themselves occupying a "troubled subject position" when their deceased sibling is labelled as an "addict" (Meen, Reime, Lindeman, et al., 2024). This concept describes a subject's experience of being in a position that is not normative and is, therefore, "troubled." As such, DRD-bereaved siblings, therefore, must understand that their siblings are socially positioned in a marginalized manner that ultimately undermines and discourages them from grieving and sharing their loss. In some ways, society expects the surviving siblings to condemn the behaviour of their siblings struggling with addiction or dying from it. The troubled subject position dehumanizes the

deceased, stripping them of their dignity and leaving them only with the identity of an addict (Meen, Reime, Lindeman, et al., 2024).

Meen, Reime, Lindeman, et al. (2024) conducted a qualitative study that examined the intersection between societal perceptions and how siblings constructed meaning around their deceased sibling's identity. Semistructured interviews with 14 bereaved siblings were completed as part of the larger Norwegian END study. Intersectional analysis was used, which helped to understand how siblings positioned themselves within the societal narratives about addiction. Sibling participants in Meen, Reime, Lindeman, et al.'s study found that the title addict was not a sufficient label to describe their sibling, and they attempted to highlight parts of their identity that extended beyond their addiction. The researchers hypothesized that the participants were attempting to counteract the label of addict and make meaning of their relationships with their siblings in a way that more accurately encompassed their sibling's identity. However, by trying to explain that their sibling was "different" from the imposed stereotypes, they are still engaging with the stigmatizing narrative, and, therefore, unintentionally reinforcing these stereotypes. Explaining that their sibling was different from the stereotype implied that their sibling was an "exception" to the norm, rather than challenging the norm and the broader stigma attached to addiction. This process of describing their siblings as an exception serves as an attempt to reconstruct their sibling's identity in a way that aligns with their beliefs and experiences with their sibling (Meen, Reime, Lindeman, et al., 2024). This study highlighted the challenges siblings face when they are caught between their own beliefs about grief and the societal expectations of grief.

The meta-analysis discussed earlier, completed by Titlestad, Lindeman, et al. (2021), revealed that bereaved family members experienced significant societal stigmatization

perpetuated by the social circles and professionals, leading to rejection and misunderstanding. This was reported in seven of the eight studies analyzed. These gaps in knowledge and understanding need to be addressed to reduce stigma, and also, be explored to better understand how it impacts families. However, these narratives, which are socially constructed and perpetuated, leave siblings caught in a narrative where they attempt to reduce stigma by suppressing their grief or reshaping the story of their sibling in an attempt to fit within cultural or societal norms (Titlestad, Lindeman, et al., 2021).

Similarly, the phenomenological study conducted by Hicks et al. (2024) through in-depth interviews with participants highlighted how guilt and relief intertwine, contributing to internalized stigma. Like how family members attempt to reshape their story, family members may feel relief after the death of their loved one, yet because society expects them to mourn, they must internalize their relief, instead feeling guilt about their feelings of relief. Individuals are then stigmatized for not mourning in the way society expects them to mourn. Essentially, there is no correct response to death with either response—grieving or not—leading to stigmatization. Cultural narratives framing addiction as a moral failing rather than a medical and psychological condition can lead siblings to experience feelings of blame, shame about their sibling's addiction, and invalidation of their grief (Meen, Lindeman, et al., 2024). Shame and stigma enforce disenfranchised grief, where the bereaved feel that their experience should not be acknowledged, as society does not deem it legitimate (Dyregrov & Selseng, 2022).

Disenfranchisement

Disenfranchised grief is when loss is not openly acknowledged, socially validated, or publicly supported; because of this, bereavement becomes isolating, making it difficult to mourn (Doka, 1999). This definition provides clarity and an understanding as to why DRD-bereaved

siblings may be disenfranchised. As explored earlier in the chapter, factors such as stigma, AL, and AG all unite to create disenfranchised grief after a DRD occurs. Families may face a wide range of professionals when dealing with a loved one experiencing addiction, and often, because these experiences may be stigmatizing or they may not meet their needs in other ways, each experience only further delegitimizes their grief (Lambert et al., 2022). Siblings struggle to express their grief because society prioritizes spousal or parental relationships, minimizing the significance of sibling bonds (Dyregrov et al., 2022; Tenhulzen et al., 2024). This societal prioritization over specific relationships marginalizes siblings thereby disenfranchising their grief further. As a result, siblings may suppress their grief to avoid burdening other family members, especially their parents, prioritizing their parents grief and needs before their own (Meen, Reime, & Selseng, 2024).

Valentine et al. (2016) completed a review of the literature on addiction and bereavement studies through the lens of bereavement theory. The review itself described the lack of relevant articles, with only four articles deemed relevant to include. The authors described how deaths from substance misuse are often labelled as "bad" deaths because their life was "wasted." By labelling DRDs as such, the lives of those lost become devalued, and the family members left behind become invalidated and stigmatized (Lambert et al., 2022; Valentine et al., 2016). After death, life is often celebrated and memorialized. For those families who have experienced a DRD it may be difficult for them because these types of death were seen as preventable and tied to, again, a personal or moral failing, lessening the perceived need to celebrate their lives and making it difficult for families to find the closure they need (Kheibari et al., 2022; Valentine et al., 2016). For siblings, their experiences with grief are not only invalidated during death, but they are also invalidated and disenfranchised early on, before their loss. Additionally, with their

experiences of loss and grief going unrecognized and unsupported for so long, by extension, their disenfranchisement becomes prolonged and accentuated. The prolonged disenfranchisement experienced by siblings highlights the unnecessary pain they face and the need for societal changes to support the grieving process of DRD-bereaved siblings further.

Conclusion of the Literature Review

This literature review has broadly explored the experiences of siblings following a DRD. It examined the themes of AL, AG, stigma, and disenfranchised grief. Although there appears to be a recent increase in research in this area, the literature remains limited. This review has drawn on available studies to piece together the entirety of siblings' experiences. AL theory and the available research were used to describe the emotional and psychological impact of living with and losing a sibling to addiction. This theoretical lens, along with the emerging literature, demonstrates how uncertainty and a lack of closure complicate siblings' experiences. This review illustrates the interplay between personal grief experiences and societal narratives, highlighting how siblings' experiences are both internally and externally influenced. The implications of these findings will be examined in Chapter 3, where this capstone will discuss how to apply them in practice and what they mean for policy.

Chapter 3: Discussion

In this chapter, this capstone will discuss the implications and applications of the research findings presented in the previous chapter. The goal of this chapter is to bridge these research findings into real-life practice by offering both applications to the field of counselling and proposing future directions for practice and policy.

Implications and Recommendations for Mental Health Professionals

The findings in this capstone make it clear that sibling experiences with loss, particularly in the context of DRD, AG, and AL, remain overlooked in the literature. Without literature supporting the topic, it makes it difficult for professionals to fully comprehend the experiences and needs of this population. Even within the minimal literature that does exist, we see DRD-bereaved as an umbrella group, with individuals in such studies not often being separated based on their relationships with the bereaved. In other words, the family systems are grouped together, and sometimes, friends are grouped into studies with family members. Without examining specific populations, such as parents or siblings, separately, it is nearly impossible to identify the unique grief experiences and burdens siblings face. The many layers of loss related to a DRD create a unique experience for siblings, which is why further exploration and education for mental health professionals are necessary to provide an inclusive approach.

Understanding Sibling Experiences in the Context of DRD

The literature demonstrates how AL itself is not necessarily an under-researched area. However, more commonly, the literature discusses dementia and other forms of AL rather than what it might be like with addiction (Boss, 1999; Boss & Carnes, 2012). For example, when searching the CityU library for articles where AL and addiction intersect, there appears to be only one viable result. The literature does not always name “ambiguity” or “ambiguous loss,”

however, the voices of the bereaved frequently describe experiences that reflect the ambiguity inherent in addiction (Sampson et al., 2023; Titlestad, Mellingen, et al., 2021). For mental health professionals, this means acknowledging the role of ambiguity with respect to DRD and its role in the lengthy grieving process for the DRD-bereaved. Although it can be challenging to infer what siblings are experiencing due to a lack of research, it serves as a reminder that the literature does not always have all the answers. To obtain the answers, professionals must always remain curious about their clients and listen to the content of their experiences without making inferences about what they think may be happening for them based on research in adjacent but different areas. This approach of curiosity and collaboration is not only necessary but ethically required according to the *Canadian Code of Ethics for Psychologists* (Canadian Psychological Association [CPA], 2017). Principle I.1 states that psychologists must "demonstrate appropriate respect for the knowledge, insight, experience, areas of expertise, and cultural perspectives and values of others" (CPA, 2017, p. 12), requiring that the lived experience of the DRD-bereaved be honoured. Psychologists also have an ethical duty to seek, develop, and maintain competence in the areas in which they practice. In a population where there is little research, this means that clinicians must remain open to learning directly from the experiences of their clients.

Mental health professionals must consider and integrate the notions of AL and AG when supporting DRD-bereaved siblings because they provide explanatory power on how the coping processes for the surviving siblings are affected prior to death. Surviving siblings were once living in the uncertainty of their sibling's substance use, resulting in a never-ending state of unresolved grief (Boss 2007; Meen, Lindeman, et al., 2024; Templeton et al., 2017). The complexity and trauma of the ambiguity of substance use require siblings to adapt both/and thinking to help them understand that two realities can exist (e.g., their sibling is present, but

emotionally or psychologically absent; Boss, 2007; Towers, 2023). Ideally both/and thinking would be introduced before the death of a sibling to help navigate the uncertainty. For professionals, this means guiding the bereaved in understanding that this ambiguity was situational and not due to a personal failure of their own. According to Boss (2004), ambiguity must be addressed as external to shift the blame away from the self. Shifting blame may help counteract the AG's impact on coping and decision-making processes, making it easier to find closure (Boss, 2007). However, unresolved endings are still a factor and will need to learn to be tolerated or even accepted. Findings from the literature described a plethora of emotional responses. Relief, anger, sadness, shame, and guilt, although a wide range of emotions, often coexist (Dyregrov & Selseng, 2022; Hicks et al., 2024; Titlestad, Mellingen, et al., 2021). When one experiences relief because a sibling's suffering has ended, they may also be experiencing sadness and shame. Some feelings go against the societal expectations of grief and can be difficult for siblings to process (Meen, Reime, Lindeman, et al., 2024; Stout & Fleury-Steiner, 2023). Clinicians must normalize and validate ambivalence and the wide range of emotions that come with such a loss, and by doing so, it may be easier for siblings to integrate their feelings into their experiences rather than trying to internalize them in an unhelpful manner (Dyregrov & Selseng, 2022; Hicks et al., 2024; Meen, Lindemann, et al., 2024).

Providing Support to Siblings

Akard et al. (2020) examined the experiences of bereaved child siblings who lost their sibling to cancer. Even young children were found to be forgotten about and ignored, which is why they were deemed the "forgotten mourners." These findings are similar to those within the DRD context, as siblings are similarly overlooked because the attention is so heavily focused on their parents' intense grief of losing a child. Participants shared their need to be acknowledged.

Although this research explored cancer-related sibling loss, the experience of being overlooked is not uncommon and is observed in DRD-bereaved siblings. Dyregrov et al. (2022) described the disenfranchisement of siblings due to minimization and a lack of societal acknowledgement, which exacerbates distress. Meen, Reime, and Selseng (2024) referred to a grief hierarchy, which placed sibling grief below their parent's grief. Many siblings explained that because of this hierarchy, they did not want to burden their parents with their grief. The creation of a grief hierarchy makes it more difficult for siblings to reach out for help because not only do they not take their own needs seriously, but society also does not (Dyregrov et al., 2022; Tenhulzen et al., 2024). For mental health professionals, this underscores the importance of validating siblings' grief as legitimate and, more importantly, as an experience that is distinct from and yet equal to that of others, even when it feels as though societal and familial norms overlook or minimize it.

DRD-bereaved described being treated differently in comparison to others who lost someone from an unexpected death (Fjær & Dyregrov, 2021). They received less support and acknowledgement throughout the entirety of their experience, including when their siblings were alive, in active addiction and even then after death. When services were finally offered to them, they had often already been through a lengthy process and felt like it was too late (Meen, Reime, & Selseng, 2024). This highlights the necessity for early intervention, with support available while their loved one is still alive, not just after the death has occurred. Although siblings want to be treated equally, equity is needed, ensuring support is tailored to their specific needs rather than applying a generic model of grief. Early support can reduce distress and foster resilience in this population (Akard et al., 2019; Boss, 2007; Towers, 2023). Family members of Hicks et al.'s study (2024) highlighted the importance and necessity of seeking out support; they recommended that siblings receive informal, social, and professional support. Although siblings

recognize that they need help, they still reported difficulties talking to others, including their family members, identifying the fear of judgment as holding them back from sharing. This illustrates how respectful, equitable, and stigma-free care is critical to provide to the DRD-bereaved.

Barriers to Care. Mental health professionals must recognize the barriers that exist for siblings accessing care. A scoping review conducted by Di Sarno et al. (2021) examined the health effects of living with a family member who has a SUD. They included a wide range (56) of qualitative and quantitative studies, which allowed for a comprehensive understanding of the strain and impact of substance misuse problems. They found that those living with a family member with a SUD reported physical problems (increased medical issues), reduced quality of life, stigmatization, and isolation. Family members were excluded from this study if their loved one's substance use was not deemed clinically relevant, meaning the substance user needed to be formally diagnosed with SUD or enrolled in services. This criterion excludes families who may be facing even greater distress because of the lack of services. The choice to exclude these families could have created a gap in the data and raises questions about the relevance of these findings to the broad experiences of families. The previous chapter articulated how siblings have been overlooked because other relationships are being prioritized. Addressing how addiction impacts family members, with or without a formal diagnosis, specifically siblings who already feel they do not require or deserve the same support as other family members, requires recognition of how the impact of substance use without a diagnosis can create a barrier to care.

It is clear that many of the barriers faced by siblings are internalized, creating the feeling of being undeserving of care and support and believing that their grief does not or should not require attention compared to other family members, such as their parents (Meen, Lindemann, et

al., 2024; Stout & Fleury-Steiner, 2023). Clinicians must thus include siblings in planning and outreach, developing programs and interventions that acknowledge the specific internalized strain of being a DRD-bereaved sibling. Perhaps if siblings feel that professionals understand their experiences better and are intentionally including them, it may help reduce the stigma and increase the likelihood of DRD-bereaved siblings asking for help (Lambert et al., 2022). Therefore, a "culture of caring" is required to validate the bereaved and to create a stigma-free space for their grief (Titlestad, Lindeman, et al., 2021).

Importance of Peer Support. Hicks et al. (2024) discussed the importance of seeking out various forms of support. The complex emotions experienced by the DRD-bereaved must be validated, and support group settings are an opportune space for this to be done with the support of mental health professionals. If siblings are allowed to share their emotions openly, they may be able to reduce their feelings of isolation and internalized stigma. Research from Akard et al. (2019), although focused on siblings who were bereaved by cancer, demonstrates that those who share their emotions and experiences have higher levels of emotional resilience and lower levels of anxiety. If DRD-bereaved siblings were able to have open communication within their family and the support of peer groups, it is possible that their results may be similar, and they could have higher levels of emotional resilience. Sharing with others may mitigate some of the effects of stigma.

Boss (2006) states that interventions with families aim to increase tolerance of ambiguity, decrease isolation, and increase human connection. In considering the principles of social constructionism, which emphasizes that knowledge is gained through interactions, grieving in a community setting may help individuals find meaning in death or the ambiguity of their sibling's life. It is suggested that this ambiguity be addressed as a family and that larger community

settings with other families are ideal for sharing stories and increasing resiliency. Siblings need to learn how to reinterpret their past and ongoing relationship with the deceased sibling to make sense of the duality of both presence and absence, while also being able to validate their experiences in a supportive group space. By sharing about their loss, new meanings and rituals can be made, which help siblings and families cope with their loss (Betz & Thorngreen, 2006). Mental health professionals must understand the importance of meaning-making processes and helping siblings reframe their narrative in order to integrate their loss into their lives.

The preference for peer-based and experiential support is an important consideration for professionals. Hicks et al. (2024) and Fjær and Dyregrov (2021) found that DRD-bereaved individuals used various types of support. However, one-third of Hicks et al.'s participants felt that only those who have lost a family member to a DRD could understand their grief. Similarly, Fjær and Dyregrov found that the DRD-bereaved highlighted the need for support from those with similar experiences or with those who understand the field of addiction. Participants revealed how important it may be to develop a dedicated organization for the DRD-bereaved to help fulfill this need of connection with others who they feel may understand what they are going through. However, participants in Titlestad, Mellingen, et al.'s (2021) study shared that their social network provided them with the support they needed, even though it was difficult to accept. Perhaps in some cases, just normalizing help-seeking behaviour is enough for the DRD-bereaved to seek out the care that they require. Addressing how addiction impacts family members, with or without a formal diagnosis, specifically siblings who already feel they do not require or deserve the same support as other family members, requires recognition of how the impact of substance use without a diagnosis can create a barrier to care.

Long-Term and Proactive Needs. Lorås et al. (2024) completed semistructured interviews with 14 DRD-bereaved siblings which explored family dynamics before their sibling's death. They found that siblings had many common coping strategies, which included attempting to maintain familial stability by avoiding discussions about their sibling's addiction, attempts to be the perfect child to help mitigate the seriousness of their siblings' circumstances and lessen the burden on their parents. Others set boundaries around their sibling and other members of their family to prevent them from being in the middle of conflicts and discussions, which often led to them taking on more of a parental role to their parents and which further added to the stress and disagreements within the family (Lorås et al., 2024). For practitioners, consideration should be given to family roles and dynamics in therapy, siblings may require a space to explore their new, old, and evolving place in the family system.

Additionally, the DRD-bereaved feel that health professionals should be assessing their needs and offering similar support as those who are bereaved by other forms of unnatural deaths (Fjær & Dyregrov, 2021). The DRD-bereaved in Fjær and Dyregrov's (2021) study emphasized the need for tailored and all-encompassing services such as counselling, grief groups, and practical skills to help them with their specific experience. It was also important to the participants that these services be proactive and ongoing, not simply providing immediate help after the death, but also including a component of continuous outreach. Many saw this proactive, long-term and accessible outreach as necessary due to the exhaustion of grief, which makes it difficult for those bereaved to reach out. One sibling described professional help as a requirement because those around them do not want to discuss "dark" things, making professionals easier to talk to (Fjær & Dyregrov, 2021). However, the burden of initiating outreach and accessing services should not fall solely on the bereaved. Instead, proactive efforts

should be made by healthcare professionals, grief support organizations, and mental health professionals to ensure care is equitable and accessible. Professionals should not assume that all DRD-bereaved individuals have the same capacity to seek help independently and instead should take initiatives such as raising awareness, reducing stigma by normalizing help-seeking, and creating opportunities for DRD-bereaved siblings. In order to align with the *Canadian Code of Ethics for Psychologists* (CPA, 2017), there must be a balance between autonomy and accessibility, and professionals adopting a proactive stance can achieve this balance.

Although the bereaved recognize the need for routine help, DRD-bereaved may still initially turn down care, but long-term, organized, and regular help may be adapted to each individual and family. Ensuring that support is available when the bereaved are ready to engage becomes critical to providing timely care (Fjær & Dyregrov, 2021). For professionals, this requires flexibility in their care models, so they can continue to evolve with the needs of the bereaved, rather than assuming there is a specific trajectory or timeline siblings may go through. Professionals and the systems they work in need to assume that there is no normal and that seeking help may not be immediate but may extend over longer periods of time. Although DRD-bereaved individuals had difficulty articulating the type of support they needed, they did recognize that they required help and that policies should ensure equitable access to support, as seen in how other crises and catastrophes have been addressed. Although Fjær and Dyregrov's (2021) participants spoke about the Norwegian policies, in the Canadian context, organizations such as the Canadian Grief Alliance (CGA, n.d.) have advocated with the support of numerous national and provincial organizations for better grief support for Canadians. The federal government of Canada has provided funding to support grief literacy in partnership with the CGA, but since the announcement of their funding in 2023, no progress has been noted (Health

Canada, 2023). Abscence of change, even with the funding available, demonstrates the lack of urgency to implement the appropriate bereavement policies for Canadians. Although the CGA is not specific to DRD bereavement and was created in response to COVID-19, recognizing the need for better grief support is a step in the right direction.

Siblings expressed feelings of neglect, mainly because the focus in the family remained on their sibling experiencing addiction before, during, and after their death (Fjær & Dyregrov, 2021). In order to be intentional about inclusion in conversations about grief and individual needs, siblings proposed that children, especially, must be asked directly if they needed help rather than relying on parents to communicate their needs for them. Promoting this autonomy ensures siblings are included and are making their own decisions, making it more likely that they will receive the attention they need, rather than no attention or the supports that someone else thinks they need. Additionally, participants stressed that most bereaved individuals require between 3 to 5 years of follow-up to address their immediate and long-term needs; this should be considered a standard expectation rather than an exception when developing treatment and support plans (Fjær & Dyregrov, 2021).

Meaning-Making, Continuing Bonds, and Therapeutic Approaches

A quote from a sibling from Meen, Reime, Lindeman, et al. (2024) clearly illustrates the oscillations and nuances of DRD:

> This isn't a story that's just, "I had a brother, and then he became a drug addict, and then he died." He wasn't the sort of drug addict you see on the street. Many probably say the same, but my brother was unique. He wasn't one of them. I need to have the opportunity to tell people about him, who he really was, rather than him being reduced to an overdose death. (p. 6)

This message is clear in many of the stories told by DRD-bereaved siblings. In practice, this implies that the sibling's life is as important, if not more important, than the circumstances of their death. Siblings need to tell the story of their sibling, and by allowing these narratives, professionals can help to counteract stigma, humanize the deceased, and support healthy meaning-making.

Often, families hold out hope for recovery or positive change, only to be disappointed when change is brief enough to create a false sense of hope and the same cycle repeats (Mechling et al., 2018). Unlike the clarity of death, which comes with rituals and a form of closure to many, AL creates confusion, disrupts family roles, delays decisions, and undermines the traditions that often hold families together (Boss & Carnes, 2012; Mechling et al., 2018). Families may find it challenging to find the closure that they need and mental health professionals must recognize the toll this takes on siblings, long before the death even occurs.

To support these clients, therapeutic interventions that emphasize creative expression as a tool for externalizing emotions may be relevant. Tenhulzen et al. (2024) found that creative outlets for healing, such as art, journaling, music, and even animal-assisted therapy, helped youth and children who lost a sibling to a cancer-related death express words they otherwise could not. These creative activities have a therapeutic value that could be applied to those who are DRD-bereaved, as the complexities of their grief may be difficult to articulate through conventional talk therapy. Professionals should consider employing such strategies to help those externalize the many complex emotions experienced by those DRD-bereaved or consider referring clients to expressive therapies.

It has been found that meaning-making is a helpful form of support for many DRD-bereaved individuals. Meaning-making involves creating purpose or finding significance in loss,

which can be essential in the healing process (Hicks et al., 2024). Mental health professionals can assist clients in exploring how they may be able to find meaning from their grief experiences. The process of meaning-making is deeply personal, and can be done in many ways, and it may be shaped by individual culture or personal preference. For some individuals, it may mean helping others, raising awareness, engaging in advocacy, or simply learning more about addiction. Titlestad, Lindeman, et al.'s (2021) meta-analysis found that advocacy, raising awareness, and peer support groups were all ways family members found meaning. Similarly, Lambert et al. (2022) conducted a qualitative study of seven families, with a total of 17 participants, which included six siblings, who described that activism was used to help alleviate feelings of helplessness and connect with others. This study included death by hanging as a DRD. Although suicide can undoubtedly be a DRD, as mentioned earlier, the additional stigma associated with death by suicide could further influence the family's disenfranchisement and stigmatization, making it necessary to consider separating suicide deaths from DRDs for more specific insights. Additionally, the experience of siblings was not explicitly addressed, as Lambert et al. (2022) only examined the family system. Although DRD's effects on the family system are a relevant and necessary research area, addressing how it affects specific family members, such as siblings, would allow for more tailored support and strategies for each individual.

Lorås et al. (2024) build on the idea of meaning-making by introducing the frameworks of salutogenesis and Sense of Coherence (SOC). Salutogenesis focuses on people's strengths and resources already available to them rather than mainly focusing on what went wrong. The framework of SOC is about finding ways to see life as comprehensible, manageable, and meaningful, even after a loss. These frameworks seem relevant when thinking about DRD-

bereaved siblings because, often, siblings are trying to make sense of their experiences. Using these frameworks as a strengths-based, resilience-focused approach can help professionals support siblings by drawing on their preexisting strengths.

Families require a way to make meaning of their loss as well, regardless of the circumstances of the death. Maintaining bonds with loved ones through rituals and symbolic gestures has been important to stay connected throughout the grieving process (Tenhulzen et al., 2024). For DRD-bereaved siblings, similar practices, such as celebrating birthdays or dedicating their achievements to their siblings, could help them stay connected to and honour their relationship with their siblings (Hicks et al., 2024). Siblings could plant trees, create memory boxes, or establish an annual ritual to honour their sibling's life and accomplishments. By doing so, they create meaning around their loss, allowing them to integrate the loss into their life narrative and could help combat the effects of stigma.

Challenging the DSM-5-TR

The DSM-5-TR (APA, 2022) defines prolonged grief disorder (PGD) as a persistent grief response that occurs for at least 12 months after the death of a loved one for adults and 6 months for children. PGD is characterized by an intense yearning or preoccupation with the deceased, accompanied by significant emotional distress and impairments in functioning (APA, 2022). Additionally, this response must exceed religious, social, or cultural norms to meet the criteria. This definition is problematic because it assumes that grief begins after death, that there is a specific timeline to resolution, and that grief has a specific normative experience.

As outlined throughout this capstone, grief begins long before death when siblings mourn the psychological absence of their siblings and anticipate their death due to their addiction (Boss, 2007). When death finally occurs, it does not mark the beginning of grief, just the continuation

of an experience that has been prolonged by AG and AL. Because siblings may experience an extended grieving period, their grief may persist for well over 12 months. However, it may not have begun after the death of their sibling, making it more challenging to apply the diagnostic criteria of PGD to grieving siblings, and perhaps because of this, siblings are missing the support they need. If PGD specifies that the death must have occurred at least 12 months prior to the diagnosis, how can the months or years of AL and AG be accounted for when the DSM-5-TR does not consider it as a relevant part of the bereavement period? This highlights another gap in addressing grief that encompasses pre- and post-death experiences.

The DSM's diagnostic criteria for PGD rely on a post-death timeline. These criteria require further exploration and expansion to highlight overlooked experiences such as the lived reality of siblings who have been grieving for years before death and are in need of clinical attention. Research on AL and AG highlights the prolonged emotional strain on siblings (Meen, Lindeman, et al., 2024; Titlestad, Lindeman, et al., 2021), underscoring the need for diagnostic criteria that better encompass the experiences of DRD-bereaved individuals who may require clinical assistance. Additionally, the DSM's emphasis on "norms" for diagnosis of PGD only serves to perpetuate societal narratives and continue to marginalize siblings grieving a DRD. Valentine et al. (2016) suggest that the societal stigma surrounding addiction can contribute to the invalidation of grief experiences, and siblings may suppress their reactions to death to avoid judgment, feeling that their grief is less valid, making it difficult to determine what the norm might be for this scenario.

Policy Directions, Limitations, and Future Research

First and foremost, it is important to acknowledge that although it is incredibly difficult for those who are bereaved, the root issue remains. How can we provide the necessary and

appropriate support for individuals with SUDs? If we do not place more research and efforts into learning how to support those with SUDs, this cycle of overdose and DRDs will continue, as will the number of bereaved families, siblings included, that will be left behind to navigate their grief. In light of this, the province of Alberta has recently announced, under the Compassionate Intervention Act, controversial plans to build involuntary treatment facilities, with Alberta Premier Danielle Smith stating, “There is no compassion in leaving people to suffer in the throes of addiction” (Farrell, 2025). The Compassionate Intervention Act will allow loved ones and some professionals to mandate individuals into treatment facilities. Perhaps the intention is to protect at-risk individuals (Farrell, 2025). However, the research and evidence supporting the effectiveness of involuntary treatment remain limited. A systemic review by Bahji et al. (2023) found little evidence to support involuntary treatment, with some studies seeing an increased risk for harm following discharge. In treatment, autonomy matters. These findings raise important ethical concerns about the lack of autonomy, challenging Principle I of the *Canadian Code of Ethics for Psychologists* (CPA, 2017), which emphasizes respect for the dignity of persons. At the core of dignity is autonomy, which is fundamentally challenged and ultimately removed by involuntary treatment. Although the word “compassion” is guiding the conversation behind these policies, using “protection” from substance use as the goal, forced treatment not only violates intrinsic individual rights, but it also traumatizes and erodes trust with those whom we have the greatest responsibility to—vulnerable populations (CPA, 2017, Principle I.9). In practice, psychologists are ethically required to continually weigh risks and benefits of treatment (CPA, 2017, Principle III.8), and when evidence for efficacy is lacking, it is unreasonable to depend on a treatment option in which is there is little support or justification. By choosing this option, we treat those who use substances as individuals undeserving of autonomy, the primary guiding

principle of our code of ethics, and we reinforce stigma against an already marginalized population.

This political debate is included in this capstone to emphasize that policy choices matter. The consequences of failed interventions do not just reflect poorly on those who make the decisions about the policies. There are families who are trying everything for their loved ones and will be feeling the consequences and repercussions of another failed intervention. Regardless, even the most effective treatment approach will not save everyone, but this capstone advocates for research, compassionate support, and evidence-based practices. Addiction will continue to take lives, and those bereaved will continue to live with complex, long-term grief. If we cannot solve the problem, we must, therefore, also invest equally in supporting those affected by DRDs. Siblings, as demonstrated, remain underserved and unacknowledged.

As has been shown in this capstone, bereavement is not an isolated experience. Loss does not begin with death, and grief does not come in a neat package that has a start and end date. Siblings begin grieving long before the loss occurs and require support sometimes for many years to follow. It has been demonstrated throughout that grief supports are reactive and not proactive, nor are they often tailored to meet the specific needs of the bereaved. Mental health professionals must advocate for policies that are flexible enough to encompass a wide range of experiences, and long-term, flexible, and accessible care is a necessity.

Overall, the research reviewed in Chapter 2 is relatively limited, with few studies available that explore the direct experiences of siblings related to DRD. Through the exploration of the literature, the experiences are often broad in nature and tend to focus on other familial roles, rather than those of siblings. In many cases, numerous roles are grouped together, and there is no distinction between these roles, making it difficult to determine how the sibling

experience may differ or if the support they require is unique. The majority of the most relevant literature originates from the END project conducted in Norway, resulting in a relatively homogeneous sample that limits the generalizability of the findings and necessitates diversity in research across various cultural and geographical contexts. There is also a lack of longitudinal research, which limits insight into the long-term grief experienced by siblings. Although AL is a significant part of the sibling experience, it is rarely directly addressed in the reviewed literature.

As such, more research is needed to understand the intersection of AL, AG, and disenfranchised grief in DRD-bereaved siblings. Social constructionism reminds us that grief is shaped by societal narratives, so we must acknowledge, assess, and change the narratives surrounding addiction to address the stigma that leaves many grieving in silence and shame. To help shift this narrative, we must continue research that can assist in advocating for the rights of those experiencing addiction or SUD, as well as the families trying to support them. It is important that future research focus on separating familial experiences to examine the specific impact of DRD on siblings. More longitudinal studies that perhaps begin during a sibling's active substance use may help us to understand the ongoing nature of AL in the context of addiction and would provide insight into how grief evolves over time. If AL were to be integrated into longitudinal studies, we may get a better understanding of siblings' grief in this context. Finally, greater diversity in research samples is necessary to ensure that sibling grief is understood across numerous cultural and social contexts.

To summarize, more education surrounding the ongoing burdens of siblings of those with an SUD could inform early interventions not just for those experiencing addiction but for the entire family system. If we want to address the stigma associated with DRDs, we need to revisit the societal understanding and policies surrounding addiction and conduct the corresponding

research accordingly. In order to reduce stigma, our policies must reflect a nonstigmatizing and evidence-based best practice, ones that are not rooted in coercion, like involuntary treatment, which simply reinforce negative and stigmatizing beliefs about people experiencing SUD (Baker et al., 2022). These narratives not only bring harm to those experiencing addiction they prevent them from seeking out help and prevent the bereaved from seeking out help as well. How is one expected to openly grieve without fear of judgment when their loved one has been described as a statistic? Social constructionism challenges us to think about these assumptions and to create policies that contextualize the DRD-bereaved and those struggling with SUDs. It motivates us to create empathetic frameworks and policies demonstrating addiction's complexity.

Reflexive Statement

The evening after my sister's memorial service, I lay in my teenage bedroom at my mom's house, Googling "grief and loss psychologists." I had never seen a psychologist before, but at that moment, it felt urgent. Even though the loss was still fresh, I knew it was so much more complex than just grieving her death. I had not just lost her that week, I had been losing her for years. I was reflecting on our relationship and felt sadness about what we once had, what we never had, and what I will never get to have. I was grieving her life and my life without her. At the same time, I felt a sense of relief. I had waited for that phone call for years, constantly worrying about her, about my parents, even though I lived thousands of kilometres away. How could I be relieved and devastated at the same time? And how could that relief carry so much guilt?

My experience in therapy gave me a deep desire to create a space for others to navigate grief and other life challenges. It ultimately led me to begin this graduate program in counselling, which is now concluding with this capstone project. I share my personal experience because I

want to note that many of my feelings surrounding my sister's life and death have not changed. Rather, I have just learned to live with it. For me, I have embraced Lois Tonkin's (1996) theory of "growing around grief" to help understand my own emotions. My interpretation of her theory is that grief does not grow smaller over time; instead, your life just continues to grow around your grief. I wanted to acknowledge this framework and relate it back to my experience with my capstone. I had chosen this capstone topic before starting this program, but I later changed my mind, primarily because it is a sad and intense topic for me. Relating this all back to Tonkin's theory, although the sharpness of my grief is not as constant, when I feel it, it remains just as powerful. Because my emotions continue to be so intense, this topic felt too close to home and too raw. I told myself I needed to find a safer topic. But then, my capstone supervisor said something that stuck with me. I cannot recall his exact words, but I understood him as saying something along the lines of: "You are already living it. Why not write about it?" And in that moment, I knew he was right.

Writing about this topic did not change my grief or alter my experience in any way. It did not take the pain away. Grief is not simple; it cannot be solved with academic inquiry, and through this experience, I still believe that we are not meant to just "get over it." Instead, I have learned that it is okay and normal to feel a plethora of emotions, and none of them are right or wrong. This experience has simply given me more knowledge, context, and an understanding of myself and others. It has also helped me grow around my grief and find more meaning in my loss. As Tonkin (1996) described, my grief has not disappeared. My life instead has expanded, leaving me space still to hold my grief, but perhaps a little differently. I am still and always will be grieving, and that is okay. This work has allowed me the opportunity to take something personal and painful and make it purposeful.

Conclusion

This capstone explored the central question: What psychological factors shape the bereavement experiences of siblings after a DRD? Using social constructionism and AL theory as guiding frameworks, this capstone explored AL, AG, and stigma and how these connect and relate to the experience of DRD-bereaved siblings. The literature review demonstrated that siblings remain an under-researched, underserved, and often invisible population in grief research and even more so in the context of DRD.

Primarily, this capstone demonstrated the incredibly complex experience of siblings grieving a DRD. A mixture of stigma, family dynamics, conflicting emotional responses, and the minimization of their experience suggests that mental health professionals must acknowledge siblings as distinct mourners whose grief frequently begins long before the death itself. The exploration of this topic demonstrated that the current diagnostic frameworks, including the DSM-5-TR's (APA, 2022) definition of PGD, fail to account for the experiences that were described in this capstone, demonstrating that there is a potential for change into the diagnostic criteria or creation of an additional framework or diagnostic criteria that fully encompasses unique grief experiences.

Practical implications for mental health professionals include the need to develop long-term, flexible grief interventions. To provide adequate support, siblings must be offered proactive support. Support would work best if it began while the sibling was still alive and then continued long after death. However, determining how siblings can be reached while their loved ones are in active addiction becomes paramount. Isolation and stigma are critical considerations that may be offset therapeutically with meaning-making, peer-based support, and community connection. Furthermore, the literature points to the importance of addressing internalized stigma

and increasing grief literacy and knowledge surrounding substance use among both clinicians and the public.

From a systemic standpoint, this capstone urges policymakers to recognize that throwing money at the problem only works if the solutions are evidence-based solutions for individuals with SUD. However, regardless of the amount of research and investment into evidence-based support, no problem will ever be solved overnight. This is why we must also invest in grief literacy and the care and support of those left behind. This capstone is timely because of Alberta's continuous push towards involuntary treatment initiatives. Political decisions must be grounded in evidence to mitigate the effects of ineffective, harmful, and perhaps unethical interventions because when these interventions fail, the failure is extended to the family system. Until addiction itself is adequately addressed and publicly supported, families who have survived the consequences of addiction must not be left behind.

Ultimately, more research is needed to understand sibling grief, specifically in the context of DRDs. Further exploration of this topic may assist in finding and implementing early interventions for siblings and others affected by addiction. Social constructionism reminds us that grief is not experienced in a vacuum but is shaped by language, culture, and policy. If we hope to reduce stigma and better support DRD-bereaved siblings, we must challenge the narratives surrounding addiction, grief, and whose pain is deemed worthy of care.

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