

The Grieving Process of Opioid Overdose Bereaved Parents in Maryland

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Abstract

In recent years, the opioid epidemic in the United States has garnered attention on a federal and local level due to the increasing number of fatal overdoses. This study aimed to explore the experiences of parents who have an adult child who has passed away from an opioid overdose. This study used the Double ABC-X model of family stress theory. Bonadaptation versus maladaptation of each parent was discussed across a multitude dimensions. Qualitative semi-structured interviews were conducted with six parents living in the state of Maryland who each had an adult child, age 18+, die from an opioid overdose 2 or more years prior to the study. Data was analyzed using thematic analysis. Themes that emerged were as follows: the grieving process, support vs. stigma, experiences with state and local services, parental guilt, shame, and unanswered questions, coping mechanisms, and post-mortem life changes. While overall adaptation levels varied among participants, all participants reported positive and negative outcomes related to their experience of grief and loss. Implications for clinical practice and intervention are discussed. Researchers also make recommendations for future research.

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General Audience Abstract

This study aimed to explore the experiences of parents who have had an adult child pass away from an opioid overdose. The study utilized Family Stress theory, a theory which focuses on how families respond and adapt after a crisis occurs, for this research. The following themes emerged from interviews with parents: the grieving process itself, support vs. stigma, experiences with state and local services, parental guilt, shame, and unanswered questions, coping mechanisms, and post-mortem life changes. While adaptation varied among participants, participants reported both positive and negative outcomes related to their experiences of grief and loss.

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CHAPTER I: INTRODUCTION

The Problem and its Setting

The United States is currently experiencing an epidemic of opioid abuse. Overdose deaths have nearly tripled during 1999–2014 (Rudd, 2016; Seth, Scholl, Rudd, & Bacon, 2016). As medical use of opioids became more commonplace, nonmedical use of opioids increased as well (Wilkerson, Kim, Windsor, & Mareiniss, 2016). Nonmedical use of opioids is defined as taking medications that are not directly prescribed, taking more than the prescribed dosage, and/or taking medications for the experience or feeling they cause (Compton, Jones, & Baldwin, 2016). Given that prescription opioids are legal, considered predictable (e.g., the dose is clearly specified on a distinctive tablet or pill), and often initially prescribed by a physician, many users view opioids as safer than other illicit substances (Cicero, Ellis, Surratt, & Kurtz, 2014).

The first decade of the new millennium saw a significant increase in the use and abuse of prescription opioid medications, as well as an unprecedented number of drug overdoses (Wilkerson, Kim, Windsor, & Mareiniss, 2016). In the mid-1990s, OxyContin, the first opiate promising multiple hours of pain relief, accelerated the abuse of prescription opioids by making large quantities of oxycodone hydrochloride readily available for misuse by way of inhalation and intravenous injection (Cicero, Ellis, Surratt, & Kurtz, 2014). There is now growing evidence that nonmedical opioid users, particularly those who inhale or inject their drugs, shift or graduate to heroin, because heroin is more accessible and less expensive than prescription opioids (Cicero, Ellis, Surratt, & Kurtz, 2014). An estimated 25 million Americans engaged in nonmedical use of prescription opioids from 2002 to 2011 (Wilkerson, Kim, Windsor & Mareiniss, 2016). The

increase in opioid overdose deaths has garnered attention from media, medical organizations, and practitioners (Wilkerson, Kim, Windsor, & Mareiniss, 2016).

Misuse of, addiction to, and death from nonmedical use of opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare (Florence, Zhou, Luo, Xu, 2016). Overdose deaths are sudden and accompanied by social and moral censure, with potentially devastating effects on the well-being of families of the substance user (Feigelman, Jordan, & McIntosh, 2012). Parental bereavement following a drug overdose of an adult child is a largely neglected subject in research despite its prevalence within society (Valentine, Bauld, Walter, 2016).

Recently, the research and literature about relational aspects of grieving, particularly parental bereavement, has increased (Klaassen, Bentum, & Gallagher, 2015; Hooghe, Neimeyer, & Rober, 2011; 2012). Parental bereavement following a child's drug overdose has historically been an under researched subject, despite its consequences for remaining family members (Valentine, Bauld, & Walter, 2016). Findings suggest stigma surrounding substance abuse imposes challenges in grieving and healing, as parents report garnering less compassionate responses from society following their loss (Feigelman, Jordan, & Gorman, 2011). The purpose of the study is examining parental experiences of grief after a child dies due to opioid overdose.

Maryland's State of Emergency. On March 1, 2017, Maryland Governor Larry Hogan signed an Executive Order declaring a State of Emergency in response to the heroin, opioid, and fentanyl crisis ravaging communities across the state of Maryland. Fourteen out of twenty-four of Maryland's counties experienced an increase in opioid-related deaths in 2017 (Vivolo-Kantor,

Seth, Gladden, Mattson, Baldwin, Kite-Powell, & Coletta, 2018). Maryland reportedly experienced 1,501 opioid-related deaths from January to September of 2017, including 1,173 deaths tied to the potent synthetic opioid known as fentanyl (Vivolo-Kanter et al., 2018). Given the drastic increase in opioid-related deaths within the state of Maryland, bereaved parents have emerged as an underserved therapeutic population. This study investigated grieving and healing trajectories of parents following the loss of their child to an opioid-related death.

What is an Opioid? Opioid is the term used to describe a substance that is able to bind to opioid receptors (Wilkerson, Kim, Windsor & Mareiniss, 2016). The more specific term, opiate, refers to a class of agents that are directly derived from naturally occurring opium (Wilkerson, Kim, Windsor & Mareiniss, 2016). Opioids are a class of drugs that include pain relievers available legally by prescription, such as oxycodone (OxyContin®, Percocet®), hydrocodone (Vicodin®), oxymorphone (Opana®), morphine (Kadian®, Avinza®), and codeine, as well as heroin, and synthetic opioids, such as fentanyl (Ghelardini, Mannelli, & Bianchi, 2015). Opioids bind to and activate opioid receptors on cells located in many areas of the brain, spinal cord, and other organs in the body, especially those involved in feelings of pain and pleasure (Ghelardini, Mannelli, & Bianchi, 2015). When opioids attach to these receptors, they block pain signals sent from the brain to the body and release large amounts of dopamine throughout the body (Ghelardini, Mannelli, & Bianchi, 2015). This dopamine release can strongly reinforce the act of taking the drug, making the user want to repeat the experience (Ghelardini, Mannelli, & Bianchi, 2015).

Significance

When a child passes away, he or she leaves behind a grieving family. When opioid users die, families attract public interest and media attention, yet oftentimes support of the bereaved is neglected (Guy & Holloway, 2007). Research shows parents of substance users are frequently ignored in treatment programs, pathologized as ‘co-dependent’ or dysfunctional, and often seen as part of the problem rather than the solution (Walter, Ford, Templeton, Valentine, & Velleman, 2017). The stigma attached to the substance user gets transferred to the family.

Given the opioid death statistics in the state of Maryland, parents of opioid abusers have emerged as an underserved clinical population. According to Valentine, Bauld & Walker (2016), a primary reason is because of the stigma associated with substance misuse deaths. While researchers have drawn attention to the suffering experienced by families worldwide in coping with a family member’s substance misuse, less research has been done to highlight the predicament of families bereaved following a misuse death (Valentine, Bauld, Walter, 2016). Prior research on opioid bereavement has focused on adult subjects in England and Scotland (Templeton et al., 2017). This study bridges a gap in the literature, studying opioid deaths and parental bereavement experiences within the United States, specifically in the state of Maryland.

Rationale

This case study provided insight into residual effects of a child’s sudden death on the parents that are left behind. The subject of parental bereavement is particularly sensitive. Seeing through the eyes of the parents lends itself well to an instrumental case study, which allowed the researcher to collect in-depth participant insights in order to explore the specific problem of opioid-related death of an offspring. This case study was bound to include six parents living in the state of Maryland, who have had a child pass away due to opioids. This case study was

limited to three sets of parents in order to achieve in-depth, granular analysis through a minimal number of cases. Having qualitative data from six different parents allowed for analysis of common themes elements that emerge from the interview data.

Theoretical Framework: Family Stress Theory

Family stress theory, although not specifically a grieving theory or model, is applicable because of its basic tenets pertaining to how families adjust and adapt after a major crisis. The death of a family member, and specifically the death of a child, is a traumatic event and a major stressor which in this theory is referred to as the crisis. The first major family stress framework was developed by Hill et al.'s (1949) in his work on the family's response to separation and reunion. He outlined an ABC-X family stress and crisis model, where A (stressor) interacts with B (family's resources), interacts with C (how the family sees the event) and produces X (crisis).

Lavee, McCubbin, and Patterson (1985) advanced Hill's theory and suggested the Double ABC-X model which incorporates additional post-crisis variables and adaptation. This included (a) pile up of demands (the aA Factor) or the cumulative effect, over time, of pre-and post crisis stressors, (b) family adaptive resources (the bB Factor) that include both existing and expanded resources, (eg. personal resources, family resources, and social support), (c) perception and coherence (the cC Factor) of the family's general orientation to the overall circumstances, and (d) is the family adaptation (the xX Factor) which is the outcome of the family's processes in response to the crisis and pile-up demands (See Figure 1; McCubbin, & Patterson, 1983). These additions create a more holistic approach in viewing how families cope with normal and non-normal events. This model can be applied to grieving in the context of the family system,

where the death of a child is the stressor (A) that leads to the crisis (X), and the family grieving process aligns with the double B factor (family adaptive resource).

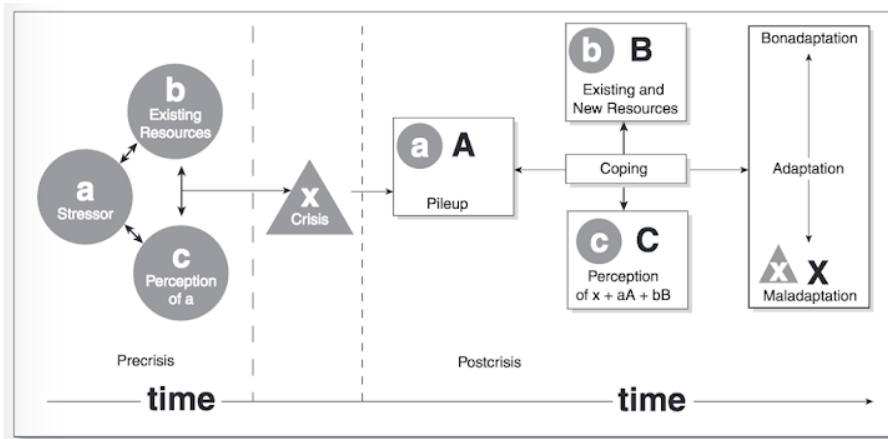


Figure 1. The Double ABC-X model (McCubbin & Patterson, 1983).

Purpose of the Study

The purpose of this case study was to explore parental grieving and healing trajectories. It attempted to close a gap in existing grief literature as it relates to opioid-related bereavement, tapping into the parental experiences of meaning making after losing their child. By conducting in-depth semi-structured interviews with parents of the deceased, this study aimed to provide information regarding grief trajectory, healing processes, experiences of stigma and/or compassion, and experiences of services. This information is needed to provide better therapy to the population of bereaved family members.

The researcher utilized family stress theory as the theoretical framework for this study. Family stress theory is a developmental theory which explores why some family systems adapt and even grow and thrive when faced with situational stressors or transitional events, while other family units deteriorate and disintegrate under similar circumstances (Hill, Boulding, Dunigan, Elder, 1949; McCubbin, 1979; McCubbin & Patterson, 1983; McCubbin, 1993).

CHAPTER II: LITERATURE REVIEW

Opioid and Heroin Abuse Trends

Cerdá, Santaella, Marshall, Kim, & Martins' (2015) study of nonmedical prescription opioid use in early adolescence, demonstrates that the most frequently reported initiation age of nonmedical use of prescription opioids is 16-18 years of age, followed by 13-15 years of age. Roughly 13% of high school seniors report using prescription opioids for nonmedical purposes at some point in their life (Cerdá, Santaella, Marshall, Kim, & Martins, 2015). Chronic nonmedical use of opioids is almost twice as high in men, though women have higher rates of being prescribed types drugs that are prone to abuse (Cerdá, Santaella, Marshall, Kim, & Martins, 2015). Men are reported to have higher rates of opioid-related deaths as compared to women (Cerdá, Santaella, Marshall, Kim, & Martins, 2015). The rate of nonmedical use of opioids is highest among 18 to 25 year olds (Cerdá, Santaella, Marshall, Kim, & Martins, 2015).

Trends in Opioid Deaths

Despite reductions in opioid prescribing, opioid-involved overdose death rates continue to increase (Schuchat, Houry, & Guy, 2017). Since 2000, the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (Rudd, Aleshire, Zibbell, & Gladden, 2016). In 2016, there were 63,632 drug overdose deaths in the United States (Seth, Scholl, Rudd, Bacon, 2018). Overdose death rates of non-Hispanic whites and Native Americans have been three times as high as Hispanic whites and African Americans (Rudd, Aleshire, Zibbell, & Gladden, 2016). Age-adjusted death rates for overdoses involving synthetic opioids other than methadone doubled from 2015 to 2016 (Seth, Scholl,

Rudd, Bacon, 2018). These increases are driven largely by the use of illicitly manufactured fentanyl (Schuchat, Houry, & Guy, 2017).

The Northeast and Midwest reported the sharpest increases in fentanyl drug reports (O'Donnell, Gladden, Seth, 2017). From 2013–2015, deaths involving synthetic opioids without heroin increased at faster rates than did deaths involving heroin without synthetic opioids in the Northeast, Midwest, and South (O'Donnell, Gladden, Seth, 2017). Mirroring the pattern in deaths involving synthetic opioids, rates of fentanyl drug reports increased significantly nationally across all regions starting in 2013 (O'Donnell, Gladden, Seth, 2017). Overdose death rates of non-Hispanic whites and Native Americans have been three times as high as Hispanic whites and African Americans (Rudd, Aleshire, Zibbell, & Gladden, 2016). Opioid overdose accounted for 66.4% (42,249) of deaths, with increases across all age, racial, and ethnic groups (Rudd, Aleshire, Zibbell, & Gladden, 2016).

Previously, opioid use was portrayed and viewed as a pandemic in low-income inner-city dwellers, however prevalence of use among middle-class individuals has increased in recent years (Cicero, Ellis, Surratt, & Kurtz, 2014). The demographic composition of heroin users who enter treatment has shifted over the last 50 years. Heroin and opioid use has shifted from an inner-city, minority-centric problem to a problem with increased geographical reach, involving primarily Caucasian men and women in their late 20s living outside of urban areas (Cicero, Ellis, Surratt, & Kurtz, 2014). This shift is suggested to have had an impact on increased media and political attention given to the topic of the opioid epidemic (O'Donnell, Gladden, Seth, 2017; Rudd, Aleshire, Zibbell, & Gladden, 2016; Cicero, Ellis, Surratt, & Kurtz, 2014).

Parental Bereavement

Relatively little is known about how to effectively assist parents following the death of a child. Burying a child is against the natural order of things, thus family bereavement after child-loss involves complexities not common to other forms of bereavement (Davies, 2004). Numerous studies conducted on the subject of parental bereavement have found the trauma of a losing a child to be painful; grief associated with bereavement is protracted and profound (Walsh & McGoldrick, 2004; Kazak & Noll, 2004; Stroebe & Schut, 2015; Barrera, D'Agostino, Schneiderman, Tallet, Spencer, Jovcevska, 2007; Alam, Barrera, D'Agostino, Nicholas, Schneiderman, 2012). Marital conflict, mental illness, and behavioral disorders are associated with parents/family members having difficulty coping with grief (Walsh & McGoldrick, 2004). Other studies of bereaved parents found that managing regrets, relying on social support, talking about the death, finding comfort in religion and/or spirituality, continuing bonds with the deceased, finding acceptance, and living for the now are important factors in bonadaptation (Barrera, et al., 2007; Keesee, Currier, & Neimeyer 2008; Eisma, Schut, Stroebe, Boelen, van den Bout, & Stroebe, 2015; Stroebe & Schut, 2015).

Bereaved parents have been offered a host of interventions ranging from peer support groups, weekend retreats, and group therapy, and individual/couples/family therapy, which are conducted by a wide range of providers, such as public health and social service organizations, hospice programs, therapists, and psychologists (Rolls & Payne, 2003). Despite attempts to develop, evaluate, and deliver effective interventions for bereaved parents, their efficacy has been debated and often underutilized (Larson & Hoyt, 2007; Neimeyer, 2000).

Parental bereavement following a substance misuse death. Valentine, Bauld, & Walker (2016) have emphasized two main themes, which provide context for and shape

responses to drug-related deaths and the implications for remaining family members. The first is social and moral stigma attached to “self-inflicted” deaths, which can be transferred to those closely associated with the deceased individual (Valentine, Bauld, & Walter, 2016). The other concerns relate to family dynamics prior to the death in terms of the pressure associated with living with a family member who is misusing substances (Valentine, Bauld, & Walter, 2016). Research has shown that openly disclosing the nature of the death, regardless of stigma, is critical to the parental healing process (Feigelman, Feigelman, & Range, 2018).

Stigmatized deaths. Social context surrounding illicit drug use and drug-related deaths involves stigmatization by members of society (Wojtkowiak, Vanherf, & Schuhmann, 2018; Feigelman, Jordan, & McIntosh, 2012). Parents of substance abusers report experiencing stigma, regret, disrupted lives, loss of support, and loss of quality of life (Dion, 2014). Parents bereaved by a child’s drug overdose sometimes misrepresent the cause of the death to other people, even family members, in order to protect their child’s reputation and avoid social stigma (Feigelman, Jordan, & McIntosh, 2012). Blame is often directly and indirectly apportioned to the parents of the deceased child (Valentine, Bauld, & Walter, 2016).

The impact of lack of sympathy in the form of blaming, was found to increase mourners’ distress, particularly their shame, humiliation, and self-blame (Feigelman, Jordan, & McIntosh, 2012). Parents’ attempts to discuss their child’s passing in a coherent, meaningful way is inhibited by negative myths and stereotypes associated with substance abusers, taking little account of the humanity of the adult child (Valentine, Bauld, & Walter, 2016). This presents a challenge for many parents.

Disenfranchised grief. Disenfranchised grief is defined as a particular type of grief that is not able to be openly acknowledged, socially validated, or publicly mourned (Doka, 2002). Many opioid-overdose deaths produce grief responses augmented by disenfranchisement, due to instances of blaming, vilification, and stigmatization of the family of the substance user (Feigelman, Jordan, & McIntosh, 2012). Research has shown that stigmatizing deaths, such as a drug overdose, complicate the bereavement experience and disenfranchise grieving individuals (Valentine, Bauld, & Walter, 2016; Hall, 2014; Feigelman, Jordan, & McIntosh, 2012; Doka & Davidson, 2014; Doka, 2002).

Meaning making. Research on grief theory has focused on the concept of meaning making (Neimeyer & Sands, 2011; Valentine, Bauld, & Walter, 2017; Wojtkowiak, Vanherf, & Schuhmann, 2018). Meaning making is the process of searching for and finding new meaning after the loss of a loved one, attempting to construct a new self-narrative (Neimeyer & Sands, 2011). In regards to substance-related bereavement, Valentine, Bauld, & Walter (2017) highlight the importance of family members' ability to make meaning of a child's death, asserting that it assists with coping and bonadaptation post-mortem. Meaning making is particularly challenging yet necessary after a traumatic death (Neimeyer & Sands, 2011). Meaning making has been shown to be increasingly difficult when the death falls outside prevailing expectations, i.e. in situations of overdose and suicide (Valentine, Bauld, & Walter, 2016).

Wojtkowiak, Vanherf, & Schuhmann (2018) proposed a meaning-reconstruction model of grief, identifying four main themes in their research on parental bereavement: 1) fragmented grief reactions, 2) social exclusion and notions of disenfranchised grief, 3) eventual acceptance of death, and 4) making meaningfulness, i.e. compiling a biography of the loss. Wojtkowiak,

Vanherf, & Schuhmann (2018) find that meaning-making is a multidimensional process. Research on meaning making in relation to grief stresses the importance of social and emotional support (Wojtkowiak, Vanherf, & Schuhmann, 2018). An individual's capacity to create meaning after the death of a family member is crucial in regaining control of one's life and rebuilding one's shattered identity (Valentine, Bauld, & Walter, 2016). Feigelman, Feigelman, & Range's (2018) study emphasizes that loss provides the possibility of life-enhancing 'post-traumatic growth' as long as an individual is able to integrate lessons of loss and resilience in daily life. Eventually, some longer-term bereaved parents report that while the pain remains, they have overcome obstacles and achieved a level of post-traumatic growth (Feigelman, Feigelman, Range, 2018; Wojtkowiak, Vanherf, & Schuhmann, 2018).

Substance-Death Bereavement Stressors

Parents who lose children to drug-related deaths, experience a higher level of grief and mental health difficulties as compared on the same criteria to parents who lose children to accidents or long-term physical illness (Valentine, Jordan, Gorman, 2011). The death of an offspring is described as one of the most traumatic forms of non-normative loss (Valentine, Jordan, Gorman, 2011; Handsley, 2001). When a death is sudden and unexpected, like overdose, sources of family stress are innumerable. Stressors include parental guilt, strained family relationships, as well as difficulty interacting with social, local, and state resources. (Feigelman, Jordan, & Gorman, 2011; Figley & McCubbin, 2016; Lloyd, Banerjee, & Jacobsen, 2014; McKinnon & Chonody, 2014; Valentine, Bauld, & Walter, 2016).

Many parents experience guilt regarding parental responsibility (Figley & McCubbin, 2016; Handsley, 2001). Intense shame can delay and prevent parents from publicly

acknowledging their child's actual cause of death (Feigelman, Jordan, & Gorman, 2011; Guy, 2004; Murphy, Johnson, Wu, Fan, & Lohan, 2003). When parents misrepresent the facts of the death, they are more susceptible to self-stigmatize and self-shame (Feigelman, Jordan, & Gorman, 2011; Murphy, Johnson, Wu, Fan, & Lohan, 2003). Concern about reputation and standing within the community contribute to family stress (Figley & McCubbin, 2016; Murphy, Johnson, Wu, Fan, & Lohan, 2003). Anticipated scorn and ridicule increase bereavement difficulties and contribute to parental pain and grief (Feigelman, Jordan, & Gorman, 2011; Murphy, Johnson, Wu, Fan, & Lohan, 2003).

Frequently blame is assigned to the parent for not finding the right treatment program for their child or for being an instigating factor in the death (Feigelman, Jordan, & Gorman, 2011; Guy, 2004; Handsley, 2001; Jordan, 2001). Overt and covert expressions of parental blame are especially troubling because they can reinforce the parent's own self-accusations and feelings of ineffectiveness in saving their child's life (Feigelman, Jordan, & Gorman, 2011; Handsley 2001). Opioid overdose bereaved parents have difficulty accepting their grief as legitimate; such deaths bring with them a sense of intense shame and humiliation (Guy, 2004; Handsley, 2001). This shame, both perceived and self-inflicted, compounds parents' obsessional review of their own blameworthiness after the death of their child (Feigelman, Jordan, & Gorman, 2011; Guy, 2004; Handsley, 2001). Substance-bereaved parents are more likely to experience marital disruption, depressive episodes, declines in mental health and physical wellness (Feigelman, Jordan, & Gorman, 2011; Guy, 2004; Handsley, 2001; Rogers, Floyd, Seltzer, Greenberg & Hong, 2008).

For parents, major sources of stress include dealing with first responders, law enforcement, and the larger criminal justice system after their child's passing (Feigelman,

Feigelman, Range, 2018; Figley & McCubbin, 2016; Lloyd, Banerjee, & Jacobsen, 2014; Valentine, Bauld, & Walter, 2016). Substance-abuse deaths often entail anxiety-producing interactions with police and/or medical personnel. Parents sometimes have difficulties disclosing the cause of death to socially significant others (Feigelman, Feigelman, Range, 2018). The response of first responders and other professionals influences the parental bereavement journey with lived experience ranging from compassionate to cold (McKinnon & Chonody, 2014). While legal, medical, and therapeutic practitioners strive to provide services, marketization and commodification of care undermine providers' compassion and can be viewed as overly callous (Lloyd, Banerjee, & Jacobsen, 2014). Research continued to investigate parental experiences of state and local services in order to better handle and respond to traumatic deaths.

Adaptation and Reorganization

Adaptability refers to the ability of a marital or family system to change its structure, relationships, and relational rules in response to situational stressors (Figley & McCubbin, 2016). Cohesion is defined as emotional bonding of family members, in combination with respect for each family member's individual autonomy (Figley & McCubbin, 2016). Negative adaptation is typified by a decrease of family balance and functioning, decrease in family integrity, deterioration of individual member/family development, and decline in family member's independence (Figley & McCubbin, 2016). Positive adaptation after substance use passing is evidenced by promotion of both individual member and familial development, and maintenance of family independence, and a strengthening of family integrity (Figley & McCubbin, 2016).

Hill et al. (1949) characterizes this familial reorganization process as the roller-coaster profile of adjustment. The roller-coaster profile of adjustment posits that there is a period of

disorganization post-crisis, followed by a mutable angle of recovery, and then a subsequent level of familial reorganization (Smith & Hamon, 2008; Hill, Boulding, Dunigan, & Elder, 1949). Reorganization refers to when the family reaches a new level of organization post-crisis. For some families, this was the same or better than the level of organization before the crisis. For others, even once the family system stabilizes, the level of organization is worse than pre-crisis.

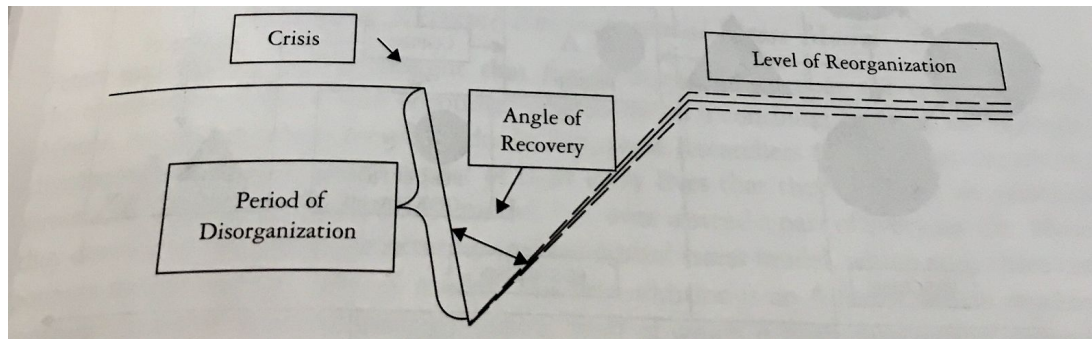


Figure 2. Roller-coaster profile of adjustment (Hill, Boulding, Dunigan, & Elder, 1949).

Social support. A major factor that contributes to bonadaptation or maladaptation is the availability and utilization of social support. Approximately half of the respondents in Neimeyer & Jordan's (2002) study reported that one or more of their close kin failed to offer them the support they expected, further exacerbating their survivors' grief. The experience of grief is unique to each individual, yet it is influenced by many factors, including the availability, type, and extent of support received by the bereaved, and whether or not the support is perceived as helpful by them (Breen & O'Connor, 2011; Dion, 2014; Figley & McCubbin, 2016). Social support for substance use bereaved parents can be accessed through group counseling, support groups, psychological therapy, marriage and family therapy, religious organizations, and community programs (Figley & McCubbin, 2016).

Difficulty informing extended family and friends about the stigmatized nature of their offspring's death often results in social isolation of the parents (Figley & McCubbin, 2016). Evidence suggests that parents who lose a child to a drug-related or overdose death encounter much the same stigmatization and exclusionary treatment that suicide survivors confront (Valentine, Jordan, Gorman, 2011). Literature provides evidence that compassionate service is undermined by stigma and mitigated by kindness (McKinnon & Chonody, 2014; Walter, Ford, Templeton, Valentine, & Velleman, 2017). Small acts of kindness based on symbolic kinship reduce parents' experiences of stigma (Walter, Ford, Templeton, Valentine, & Velleman, 2017). Stigma can be evident through instances of stereotyping, othering, and disgust (Walter, Ford, Templeton, Valentine, & Velleman, 2017). Although professionalism often entails emotional detachment, research has found that cold professionalism is as disturbing to grieving parents as explicit disgust (Walter, Ford, Templeton, Valentine, & Velleman, 2017). Being able to access and rely upon existing and new resources during times of stress impacts family resilience outcomes (Smith & Hamon, 2008). Mental health professionals are in a unique position to provide support resources to the family of the substance-abusing individual (Dion, 2014). As such, further study of this at-risk population must be conducted to help inform new research, policies, and clinical practices.

CHAPTER III: METHODS

Design

The purpose of the proposed case study was to conduct an in-depth exploration of parents' grieving and healing trajectories after the death of a child due to opioids. Yin (2009) defines a case study as an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. Comparably, Stake (2008) notes that a case study is defined by interest in an individual case, not by the methods of inquiry used, and that the object of study is a bounded system. Bounded means that the researcher sets clear parameters for participation and has definitive objectives regarding the focus and geographical extent of the research. These definitions inform the design of the proposed multiple case study.

This instrumental case study identified and examined the bounded system of six parental units living in the state of Maryland, who lost their child to opioids at least two years prior to the study being conducted. The scope of the study is limited to 6 parental units, as the goal is for the research to be as in-depth and granular as possible while examining thematic similarities and differences within the sample. This case study is spatially bound to parents residing in the state of Maryland because a primary goal of the proposed study is to explore the experience of losing a child given the increase of opioid deaths within the state.

Participants

Data was collected from parents whose child had passed away for at least two years prior to the interview process. Two years was used because as it has been indicated that the passage of time is critical in achieving greater emotional distance from their experience of loss (Feigelman, Feigelman, & Range, 2018). As such, it is assumed that participants were more comfortable

discussing their experience with the researcher. This time was also critical for the study, as it provided a wider window to talk about the participants' grieving and healing experience.

Recruitment. Recruitment was done through peer support groups designed for families or individuals who lost a loved one to substance abuse or addiction within the state of Maryland. Support group liaisons assisted with recruitment of participants within each group. This liaison can be a group leader or member. The liaison handed out fliers at support group meetings. The researcher did not approach participants; rather contact was initiated by the support group liaison. Potential participants then contacted the researcher directly to discuss the study, receive informed consent documents, and then decide if they would like to participate in the qualitative interview process.

Procedures

The primary researcher followed the following procedures. The primary researcher obtained approval from the VT Institutional Review Board (IRB). Recruitment was done using fliers handed out by the gatekeeper at parent support group meeting sites. The fliers included pertinent details of the study, including subject matter, and intended purpose of the research. Once the study was introduced to group members by the gatekeeper/group facilitator, the researcher was invited to be an observer at one support group meeting in order to introduce the research to parents in the group.

The gatekeeper then provided parents with the researcher's email address and phone number. Parents were instructed to reach out to the researcher if they had further questions or would like to be a participant in the study. If a parent decided to participate in the study the parent was sent the informed consent document which contained pertinent information regarding

the study's risks, benefits, voluntary nature, method of data collection, and handling of interview data/results. Before the interview process began, the parent signed the informed consent document and sent the signed document back to the primary researcher. Prior to the first interview, the researcher screened each parent to assure that he or she met all requirements for participation in the study. Each parent completed a brief screening via encrypted email. Demographic data about both the interviewees, as well as the deceased child was collected and recorded by the researcher. Before scheduling interviews, all necessary forms (informed consent, demographics, etc.) must have been signed and sent back to the researcher. After the screening process is complete, initial interviews were scheduled in the order in which the parent responded to the researcher.

Instruments

Interview structure and protocol. The proposed study used a semi-structured interview protocol to focus on a number of areas of inquiry, including the death itself and events following, coping mechanisms, meaning making, stigmatization, and perceived support since the death. Initially, each parent was asked to discuss his or her experience, beginning wherever he or she saw fit.

The researcher asked the following open-ended questions:

1. What is your experience as the parent of a child who has died from opioid overdose?
2. What resources have you utilized post mortem?
3. What has been your experience of bereavement?
4. How has your life changed since your child's death?

Interviews were conducted face-to-face for greater understanding of nonverbal cues such as body language, tone of voice, and underlying emotions. Interviews ranged in length from 50-90 minutes per parent. Parents were interviewed individually rather than in a dyad. Interviews were conducted in a place of the participants choosing in order to maximize their comfort. Parents and their children were assigned pseudonyms in order to assure confidentiality and anonymity. All data was stored in a password-protected electronic device only accessible by the researcher.

Demographics. Demographic data was collected from each parent, as well as their deceased child. Parental demographics asked for the number of years it has been since their child passed away, the parent's current age, their age when child passed away, as well as race, ethnicity, religious affiliation, highest level of education completed, occupation, income, marital status, and city and county of residence. Demographic information collected regarding the deceased included the age at which he or she passed away, their race, ethnicity, and religious affiliation, highest level of education completed, occupation, and income, as well as marital status and city and county of residence. All demographic information was collected and reviewed prior to the parent being interviewed by the researcher. Information can be found in Appendix C and Appendix D.

Data Analysis

Interviews were transcribed verbatim. Participants were then given transcripts of their interviews and asked to correct, clarify, or redact portions of their responses until no further changes were requested. Interview transcripts were then used for qualitative analysis. The researcher read the transcripts a number of times, analyzing the content in order to become deeply immersed in the interviews. The researcher completed an open coding of the transcripts

using Stake's (1995) approach of 'clustering' data into categories and classes. Transcripts were highlighted using a variety of colors to reflect the researcher's initial relationships with selected sentences, key words, and phrases. Categorical statements and salient themes were clustered and organized into classes, which reflect the experiences of parents interviewed. Broad classes that encompass the emergent categories are reported in the study's results section.

Criticisms

The absence of systematic procedures for case study research is something Yin (2009) sees as concerning due to a relative absence of methodological guidelines. A second issue is that of construct validity. This concern applies to the reliability and replicability of single case study analysis. Single case study analysis has been subject to a number of criticisms, the most common of which concern issues of researcher subjectivity, methodological rigor, and external validity. While a single case study is strong in terms of particularization, it lacks generalizability. In order to increase construct validity, reliability, and replicability, further research must be conducted with a greater number of parents who have lost an adult child due to opioid overdose.

CHAPTER IV: RESULTS

This case study explores the experience of parents whose children have passed away due to opioid overdose. The results discuss mitigating factors of parental grieving and healing.

Looking at the results holistically the following six themes emerged: 1) the grieving process, 2) support vs. stigma, 3) experiences with state and local services, 4) parental guilt, shame, and unanswered questions, 5) coping mechanisms, and 6) post-mortem life changes.

The Grieving Process

The parental grieving process is neither linear nor finite, and is influenced by the support of others as well as the passing of time.

According to Jim,

We have friends say, "We really miss you. We miss the you that you were." Because the grief changes you. Grief is something that never goes away, and, in my mind, it becomes part of you. You carry it differently at different times.

Jim provided the following analogy to describe his experience of parental grief,

My way to describe to people what our, what my grief is, is that on the day, on the day he died, it was like the world handed me a big stone. And I knew that I would carry that stone every day for the rest of my life. And in the beginning the weight is incredible, because you're not used to carrying it. But you learn to carry it. And the muscles that you need become stronger, and there are people who will help to carry it, when you can't. And it becomes part of you. There are things that happen that make it easier to carry at times, you know. We talk about the things that we feel lucky about, the things that we're joyful about, and they ease some of that, but the weight is still there. You learn how to live with it, but it becomes part of you, and that's what the grief is. It's part of us.

The grieving process for participants included 1) shock and denial, 2) sadness and depression, 3) anger, 4) triggers, 5) acceptance and meaning making, 6) support and stigma, 7) experiences with state and local services, 8) parental guilt, shame, and unanswered questions, 9) coping

mechanisms, 10) maintaining connection, and 11) post-mortem life changes. These subthemes are explored below.

Shock and denial. All six study participants stated that they initially experienced shock and denial when they received the news that their child had passed away from overdose, as well as in the aftermath of the death. Danielle reported, “His death was a complete shock. It’s been horrible. He died in February 2017, we didn’t really know he had a problem until October, so very few months.” Similarly Layla stated,

Up until that point, because I didn’t have any concrete evidence, I just thought that they had the wrong person, you know what I mean? I just knew that they were going to let me in that room, and it was going to be the wrong person, but it wasn’t.

Experiences of shock and denial are consistent amongst all six research participants. Participants also indicated that their shock and denial was also consistent with memory issues and shock. For example Danielle reported,

I can’t even remember so much of that time, as a matter of fact, the only reason I know what took place at the memorial for the most part was because I can look at the website where all the speeches are recorded.

Once shock and denial began to subside, parents reported that their sadness and depression became more prominent.

Sadness and depression. Parental sadness as described by research participants can be characterized by inability to complete daily tasks or activities, intense emotional and physical pain, lethargy, apathy, and even lack of will to live/consideration of suicide. Danielle stated,

I wasn’t sure if I wanted to live. I truly considered taking my life. I said [to my therapist], “Will I ever get over this pain? It’s just, it’s all consuming, every part of your body hurts because you’re so sad.”... I still have really bad days, after he died I told myself I would never not get out of bed, so I get out of bed every single day.

Another participant, Anne, stated,

I find myself not having the energy sometimes to, just because I'm exhausted from all of it, and I don't feel like I have the energy to put the effort into it. So that's a little concerning. And then I get, I feel better for a while, and I feel worse for a while. Her husband, Sam, concurred stating, "I don't know if you're clinically depressed, but you're not excited about things, you don't care about things." As aforementioned, parents do have days where they feel their sadness and depression more intensely. This is evidenced by Anne stating,

Sometimes it really hurts, and you don't ever know which time. I mean I can see the kids getting on the bus every day and all of a sudden, one day it will just stab me. So you don't ever know when that's going to happen.

In their interviews, parents consistently reported that sadness and depression fluctuated.

Anger. Parental depression and sadness can be compounded by feelings of anger. One interview response indicated being angry at God. Anne stated, "As far as being angry at God, I'm trying to be better. I feel like I'm getting better at that. But I was very angry for a long time."

Another mother, Paula, described her anger towards other parents,

I don't have time for gossip, people, things that used to bother me...Sometimes, I'll snap...the way [people] talk about their privileged children was annoying me, and finally I just said, "Well, if that's all you have to worry about. My son died so that just seems so trite to me." I had to, and that shut them up. I just couldn't hear them prattle anymore.

Anger was a common emotion experienced by participants in this study.

Triggers. Parental sadness and anger can reportedly be triggered at any time. The research suggests that parents can be triggered by a variety of things: holidays, birthdays, anniversaries of death, attending church, going to a wedding, hearing a familiar song, etc. Of the six research participants, all six mentioned that holidays are the most triggering times for them. As Sam described, "Certain days of the year that are just sadder than others that's all. His birthday, [his date of death], holidays....always a little tougher than it used to be." Other

instances, such as revisiting a place a child spent time, being in church, attending a wedding, missing milestones, and particular songs, were reported to be triggering for parents.

Anne discussed the subject of a triggering place stating,

I have a hard time going back [to church] now. I keep telling myself I'm going to, but I tried for a while, I get very, I just get sad. We go to the same church that we've always gone to, the church I had him Baptized in, so to go to that church is very difficult.

Danielle also discussed the subject of triggering events,

A lot of my son's friends are getting married and having babies. We've been invited to quite a few of those weddings, and it's very hard to go to a wedding where you see your son's friends get married and you know your son would have been in the wedding. Like six months after he died, and I could barely deal. It was so horrible, it was so horrible. But now we go to a wedding, and we can actually have fun, and it just gets a little easier as time goes on.

Additionally, Paula mentioned feeling triggered by music, "You can be fine, and then a song on the radio can throw you over the edge." In analyzing this data, it is evident that triggers are both overarching and parent-specific.

Acceptance and meaning making. While time does not nullify the presence of shock, sadness, depression, anger, or triggers, the data does make clear that, over time, parents are able to come to terms with their loss. The data suggests the passage of time does change how parents feel about their child's passing. Danielle describes,

I still experience pain, but it's just a little numb-er...you know, time goes on, and sooner or later you kind of deal with it. It's like, life does move on, and we're moving forward, we're not moving on. It will be three years in February, and yes, we have, we are stronger, but still we miss him. I think as time goes on, my sadness might not be so bad, but it's something that we have to live with forever until I die and join him in Heaven.

The passage of time appears to give parents the opportunity to develop a new outlook and make meaning of their child's death. Layla said,

At least I had him for 32 years, there's people out there that lose their children at much younger ages, you know? That pain is still there, the hurt is still there. But I feel like it had its reasons for happening, and one day we'll figure out why.

To this same effect, it appears parents are able to make meaning out of tragedy and re-form their identities based upon who they are post-loss. Jim stated,

I have a phrase like, "This is who we are now. We are the luckiest of the unlucky." You know? We've had the most horrible thing happen and yet we've had the most amazing things happen. And you, how do you square that? I mean, this is life, and in some way we're, you know. There's nobody who gets out of this world unscathed. While I'm going to grieve, and while there's going to be pain, it isn't going to be the sum total of who I am for the rest of my life. It's going to be part of who I am. And so in some ways I go, "I'm probably a better person."

The data suggests that a child's death provides parents with an opportunity for post-traumatic growth and identity reformation. Grief, while devastating, can be transformative.

Support vs. Stigma

The theme of support versus stigma was one that permeated every parental interview. Support versus stigma included subthemes such as 1) disclosure, 2) support (from partners, friends, family, and peers, and 3) stigma (from community members, the media, state and local services, and oneself).

Disclosure. According to the data, one important feature to consider regarding support and stigma is the decision to disclose cause of death. Disclosing cause of death to family and friends is shown to impact support received, as well as influence the healing process. The data shows that parents who were more readily willing to disclose their child's cause of death as an opiate overdose did not report experiencing as much stigma as they may have initially expected. There also appears to be a difference in level of disclosure based on level of closeness. Parents

were more willing to disclose truthfully to their family and close friends versus their co-workers and acquaintances. On the subject of disclosure, Danielle stated,

We decided right from the start, we're going to tell the truth...Our friends have been very supportive. Family has been very supportive. You might think that people would look down on us, "How could your son die of an overdose?" but everybody was very sweet.

Similarly, Jim discussed grappling with disclosure stating,

I think in the beginning with losing a child to an overdose is wondering how you're going to talk about that. And because when you're struggling with a child with addiction, it has been the case that most people don't talk about it. So, when you lose a child to the disease of addiction, a lot of people don't know that your child had a problem to begin with. So, you're then faced with the challenge of how am I going to feel about telling everybody? And I think we decided very early on that it was important for people to know and to not, in any way, hide from it.

As Jim describes, there is a process that goes into the decision of whether or not to disclose. This process involves not only disclosure of the cause of death, but that their child had a substance abuse problem to begin with, as this news often comes as a shock to family and friends.

Some parents know they are going to be open from the start, however, other parents are more hesitant, and disclose more over time. Lisa, a nurse, described, "I don't know why, it's almost like, six years have gone past, and I talk about it more openly now, but when it first happened, I didn't. I didn't talk about it much, I kept it to myself." Danielle, a social worker, discussed her hangups about disclosing the nature of her son's death, particularly to people in her workplace. Danielle stated, "I couldn't tell [my clients] that he had overdosed. These are clients that are using themselves. I couldn't tell them that me, the social worker, had a son who died of an overdose." The data suggests those in helping professions, a nurse and a social worker, were the participants who were most hesitant to disclose cause of death. Responses seem to suggest

this is due to worries regarding judgment, as well as some self-judgment that they are the parent of a child who was abusing opioids and eventually died due to overdose.

Support

Experiences of support were reported to be critical to parents' grieving and healing process.

Parents stated that they received support from 1) partners, 2) friends and family, and 3) peers.

Partner. Interviewees reported a wide range of experiences regarding partner support, some positive, some negative. Interviewees reported hearing statistics such as 50% of all parents who have a child die from an overdose get divorced or break up with their intimate partner. Five out of six participants reported still being in their marriages, while one participant described being left by her significant other due to her prolonged grief. Evidence shows that couples who have been together for long periods of time and are married rather than dating have greater success staying together after their child passes away. Anne stated,

People split up after losing a child, it's like 50/50. I don't know why we're really different, it's not like we're better or smarter or have a better relationship or anything like that than most people. I don't think we're in danger of splitting up over it...we have a lot of things in common that we like to do, travelling, so we continue to do that. We enjoy it, and we still do have fun, you know? So it's possible.

Her husband Sam agreed with Anne stating,

I think we realize we're both in it together, and there's no way we're going to do anything separately. I know we try to stay busy and we probably don't talk about it as much as Anne would like, and she probably talks to other friends more, family more. But if we get really sad and she gets really sad, I just have to be there. And want to, for that matter.

Other participants discussed having difficulties due to differences in the way each partner grieved, however they were able to stay together despite these differences. Paula reported,

Jim and I have been together since we were teenagers. We were 18 and 17 so you either grow together or you grow apart at that point. I know a lot of marriages don't make it after the death of a child. There's definitely rough patches because you grieve differently.

On the same topic, Danielle said,

My husband and I are very different. When Jake died, I kind of went into a, I couldn't do anything...My husband, he needs to be busy, so he planned everything, he ran everything by me. So we worked really well in that sense, I had to survive and he needed to plan everything, and do everything, he did an amazing job.

While some couples found they were able to provide support to one another, another participant describes not getting her needs met by her partner, eventually resulting in a breakup. Layla described her experience stating,

The person I was dating for 10 years and was very supportive during the time of my son's passing; we're no longer together. The support that he gave me when it first happened, it slowed down and eventually ended, almost like, kind of a get over it type thing. Those words never were said out of his mouth, but I felt it like, "You should be over this by now." I needed more of those hugs that I got when it first happened, and more of let's sit down and talk about it, and I didn't have that anymore so I just needed it. I asked for it and didn't get it.

After Layla and her long-term boyfriend broke up, she moved back in with her ex-husband. On this subject, Layla stated,

I needed somebody, so I'm actually living with my ex-husband again, and although it's not a romance...we can share in that grief with each other, you know what I mean? We can share that we've lost a child together, and laugh, and cry, and all those things that couples do, even well after the death has happened.

The interviews show that one's partner is a vital source of support. Having a partner who shares the pain of losing a child is demonstrated to be a greater support than a partner who has not had the same experience. All participants ultimately relied on their partner for support (four participants are still partnered with each other; one remains with her husband, though he is not included in study, and one went back to living with her ex-husband after her boyfriend left her.)

Friends and family. In addition to partner support, larger systems, such as family and friends provide support to the grieving parent. Anne stated,

We have a lot of great friends and...we've got a lot of family and they were all here for us...we had a tremendous amount of support. You lean on the people that you leaned on then, you just continue to do so.

Jim stated,

I have a group, we play a type of golf but...we have a championship series and a couple of trophies we give out...and they renamed one of them after my son. You know, part of me goes, "Not that big a deal," but they wanted to do something that they thought would mean something. So that was pretty cool.

While the experiences above are positive, participants also described negative interactions with family members and friends.

Jim also said,

People who you know who may not and so close to you that they knew that you've lost your child who you're going to run into and they're going to ask you how your kids are, and I swear to God there are some people who will ask that question and you will tell them something like that, and they actually go on like, "Wow that sucks! Anyway how about those Ravens?" And it kind of takes your breath away.

While Jim speaks of an instance of overt disregard, another participant, Layla, describes the pain of friends and family not asking her about her son,

Yeah, you know it's like people don't ask anymore, they don't ask anymore, and you feel secluded. They stop calling and stop thinking about it, and stuff like that. So I think that's been the hardest part...I guess the biggest fear you have when you lose somebody that you love so much is that people will start forgetting about them.

Participant responses illuminated the importance of continued discussion of the deceased child, as well as the need to be sensitive and acknowledge the circumstances of death, rather than ignoring them. The death did not result in breaking up existing marriages of the parents and in one instance it resulted in the reconnection of parents previously divorced.

Peer-to-peer support groups. The research shows support from loved ones is bolstered by participation in peer-to-peer support groups. Interview results demonstrate it is important to

find a substance death-specific support group, rather than a general grief group. Sharing with other parents in the same situation as themselves was more helpful than sharing with individuals who had lost parents, spouses, or young children to illness or accidents, etc. As Anne states,

I went to a group at a church, not our church, but a friend's church, who they were doing this grief support and it was going to be like once a week for six weeks, and I went to that once or twice. No one had lost a child, one person had lost a child many many, many years ago to a disease... Everybody else had lost, mostly parents, older parents and one woman had lost her husband, and I didn't feel like I related to that.

The impact of peer-to-peer support groups cannot be stressed enough. Jim states,

I found out about [the peer support group] because of a friend of mine who lost his son, who was somebody we had talked over the years about our sons and their situations. He knew about my son and then he lost his son. It's hard to hear how many people lose their kids in how many different ways, and yet you hear something that helps you too, and it's very strange. Very strange that you're sitting around sharing these things that are just as awful as you can imagine and somehow, you're better off when you leave than when you came. Even though your circumstance didn't change, somebody may have been able to give you a perspective that you didn't have.

Layla, another support group member, says peer-to-peer support group members have become like extended family members to her,

You feel like [group members] are an extended part of your family, you know? And you can be yourself there, you can cry and just talk about awful things that nobody else would understand, you know? That [group] was life changing for me, to actually be in a room with other people that experienced the same ups and downs and highs and lows that I did.

Stigma creates emotional support that is tempered by judgement. Four out of six interviewees described peer-to-peer support groups as being the most important, invaluable, and impactful in terms coping and receiving social support.

Stigma

In interviewing parents, one common thematic element is the presence of stigma. Paula described, I do feel like, silent judgment from people, they think you must be bad parents if you

tell people your son died of a drug overdose. Layla discussed the reactions she gets when she discloses how her child died and the difficulties that stigma has created for her:

People avoid the situation and when they do ask you how you lost your child, it's when you say, 'drug overdose' you almost get this feeling like, I don't know how to describe it, like a disapproval, or a shamefulness. You know what I mean? It's just like you get a different, "I'm sorry." You don't get the I'm sorry as if someone you loved passed away of an illness, you get almost this frowning face like, "Whoa, I'm sorry." Probably one of the hardest things to deal with is that you don't get that, "Oh my gosh, I'm sorry!" kind of sympathy from people.

Danielle discussed how the opioid epidemic is portrayed by the media versus how she feels it should be portrayed:

People are just really learning that it's a disease. We think it's very important for people to know, and our friends and family know this, we come from a middle class family, our kids went to the best high school in the area, very close family, all our kids are educated, went to college, Jake was working on getting his masters. He had a job, he was also a football coach. That's important for people to know. He wasn't just hanging out, doing nothing, or homeless living on the streets...So anyway that's another thing, we [have] got to shatter that stigma.

Danielle wishes to change the imagery and connotations associated with opioid addiction. Her sentiment is that the media and society cannot see opioid addiction as exclusively reserved for low-income or homeless individuals. She wants people to know that addiction can happen to anyone regardless of their financial, educational, or social status.

Experiences with State and Local Services

When asked about experiences with state and local resources, parents had a variety of things to say about 1) first responders and 2) law enforcement.

First responders. Parents' experience with first responders varied. Some experiences were positive, others less positive. Danielle described,

The paramedics were incredible...they tried, they worked on him for half an hour, they gave him three shots of Narcan. They didn't want to give up. Then, when they were taking him out in a body bag, and I said I needed to look at my son one more time, they

unzipped the body bag, and they all stood there with their hands behind their back like, they were very, very respectful. And they let me take as much time as I needed, you know just to look at him, and tell him “Don’t worry you’re going to be with us forever.” And they were very respectful, so...they did a good job in a horrible, horrible situation.

A less positive experience was described by Anne,

I could hear them downstairs just kind of cutting up with each other. Not blatant, but I could hear them... they were down there kind of laughing and, you know, not at [my son], but just they were at work... they were at work and they were doing their job.

Sam described a negative experience with emergency responder grief counselors,

They brought in grief counseling people from the county who started asking you all these questions, it just happened an hour ago and you don’t have any time to process anything and I just was really pissed off at them, like I was getting ready to throw them out of the house. Two people that showed up and started asking questions like, “How do you feel?” It’s just, you don’t have time to even begin to think about any of that.

Callous attitudes and overwhelming amounts of questions from first responders are unhelpful to parents in situations of death and loss. It is critical that parents feel that they and their loved one are shown respect and compassion by first responders.

Law enforcement. On another front, parental experiences with law enforcement again range from positive to negative. Positive reports from parents included law enforcement being respectful and feeling like they were doing their job. Negative reports regarding law enforcement reported lack of follow up, lack of communication of pertinent information, not pursuing the dealers of deadly synthetic opioids, and stigma within the police force related to overdose deaths.

Only one out of six participants had a positive experience with law enforcement. Danielle stated,

Law enforcement came in, because they had to make sure it wasn’t a homicide, so they came in and they went through his whole room looking for drugs, they declared it an overdose. I thought that the police who came to our house were incredibly respectful.

Sam had a less positive experiences with law enforcement professionals,

The police did say giving his cellphone was required, that we had no choice but to give them the phone. I had no hesitation in giving them the phone, but they made it clear that

we didn't have a choice. Weeks went by and we didn't hear anything from anybody. They never called us, they never investigated anything, they never asked any questions about where [he got the drugs from], nothing... We never heard from them after that day.

Jim, whose son overdosed in Miami after leaving a rehabilitation center there, reported,

The police in Miami were horrible. I tried four years to get them to follow up on where [the drugs] came from, because what he was given killed seven other people. He was in the morgue with seven other people. They wouldn't truly investigate it.

Jim went on to say:

I had a sergeant in the Miami Police Department basically say, "Well your son was an addict you know, he was partly responsible." And I said, "You have got to be kidding me. That's how you look at it? I hope this doesn't ever happen in your family." That's the thing that bothered me, so the stigma goes so deep that we're not willing to do anything about it in law enforcement.

The data suggests a vast discrepancy in interactions with law enforcement professionals. In order to provide better services to parents, interviews suggest law enforcement professionals should follow up with parents regarding details of the investigation, pursue dealers of deadly synthetic opioids, remove personal bias, and monitor stigmatizing language when speaking with parents.

Parental Guilt, Shame, and Unanswered Questions

In surveying the interviews, themes of parental guilt, shame, and unanswered questions arose. Struggling with unanswered questions and guilt are shared experiences for many participants. According to Layla, "You go through your own guilt as to, "What did I do wrong?" There's almost like a shamefulness. That's the first thing you think of as a parent, "What did I do wrong? What could I have done differently?" Similarly Jim stated,

Every parent I've ever talked to, who cared about their kid at all, they all said the same thing, "What could I have done? What did I miss? I don't understand why this happened. Why isn't there an answer? I just want my child back." And it really hasn't mattered how it happened, because at the end of the day, their child is still gone.

Interview responses indicate unanswered questions contribute to parental shame and guilt.

Multiple participants echoed similar sentiments to one another regarding unanswered questions.

One participant, Danielle, questioned,

“When did he start doing this? How did it happen? How?” I lay awake at night and I think to myself, “Should I have known? We’re a very, very close family. We have so many questions that will never be answered, so I guess that makes the grieving, I mean...no matter what the grieving is horrible, but the questions...it’s horrible.

Questions regarding the initiation of their child’s opioid use and circumstances related to their death permeate parental responses. Anne stated, “We don’t know how it started, we don’t know who gave it [to him].” Danielle also stated,

I’m assuming he decided that he needed to self medicate [for his bipolar disorder]. I don’t know how he started on what drugs, my guess is first he could get his hands on pills, and then he couldn’t afford the pills, so he went to heroin, and I’m pretty sure he had no idea that he was taking pure Fentanyl on the day he died. But once again, I don’t know.

Interview responses illuminate the painful nature of unanswered questions and the lasting impact such questions have on parents.

Coping Mechanisms

The major subthemes of parental coping mechanisms were 1) staying busy and 2) doing bibliotherapy and writing. Interviews illuminated the importance of staying busy in order to keep one’s mind occupied and to thinking about things aside from their loss. The following coping skills were utilized by research participants: traveling, being out in nature, working, writing/journaling, reading, listening to audiobooks, going to the gym, spending time with children, grandchildren, and friends, and staying busy. Layla said,

I find that I keep busy by working, I’m a workaholic. I work a lot, and I do have...two beautiful grandchildren, staying busy with them. Just staying busy is all I can say is how I cope with it. So I work a lot...I’m a nurse and I just enjoy what I do, and so working a lot just keeps my mind busy. Idle time is not good.

Anne echoed the same sentiment,

I stay pretty busy. I have to keep my mind. I've read a lot for a long time. I hated being in the car by myself because I just think too much so I started listening to books in the car which helped a lot for me so. Or when I wake up in the night because I don't want to lay there and think about it, I read. It can be exhausting sometimes, being that busy all the time, but it's better than dwelling on it or thinking about it.

Research responses indicated idle time and dwelling on the child's death are counterproductive to the parental healing process.

Bibliotherapy and writing. In categorizing interview responses it became clear that bibliotherapy and writing are critical means of healing for many study participants. Some participants read books related to the opioid epidemic, substance abuse, the brain disease model, grief, and the death of a child. Anne found books helped her better understand addiction:

There's a lot of books, and some of them are very good. It doesn't make it go away, but it makes you understand that there's a perfect storm of a whole bunch of things that have happened and there's so many people, good, decent people with loving, supportive families who have ended up dead because, and reading makes you come to some kind of I don't want to say peace, but some understanding maybe of it all.

Many parents described writing in some way or another as an important coping skill. Responses regarding writing ranged from writing letters to their dead loved one, blogging about their experiences, and journaling. Jim, described writing as a form of "self-therapy" stating,

I've written journals, I've written things that help me get some things out of my head that otherwise just keep rolling around, and it's one of those things, it's both tortuous and good at the same time. I don't know, it's like self-therapy or something. A lot of what I've written is very melancholy and yet there's a lot of things that have happened to us that give us hope, and that give us strength, and I want to write about those things too, because they're still a part of our story.

Anne also describes writing as being a means of self-therapy,

What's helped me a lot was that I write to Mark. I always kept a journal since the time I found out I was pregnant and I still do...It just makes me feel like I'm still connected and that's been very helpful to me. Right after he died, I just started writing down everything

I could remember...just because I knew I wasn't going to remember it later...so that's what has been very therapeutic for me. Just the writing.

Through these interviews, it is clear journaling and bibliotherapy on addiction and grief are personal coping mechanisms that can be done without the need of a therapist or support group.

Maintaining Connection

The data indicated maintaining connection to their deceased child was important to parents. Interviewees maintained connection in the following way: continuing to live in the same house, keeping pictures of their child hanging up in their house, memorializing their child's room, wearing their child's clothes, spraying their cologne, driving their child's car, going to locations their child loved, going to their child's grave, posting pictures of their child online, and talking aloud to their child.

Jim discussed him and his wife's decision to continue living in the same house, "We're still in the same house. We talk about, we've actually talked about, do we want to stay here? And you know there was a time I thought no, but this is where I feel him." His wife Anne stated,

He was born in this house...you know he lived in this house his entire life and so everywhere we go...there are memories of him being there. I see a school bus stop down here on the corner, and I see him in first grade, getting on the bus. It's constant. And that's okay. Most of the time that's okay. I may never want to leave here because of that, because I don't want that to go away.

Paula talked about her ritual of having daily conversations with her son,

I talk to him everyday, I literally go outside and talk to Riley everyday. I go to the deck and talk to him. Mostly just outside, but I do everyday say "Riley, this sucks. I can't believe you've left me.

Danielle discussed memorializing her son's room and maintaining connection to her son through sensory memories:

I haven't taken his room apart yet...we have a memorial in there of all his favorite things...that'll probably come down soon, but it's been almost three years. I just go in

there and I sit and look at everything, some of the things are just really silly. He loved the ocean, so there's a seashell, his favorite book, his wrestling trophy, his football trophy, just silly things; his cologne. Every once in a while I'll just spray his cologne and it just brings back his smell.

Finally, Paula talked about an instance of a very tangible connection to her son:

My son's girlfriend found out she was pregnant a month [after he died]. But just like I knew that he had died, I knew that she was going to be pregnant. I just knew. Maybe every mother hopes, and I think that that's true for my friends that have lost their sons especially, they have many, many, many of them had said to me "I wish that my son...that there was somebody pregnant." And my former principal, who lost her son 15 years ago, when she found out that I was going to be a grandmother, said "Oh, God, what a gift." And I did view it that way, as a gift.

There are numerous ways parents maintain connection to their child post-mortem. Maintaining connection is indicated to be an essential piece of parents' experiences of grieving and healing.

Memorialization, rituals, and signs. Interviewees spoke of memorializing, ritualizing, and interpreting signs in order to maintain connection to their child. Danielle spoke of having memorializing her son by having plaques in significant locations,

He used to hike on the canal, and we got a bench for him, and it has a plaque on it, so we can walk to that bench and overlook the canal, and just think about him. And we had some friends who put a brick over at his college with his name, and his birth date and death date, and they're also going to put a bench over at the high school where he went to school and coached. So there's a lot of memory things.

Regarding rituals, Danielle additionally stated:

For a long time we burned a candle for him every night, for two years we got a calendar and turned the calendar every month, just I don't know why, it's just little things like that that just were and are so important. I go to his grave and I decorate it. He loved St. Patrick's Day so I decorate it for St. Patrick's Day and I just, I don't know, I guess I feel closer to him, even though I believe that he's right here with me.

Anne also spoke of feeling connected to their loved one through signs,

[My husband] sold his car and drove my son's car for months. Immediately after he sold his car, the horn just started going off, randomly. Every now and then he'd be [at work], somebody [in his office] would come in and say, that there's a car out there in the parking

lot with a horn going off. There was a night it went off in the middle of the night and we said it was going off because that was Mark saying why did you sell your car?

Jim also reported seeing signs from his deceased loved one:

For some bizarre reason, since he died, we've all started finding dimes. And you say, "Okay, you find some dimes." We have like 200, and they appear in the most strange situations and places. I don't know, I don't really care, except I know that objectively, it happens. Why it happens, I don't know, I really don't.

His wife Paula corroborated this stating, "You know we find dimes, that's why you see all the dimes there, but we really do. I find them everywhere. We have so many dimes. I always thank him, "Thanks, Riley, thinking about you too."

Memorials, rituals, and signs are important to parents in maintaining a connection to their child.

Community building and activism. Parents who have lost children to opioid overdose seek ways to connect with others in their community, and often take on some form of activism. These experiences range from speaking engagements, to working to increase sober housing options and more effective treatment facilities, becoming involved in substance abuse research, facilitating a support group, fundraising for and participating in opioid awareness walks, talking to high school students and parents, and speaking on Capitol Hill. Anne stated, "I'm facilitating [the peer support group], so it fits. I'm trying to learn how to say the right things, and to have conversations that will help people. Jim said,

I did a talk in August for Overdose Awareness Day. I've been able to be involved with organizations that are building sober living facilities or looking to try to expand and build new treatment facilities, and I'm like, "Okay, great, I'm all in, I'll help with that project, that would be great to be involved in because I know what this is." I've got involved with a group that, the University of Maryland Medical School that was trying to do some research on a basically a vaccine that would cure, or be a long term answer to something.

Danielle discussed activism, this time on a national scale, “My husband spoke at an opioid awareness walk. He’s also been on the Hill, he spoke in 2017 when the opioid crisis was front and center.” Danielle used advocacy to address the judgement she experienced.

Interview responses suggest that losing a child to opioid overdose increases desire for community building and activism. Parents are able to make meaning through providing support to others, educating the public, participating in research, developing new programs and facilities, and breaking down stigma surrounding the opioid epidemic.

Post-Mortem Life Changes

Interview results indicate that losing a child to opioid overdose creates a shift in the family system, a shift in level of empathy, and a shift in perspective on what is important.

Shift in family system. Anne described changes in her family system the following way:

I mean the obvious thing that you had two children and now you only have one and think about the future. That future is very changed as far as grandchildren and brothers, [my younger son] not having a brother. The future is very different than it used to look as far as our family, and holidays and birthdays and just things that you know are never going to be like they were before. Not what we imagined.

Another participant, Danielle, touched on a negative aspect of shifting family dynamics as it applies to grieving siblings stating,

We felt like my daughter was trying to step into his shoes. And I don’t mean substance abuse, I mean trying to take his place, he was always the spark of our, whatever was going on, he was the one who got everybody going...We felt like she was trying to step into his shoes, and our therapist really helped us to deal with that, and helped her to understand that...she is her own person, she should not feel that pressure to take over where he left off.

Danielle described an increased level of closeness among her family members, particularly her husband and two remaining children, “When you lose a family member, it changes the dynamics of your family. I think we’ve all become closer. We needed to support each other, so we’re lucky

that we have that. We all talk a lot.” Given what is known about basic family systems theory, when a piece of the family system changes, in this case having a child passing away, the rest of the system changes as well. This shift is echoed in the data.

Shift in empathy. A common thematic element in terms of post-mortem changes is a shift in empathy for others, ranging from negative to positive. Danielle stated,

I had no empathy [after he died] for my clients. First of all, I was lucky that I could retire. Second of all, I knew that I could not be as good of a social worker. If you can't show any empathy, forget it, so I had to leave.

Contrastly to Danielle, Layla had a different reaction. Her level of empathy for others actually increased. Layla stated,

I kind of am more sympathetic to other people. You look at people on the street different, you look at the person lurking next to you different. You look at people like, people have struggles that they don't even talk about, you know what I mean? That they are dealing with on a daily basis and it just makes you realize that the person who's on the corner every time I walk, I ride past, it is somebody's mother, father, sister, brother that's struggling, you know what I mean? And even though I kind of had that before, because I had a child that was struggling, it's even more that I'm more aware of it now.

These responses indicate a range of responses regarding shift in empathy. It is normal to feel burnt out and have less empathy for others, and it is also normal to feel increased empathy.

Shift in perspective. Just like there is a shift in level of empathy, there is also a shift in perspective, particularly in relation to what parents find stressful and important in life. A common theme is not stressing about the “little things.” Sam stated, “The little things in life just become irrelevant, I don't know.” Layla echoed the same sentiment, “I feel like I'm a different person, like I'm not that same stressed out person, getting upset over minor little things anymore like I used to.” Jim discussed a shift in perspective regarding the nature of the cause of death stating,

There's lots of people who lose kids to all kinds of medical reasons, all kinds of circumstances and accidents, and suicide, and everything imaginable, that you never really want to imagine, but it's there. And what I've come to understand is, we're so much more the same than we are different. What people go through, the way we try to go on with our lives, and the pains and the disorientation that we feel are the same. The method matters so little compared to the outcome.

While losing a child to any circumstance is devastating and life-changing, it is important that clinicians understand disenfranchised, complex grief associated with opioid overdose deaths.

Protracted grief requires ongoing support from family, friends, researchers, and therapists.

CHAPTER V: DISCUSSION

According to this research on parents with a child who has died from an opioid overdose, grief evolves. Parents described grief as something that stays with you, changes you, and becomes a part of one's identity. Grief is not experienced as being linear or finite. Rather grief is protracted and is shown to be an ongoing process of parental adjustment, recovery, and reorganization post-crisis.

Parental accounts of the grieving process coincided with Hill, Boulding, Dunigan, & Elder's (1949) model of the roller-coaster profile of adjustment. According to the interviews, parental and familial reorganization after a child's opioid overdose death matched all of the components of the roller-coaster profile of adjustment model. The interviews all showed there is a period of disorganization post-crisis, followed by a mutable angle of recovery depending upon the parent, and subsequently a level of familial reorganization (Smith & Hamon, 2008; Hill, Boulding, Dunigan, & Elder, 1949). Every parent discussed their own experiences of disorganization, recovery, and reorganization. The ways in which each parent coped with the death, in combination with the support or stigma they received, impacted each parent's angle of recovery.

When looking at the angle of recovery and reorganization it is important to consider Walsh and McGoldrick's (2004) research which posited that marital conflict, mental illness, and behavioral disorders were associated with parents difficulty coping with grief. While partner discord was shown in one parent's interview, it was not shown in the other five. In fact, this current study showed that parents who experienced the loss of a child due to opioid overdose became closer and dealt with their grief in different, yet complimentary ways. Participants had

symptoms of depression, and in one instance suicidal ideation, however it was not clear if this was part of uncomplicated bereavement or was an Adjustment Disorder with Depression.

Like previous studies of bereaved parents (Barrera, et al., 2007; Keesee, Currier, & Neimeyer 2008; Eisma, Schut, Stroebe, Boelen, van den Bout, & Stroebe, 2015; Stroebe & Schut, 2015) the current study found managing one's own regrets, reliance on social support, disclosing cause death, continuing to talk about the death, continuing one's bonds with the deceased, coming to a place of eventual acceptance, and living for the now with new perspectives on life were important factors in bonadaptation post-mortem. Parents who struggled to make meaning of their loss, received less social support, and experienced more stigma were more prone to maladaptation post-mortem.

The results of the current study corresponded most significantly with Wojtkowiak, Vanherf, & Schuhmann's meaning reconstruction model of grief (2018). Their research on parental bereavement matched with parental interviews for this study. Parent's interview responses illustrated all of the components of the meaning-reconstruction model of grief. All of the parents interviewed experienced fragmented grief reactions, social exclusion, disenfranchised grief, acceptance of that death, and meaning making. This last piece, meaning making, was done most consistently through parent's writing, journaling, memorializing, or speaking with one's loved one. Journaling was shown to help parents make meaning through compiling a detailed biography of their loss. The meaning-reconstruction model of grief corresponds with the results of this study. As such, it is important for researchers, as well as clinicians, to familiarize themselves with this model when working with opioid-bereaved parents.

Clinical Implications

Marriage and family therapists have a responsibility to be able to effectively provide treatment to a wide variety of clinical populations. One such population is opioid-overdose bereaved parents. Through this research, the goal is that marriage and family therapists will be better able to serve this population. The study results indicate what therapists are able to do to provide more competent services to parents. Marriage and family therapists must be aware of the emotional toll working with this specific population can take, and practice self-care. Therapists should have their own therapist to process and work through any vicarious secondary trauma.

Partner, familial, and peer support are most helpful in coping with the death of a child from an opioid overdose. The biggest source of support comes from individuals who have experienced the same circumstances. Shared pain is important to feeling wholly understood. Therapists should suggest peer support groups to their clients. Practitioners should also be aware of what support groups are offered in their community or start a support group of their own. There is a need for a greater number of opioid-specific support groups. Parents in the study felt supported being in a group with other parents who had lost a child to opioid overdose.

Parental interviews suggest peer support groups are particularly effective in feeling understood and supported throughout parents' grieving process. As in most cases involving substance abuse treatment, group modalities would appear to work with this population. Group therapy allows participants to share experiences, compare and contrast stories, process their loss, gain valuable insight, experience camaraderie and fellowship, and enhance their social support networks. It would be helpful if the group leader was an in-group member, as this appears to provide an even deeper sense of shared experiences of grief, pain, and loss.

Similar circumstances of death help parents to feel better understood and lessen feelings of shame, judgment, and stigma from their therapist. As such, the therapist would have to process their own child's overdose death thoroughly. The therapist would need to consistently work on managing transference and countertransference during the group. The therapist would also need supervision to monitor this, in addition to taking a candid account of their readiness to lead a group around this difficult subject matter.

Although parents are best assisted by therapists who have experienced the loss of a child to opioid abuse, this may not always be possible. The most effective therapist appears to be one who can demonstrate an inherent understanding of the difficulties associated with this particular form of non-normative loss. Clinicians can be more aware of how to process through non-normative loss with clients by being informed by family stress theory, meeting the client where they are at within the roller coaster profile of adjustment, reading literature on the subjects of opioid overdose and parental grief, familiarizing themselves with the unique aspects of the parental grieving process by finding peer support groups with facilitators and participants who are willing to have clinicians and researcher observe their group process.

Narrative therapy could potentially be useful in working with parents who have lost a child to opioid overdose. For parents in this study, the meaning making process often involved compiling a biography of the loss through the writing of blogs, poems, and speeches. This allows for deeper understanding and insight regarding their child's substance abuse and subsequent passing. The parent's 'thin' narrative would be able to be thickened. The parent would be able to story and re-story their loss, which allows for increased comprehension, as well as more

opportunity to make meaning of the loss. As such, narrative therapy would potentially be an effective treatment modality for parents who have lost children to opioid overdose.

Lastly, it is important to state that working with a parent of a child who has died due to an opioid overdose can be unsettling and difficult for a clinician. Discussing this particular subject matter can cause the therapist to experience secondary trauma. Symptoms of secondary trauma can include compassion fatigue, depression, anxiety, feelings of isolation, physical pain, and sleep problems. As such, it could be important for a clinician working with this population to have a wellness plan in place and practice regular self-care. A possible part of this wellness plan could be the clinician obtaining a personal therapist. This can give the clinician a safe, confidential space to process experiences they hear about from their clients. Just as parents need support, clinicians who work with them could also potentially benefit from a therapist as well.

Limitations

The major limitation of this study is its small sample size. Recruitment of additional parents to be study participants is needed to further explore parental grief after losing an adult child to opioid overdose. Interviewing a greater number of participants would allow existing themes to become more saturated, and new themes to emerge. Due to overwhelming grief parents experience, recruitment can be difficult for this type of study, however finding more participants would help the study to be more comprehensive.

It is important to note that research participants all belong to the same ethnic and racial group. Recruitment of additional participants would hopefully result in a more ethnically and racially diverse sample. Additionally, parents sampled all had male children die from opioid overdose. While this gender disparity is indicative of current fatal opioid overdose trends, it

would be important to sample parents with female children in order to account for similarities and differences associated with the gender of the deceased child.

Future Research

In terms of future research, it would be interesting to look at parental dyads, rather than singular parent interviews. Conducting qualitative research by doing dyadic qualitative interviews, the researcher could compare and contrast parental experiences, as well as investigate the couple dynamic both before and after the child's opioid overdose death. A limitation of this potential study could however be that not all parents are married, and the study could be seen as perpetuating heterosexual norms.

Many parents discussed strains on their remaining children, the siblings of their deceased child, however this particular study only focused on the parents. More research is needed on the subject of sibling grief. As systems theorists look at entire systems, further research must not only consider parental grief, but the grief of members of the family system.

Additionally, given that all of this study's participants are parents of male children, it would be beneficial to conduct a further study in which study parameters limited qualitative inquiries to those with female children who died due to opioid overdose.

Finally, research is needed across state lines to investigate potential differences in responses and reactions to opioids on a state level. It would be beneficial to look at state responses by region, analyzing regional patterns and considering the impact of geographic location on parental grief, particularly experiences related to stigma versus support.

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APPENDIX A: INFORMED CONSENT DOCUMENT
Consent for Participation in Interview Research

The purpose of this study is to explore parents’ experiences of grief and healing after losing a child to an opioid-related cause.

This study will be conducted through Virginia Polytechnic & State University and the researcher has obtained IRB approval to conduct research via qualitative interviews with human subjects.

1. Participation in the study is completely voluntary.
2. Participants can drop out of the study at any time without penalty.
3. Participants will find the discussion interesting, thought provoking, and meaningful.

However, if a participant experiences discomfort in any way during the interview, he or she has the right to decline to answer any question and/or end the interview.

4. Interviews will be held face-to-face at a time and place of the participant's choosing over a time period of 60 days (approximately 2 months).
5. Each interview will last approximately 50-90 minutes per parent.
6. Data will be audio recorded and transcribed verbatim.
 - a. The researcher and participants will review transcripts for accuracy & clarity.
 - b. Participants can access transcripts any time to clarify or redact information.

Participant 1 Signature: _____ **Date:** _____

Participant 2 Signature: _____ **Date:** _____

Primary Investigator Signature: _____ **Date:** _____

APPENDIX B: INTERVIEW PROTOCOL

Each parent will be asked to tell his or her story, beginning wherever he or she sees fit.

The researcher will interview the parent and subsequently analyze the data with the goal of gaining a more comprehensive understanding of parental grief.

The researcher will ask each parent the following open-ended questions:

1. What has been your experience as the parent of an adult child who has died from an opioid overdose?
2. What resources have you utilized?
3. What has your experience of parental bereavement been like?
4. How has life changed since your child's death?

Overall, this study aims to provide insight into parental grieving, coping, and bonadaptation versus maladaptation post-bereavement. By conducting in-depth semi-structured interviews with parents of the deceased, this study hopes to provide information regarding grief trajectory, healing processes, experience of stigma and/or support, and experience of state and local services. This information is necessary in order to provide more effective therapeutic services to the specific population of opioid-bereaved parents.

APPENDIX C: PARENT DEMOGRAPHICS TABLE

Pseudonym:	Anne	Sam	Jim	Paula	Layla	Danielle
Q1: Age	64	60	54	55	55	60
Q2: Age at passing	59	55	51	52	49	57
Q3: City, MD	Ellicott City	Ellicott City	Ellicott City	Ellicott City	Glen Burnie	Bethesda
Q4: County, MD	Howard	Howard	Howard	Howard	Anne Arundel	Montgomery
Q5: Race	Caucasian	Caucasian	Causasian	Causasian	Caucasian	Caucasian
Q6: Ethnicity	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White
Q7: Religion	Catholic	N/A	N/A	N/A	Catholic	Catholic
Q8: Current Rx Status	Married	Married	Married	Married	Divorced	Married
Q9: Sexual Orientation	Heterosexual	Heterosexual	Heterosexual	Heterosexual	Heterosexual	Heterosexual
Q10: Level of Education	B.A.	B.A.	2 Masters & J.D.	B.A.	A.A.	Masters
Q11: Occupation	Insurance Sales	Insurance Sales	Attorney	Educator	Nurse	Social Worker
Q12: Yearly income	30,000	200,000	200,000	35,000	85,000	Retired

* All parent names are pseudonyms given to ensure confidentiality and anonymity.

APPENDIX D: CHILD DEMOGRAPHICS TABLE

Pseudonym:	Mark	Mark	Riley	Riley	George	Jake
Q13: Age at passing	23	23	23	23	32	27
Q14: City, MD	Ellicott City	Ellicott City	Ellicott City	Ellicott City	Glen Burnie	Bethesda
Q15: County, MD	Howard	Howard	Howard	Howard	Anne Arundel	Montgomery
Q16: Race	Causasian	Causasian	Caucasian	Caucasian	Caucasian	Caucasian
Q17: Ethnicity	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White	Non-Hispanic White
Q18: Religion	Catholic	Catholic	N/A	N/A	Catholic	Catholic
Q19: Sexual Orientation	Heterosexual	Heterosexual	Heterosexual	Heterosexual	Heterosexual	Heterosexual
Q20: Level of Education	One semester short of Bachelor's	One semester short of Bachelor's	HS grad/some college	HS grad/some college	Some high school	B.A.
Q21: Occupation	Student	Student	Driver, Sales, Recovery House Manager, Marketing	Driver, Sales, Recovery House Manager, Marketing	Disability	Teacher/Coach
Q22: Yearly income	N/A	N/A	Episodic work only	Episodic work only	17,000	unknown

* All child names are pseudonyms given to ensure confidentiality and anonymity.

APPENDIX E: THEMES TABLE

<i>Overarching Theme:</i>	GRIEVING PROCESS	SUPPORT	STIGMA	PARENTS SHAME & GUILT	COPING	STATE AND LOCAL SERVICES	LIFE CHANGES
<i>Subthemes:</i>	Shock & denial	Partner	Self	General	Bibliotherapy and writing	First responders (+, -)	Shift in family system
	Depression & sadness	Friends and family	Familial	Parental	Maintaining connection	Law enforcement (+, -)	Shift in empathy
	Anger	Peer-to-peer support groups	Societal	No Guilt	Memorialization, rituals, and signs		Shift in perspective
	Triggers			Unanswered Questions	Community building and activism		
	Acceptance and meaning making						