Sibling bereavement when death is drug-related: A qualitative study

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Name: Julie Perrin
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Acknowledgements

When I first embarked on this research venture, I recall attending an orientation seminar for higher research degree students. The mature aged woman speaking had just graduated with her PhD. She said it had taken ten years to complete. This comment has stayed with me. It was not something I wanted for myself but with births and deaths in my family, interstate and international moves, adolescent rearing, grandmotherly doting, and work commitments, I find myself in the same place more than ten years later!

Research of this nature cannot be done without a decent cheer squad. My cheer squad are my many friends who dare to ask if I have finished yet. They are the ones who want to read this thesis, who listen to me talk and continue to be genuinely interested. You know who you are! Cheering the loudest in my corner have been my husband – Ewan – and my daughter – Jacqueline. They have listened, consoled and encouraged me and helped celebrate the little wins along the way. It is Ewan more than any other person who has shared this experience intimately and intensely with me, he made room for the research in our already full lives, has been solid beside me and bolstered me when I have been plagued by self-doubt. Also cheering me on, with a firm steady hand, providing the guidance I have needed every step of the way, are my research supervisors Susan and John. We have worked as a team. I don’t know how it happened, but I am so fortunate to have had them with me for the last decade. More than anything, their unflinching belief that my research is of value to the helping professions has been inspirational. My cheer squad has truly sustained me and for that I am deeply appreciative.

My research topic is focused on sibling bereavement. Like so many people who research or practice in thanatology, my interest is born out of personal experience. I wanted, in part to understand the experience of my three children Joshua, Joel and Jacqueline when their brother Geordie died. I also wanted to add to the body of knowledge in a neglected field of practice.

Finally, to the 21 people who contributed to this research project I am sincerely grateful. Without you there would be nothing to write. You trusted me to represent and interpret
your stories. I have revisited our conversations so many times your stories are etched into my mind. You all helped me to understand the gravity and profound richness of your experiences, and the enduring nature of the sibling relationship after death. As one person said, “I always have a brother”.


Ethics approval

In accordance with the National Health and Medical Research Council’s *National Statement on Ethical Conduct in Human Research (National Statement)*, the Charles Sturt University Human Research Ethics Committee approved this research on 18 July 2013. The protocol number issued for this project is 2013/133 (Appendix 1).
Professional editorial assistance

Paid editorial assistance was obtained, with written permission from my supervisor, by Ross Peake who is a professionally trained copyeditor and proofreader who specialises in the humanities and social sciences. Mr Peake’s work was limited to formatting, grammar and style, as per the Australian Standard for Editing Practice (ASEP) Standard D – Language and Illustrations and ASEP Standard E – Completeness and Consistency. Mr Peake did not alter or improve the substantive content or conceptual organisation of the thesis.
Abstract

This research develops a rich understanding of the participants’ experiences of sibling bereavement when the brother or sister dies for a drug-related reason, and informs social work practice theories in bereavement, drug and alcohol, and families. The sibling relationship is one of the four significant lifetime attachment relationships formed alongside parents, partners, and children, yet the relationship receives less attention in research and practice. This qualitative study uses Gadamer’s philosophical hermeneutics to guide all aspects of the research project. Hermeneutic phenomenology concerns the interpretation of experience; philosophical hermeneutics includes an additional component which is the phenomenology of understanding – how understanding occurs in the first instance. Therefore, philosophical hermeneutics presents a dual process of how understanding occurs, and understanding the experience.

The study involved 21 people, all of whom described the death of their sibling as drug-related, and had been bereaved for longer than five years. Conversations revolved around their experiences using a semi structured interview. The analysis was undertaken using three distinct fields of practice (horizons) – thanatology, drug and alcohol, and family therapy. This yielded 63 interpretations of the same experience from very different standpoints. The key outcome of the research resulted in multiple ways to understand a situation. Taking different standpoints to intentionally alter the view, brings with it flexibility, making room for new possibilities, new ways to understand, new ways to support, and new ways to act.

In all the fields related to this research, it is apparent there is much to be gained by tuning into the sibling. In thanatology, sibling bereavement is an intense life-changing event, carrying implications throughout the lifespan. The magnitude and extensiveness of change that occurs for the individual and family, and the secondary losses experienced, are deserving of public attention, recognition and emphasis, in theory and practice. The notion of disenfranchised grief is a critical concept in the research because it publicly and privately silences bereavement and makes the experience ‘less than’. In the drug and alcohol sector, where a drug-related death is often a stigmatised death, it is also subject to
disenfranchisement. The sibling is sadly neglected. For example, the stress and worry experienced by siblings can be extraordinary but also their potential as a resource is currently unrecognised and, therefore, under-utilised. The sibling relationship is nestled within the broader family culture, which is intricate and nuanced, with intimate knowledge of all family members. There is a need to be respectful that drug use and death are family affairs; understanding the family culture and how the family protects individual members and the family as a whole is critical. By also emphasising the benefits of ongoing connection and belonging, the involvement of families and siblings in the drug and alcohol field is encouraged.

Highlighted in this study is the stigma associated with drug use and how it reverberates through all relationships. Harsh judgements are made of individuals, their siblings and family. The research findings show that protective responses are instigated to shield relationships, driving duality and secretiveness and forcing silence.

Through in-depth analysis of the sibling relationship, in the context of drug use and bereavement, this research is thought provoking while promoting newer, broader and deeper understandings in the fields of thanatology, drug and alcohol and family therapy. Recommendations are made for social workers in regard to the significance of sibling bereavement. These include: the disenfranchisement of sibling bereavement when their brother or sister dies for a drug-related reason, how family culture shapes the sibling relationship, and impact of drug use on the family, the stressors endured by the siblings and the family through drug use, and the stigma that flows from drug use to death and bereavement. Social workers are also reminded through the research that there are always multiple ways to understand a situation.
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Chapter 1: Introduction

Background to the study

The sibling relationship is unique and imbued with the complexities of family life and depth of knowledge, however, it is not often given attention in research on bereavement, drug use or families. This research project explores the experience of sibling bereavement when the brother or sister dies for a drug-related reason. When considering the phenomenon, it becomes apparent there are three discrete subject areas within this study – drug and alcohol use, the sibling relationship and bereavement – therefore it is helpful to understand the three subject areas. While the primary focus of the research is to look at the nexus, the point of overlap, between all three subject areas consideration will also be given to sibling relationship overlapping with bereavement, sibling relationship overlapping with drug and alcohol use, and the bereavement overlapping with drug and alcohol use. The purpose of the research seeks to understand the experience for these siblings and as such, it is a phenomenological study falling into the category of qualitative research. An understanding of siblings’ experiences when their brother or sister dies for a drug-related reason is augmented by understanding some of the key issues and gaps in knowledge for the three discrete subject areas. In the next three paragraphs, beginning with bereavement, I have summarised these issues and gaps and demonstrate how I used the information to guide decisions about the research design.

I began thinking about sibling bereavement almost two decades ago amid my own bereavement, following the death of my eldest son in a car accident. Reviewing the theory and practices surrounding grief and loss for my Honours thesis helped me understand my own bereavement but simultaneously piqued my interest regarding my children’s experience of their brother’s death. As I became more interested in their experience, I realised there was a dearth of information on sibling bereavement. As their mother, I knew that my other three children all experienced their brother’s death differently. When I decided to engage in doctoral studies, it seemed a natural progression for me to focus on sibling bereavement. That said, I was also keen to draw on my professional experiences in the fields of drug and alcohol, and family therapy; accordingly, the research topic of ‘sibling bereavement when death is drug-related’ was developed.
My interest in family therapy has been ongoing since initial training in relationship counselling during the 1980s and again later when I completed a Master of Social Work in advanced practice specialising in couple and family therapy. Family work has always fascinated me. Not only is family work more about people in a relational context and working from a systemic perspective, but I also find it more challenging and complex than individual work.

For more than 35 years, I have worked in the drug and alcohol sector. I complemented my work experiences with study and, in 1995, graduated with a Master in Primary Health Care specialising in the addictions. My work experiences have been in government and non-government sectors in both community and inpatient settings. In direct practice roles I have worked with people in withdrawal and on opioid replacement pharmacotherapies and have offered counselling. In indirect roles I have worked in educational or health promotion, professional consultation, research, and policymaking, with a significant amount of time in management roles.

For many years in the 1990s, I occupied a senior management role and was actively involved in numerous national committees/working groups. Nationally, in the 1990s, there was discussion about heroin trials which led to services participating in multicentre clinical trials using other drugs like buprenorphine to manage heroin dependence and withdrawal. New treatment interventions are common in the drug and alcohol sector and, during this time, court-based treatment referral services, sobering up places and services for families were introduced. It was also during this period that heroin available in Australia was known to be purer and as a consequence many people using that drug died, including many long-term users. The plight of the parents and other family members with whom I had contact left me thinking that we (the system and the way services are provided) were lacking in the way we managed, designed and implemented services and processes.

In 2000, I was in need of a change, I left the workforce and returned to study, this time to anthropology. A year later my son died. The ‘rug was pulled out from under my feet’ and my
study suffered. Every day was consumed with just living. After failing to regain any study momentum, I returned to part-time work in a rural community health service, as a drug and alcohol clinician and began studying social work by distance education. Four years later I took up more part-time work at Relationships Australia as a family therapist, until I opened a private practice as a mental health accredited social worker. Today I describe myself as a social worker specialising in mental health which encompasses drug and alcohol, relationship work, and bereavement. It seemed natural that I would draw on my experiences in those fields of practice for the purposes of further higher degree study.

It is a combination of working as a social worker in direct practice, considering ideas revealed by a review of the literature, as well as my personal experience, that led me to decide that I would not tell participants in any research project about my son’s death. This is not a decision I made lightly and the decision takes account of multiple factors. First is my desire to do no harm to participants while doing the research. I am acutely aware that sibling bereavement is often viewed as lower on the bereavement hierarchy in comparison to other significant relationships, and I did not want to reinforce that perception. The sibling relationship is an attachment relationship, one of the four significant attachments we will have in our lifetime –siblings, partners, parents, and children. Hence, the idea of a hierarchy leaves me feeling uncomfortable. Marshall (2013) refers to it as a disenfranchised loss where, “our society, through many prominent institutions, promotes the idea that siblings are not primary griever’s” (p. 13). One of my children reflected to me recently that my experience as a parent was probably worse than his. In response I wondered, where does this leave him with his experience? My heart aches for my children enduring their brother’s death, their own bereavement and the permanent changes to their family while continuing to move through the lifecycle; such a difficult experience to have had for each of them. Second, over the years since my son died, I have noticed a pattern when I am talking to others about death and bereavement where parental bereavement seems to become elevated as ‘the’ bereavement over all other bereavements experienced, including those of partners, children and siblings. Despite reflecting on these conversations, I am not sure how the privileging comes about; I have not been able to discern when or how it creeps into the conversation. As I do not have sufficient awareness of the processes that allow this to
happen, I could not guarantee it would not happen during the research interviews. I thought of possible strategies that might help if this occurred. One of the things I do with other people when we talk about death is to ‘make light’ or ‘brush off’ my bereavement by saying something like, ‘oh it was a long time ago now’, as a means of getting the focus back onto the person; however, I thought this could be perceived as disingenuous by the participants, especially as the study is about their bereavement experiences. I was clear the interviews needed to remain focused on the person being interviewed; therefore, the best strategy was to not mention my bereavement experience. Prevention seemed a far better option than remediation in this circumstance.

While having my own experience of bereavement does not make me an expert in the field of thanatology, it does make me an expert on my own experience. The decision not to discuss my son’s death is not the same as denying my experience. My bereavement is well and truly woven into every part of who I am today, and I cannot unthread this part of myself. I found that during the interviews, I could draw upon my experiences and convey understandings by offering some words that may resonate with the person. That said, I remained alert to the potential for me to overlay my experiences about bereavement through tentativeness, curiosity and openness with the person with whom I was in conversation. Some of the people I interviewed may have had prior knowledge of my experience or surmised as much during the interview, but this was not articulated by me, and the focus remained squarely on the person. I can only hope that any participants reading this report can understand my decision.

By now I think my interest in the research topic will be obvious. I am influenced by a combination of work experience, personal experience and study. These are three areas of work in which I specialise and topic areas about which I feel passionate.

**Structure of the report**

Following the introduction chapter to the thesis, chapter two presents the literature on what is known about sibling bereavement when a brother or sister dies for a drug related reason.
In chapter three, the theoretical orientation is outlined, including a detailed consideration of the ontology, epistemology and axiology that inform my work. This consideration necessarily informs my research interests, and segues into the underpinning philosophy guiding the research project. In chapter four, Gadamer’s philosophical hermeneutics is examined and explained. In this chapter the reader is introduced to the dual nature of Gadamer’s philosophy in terms of understanding experience as well as the phenomenon of how understanding is possible.

Chapter five describes all aspects of the research design as underpinned by Gadamer’s philosophy. In this section some of the challenges experienced are explored, including recruiting people to the study and analysis of the research material.

Chapters six to eight are large chapters. They form the body of the thesis, containing findings, analysis and discussion. Each chapter is structured in the same way, highlighting topics of conversation, the interpretative process in identifying the familiar and the new, discussions on each topic, and a chapter summary of all new understandings. Each chapter examines the participants’ experiences through specific subjects; the horizons of bereavement, drug use, and family. Each of these horizons provides a very different view for interpreting the experiences, therefore yielding numerous insights.

The final chapter, chapter nine, pulls together the new understandings. Here the research questions are revisited, and the new understandings from each horizon are combined and presented. This chapter concludes with recommendations for the helping professions in bereavement, drug use, and family work.

The literature review which follows is organised to be consistent with the large chapters of the thesis. Therefore, the review investigates and reports on the three discrete subject areas namely bereavement, drug use, and family. In the process of reviewing the literature, gaps in knowledge are identified, thus informing the research questions for this project.
Chapter 2: Literature review

Introduction
The literature review is organised into three sections, with each representing a discrete field of practice and research: bereavement, drug and alcohol, and family therapy. The structure of each section is the same: definition of terms relative to the field, examination of the overarching literature informing these fields of research and practice, review of the specific literature available on siblings, and a summary of key findings. In this latter part of the review, I introduce some initial analysis and reflection, particularly about gaps in the literature, and build towards the justification and formation of the research questions.

Bereavement
In this section I begin with definitions used in thanatology and then move to an overview of the literature. In considering the sociocultural context of thanatology research and social perceptions of bereavement, I outline the influences from both Freud’s work in 1917, and Kübler-Ross’s work in 1969. Kübler-Ross (1969) built on Freud’s work and in doing so set the stage for the pathologising of bereavement. In direct contrast to ideas that pathologise bereavement, is the literature on continuing the bonds, where interacting with the dead is seen as normal (Klass, 2006), as are resilience, growth and learning to live with grief; all of which align with some of the research findings on sibling bereavement. Special attention is given to Davies (1999), who is one of the earliest and most prominent researchers on sibling bereavement. The section finishes by examining the Packman et al. (2006) research that applies the concept of continuing bonds (inclusive of attachment theory) to sibling bereavement.

Sibling bereavement falls into the realm of thanatology which is the study of death, and the related phenomena and practices (Doka et al., 2011). There is broad literature informing this field of study and numerous terms are used, often interchangeably, such as mourning, grief, and bereavement. Stroebe et al. (2007) define ‘grief’ as the private internal emotional reaction to the death of a loved one or loss of something important; and ‘mourning’ as confined to the public sociocultural expressions around the death of a loved one such as funerals (Stroebe & Schut, 2008). Buckle and Fleming (2011) define bereavement as the rupture of a loving relationship through death. Based on these definitions and the fact that
my research is focused on the sibling relationship, I have used the term bereavement throughout the thesis as it locates the experience in the relationship and is inclusive of both the personal and public experiences.

There is extensive research literature on bereavement that is focused on population groups; their contexts, consequences, coping, caring and interventions (Neimeyer, 2001; Neimeyer et al., 2011; Stroebe et al., 2001). In addition, there is much debate in the literature regarding what constitutes ‘good research’ about bereavement, with many authors arguing for improved scientific design in terms of methods, measures and interventions to ensure reliability and validity of that research (Currier & Holland, 2007; Neimeyer, 2000). There is also a call for long-term follow-up studies that measure various life domains, as much of the research is temporally located around the time of death or soon after, that is, within 12–24 months (Currier & Holland, 2007). This is possibly because retrospective quantitative studies are difficult to validate and longitudinal research designs are expensive. Overall, quantitative studies have dominated the type of research produced and been concerned with the assessment of the individual’s grief, treatment and the psychopathological processes (Parkes, 2011). In their review of both quantitative and qualitative bereavement literature, Neimeyer and Hogan (2001) advocate for more qualitative research as a means of painting “a picture of bereavement that is far more complex and less tidy than that suggested by the artificially simplified and controlled canvasses of quantitative questionnaires” (p. 113). The use of qualitative research methods has deepened theoretical understandings about the bereavement experiences for individuals, in terms of age and gender, and also about social situations including in families, communities and other cultural contexts (Parkes, 2011). This overview of the literature suggests two things – there is a gap in knowledge around bereavement in the longer term and there is a gap in qualitative research aimed at understanding the experiences of bereavement. These gaps informed my decision to undertake a qualitative study aimed at understanding the experience of bereaved people more than five years since the death. In summing up the development of bereavement studies over the years, Parkes (2011) says that bereavement can be problematic personally but can easily disrupt social systems as well.
Giljohann and Norrish (2010) contend that how bereavement is expressed is influenced by cultural, social and familial contexts. Situations like anniversaries, and rituals around anniversaries, can allow for the controlled renewed grief reactions or mourning (Ribner, 1998). Ribner (1998) contends there is no specific end to bereavement, and grief recurs particularly at the time of death, on birthdays or other special dates, albeit less intensely as time passes. Others are stronger in their views that in contemporary western societies we are remote from death and death-denying (DeSpelder & Strickland, 2015). So, even though death is an inevitable, natural and an expected part of life, it has been removed from public view and conversation (da Silva et al., 2007). McBride and Simms (2001) posit that we live in a form of “institutionalised denial, fostered by a declining influence of religion and its rituals, the lack of education about bereavement on all levels, and a media-induced positive characterisation of people who push on despite loss” (p. 60). Da Silva et al. (2007) argue that seeing death as separate to living and keeping it segregated (for example, in the hospital setting) means that we have a reduced capacity to deal with the stress of grief and the disruption to family functioning.

The above views resonate for me and my experiences, and make me curious; when death is really an integral component of life, how is it that we have arrived in this death-denying place? Berzoff (2011) sheds some further light. She contends that Freud’s work dominated the approach to bereavement for the best part of the 20th century with the presuppositions that ‘grief work’ and ‘letting go’ essentially constitute good grieving. Grief work in this context is about truly feeling or confronting the intensity of the grief with the aim of ‘letting go’ (decathexis, disconnecting, detaching or withdrawing energy) from the attachment relationship, that is, with the person who died, so as to reinvest or re-engage in the living and/or to love again (Berzoff, 2011).

Early in the 1960s, another influential contributor to thanatology was psychiatrist Kübler-Ross. She emerged on the scene, building on Freud’s presuppositions of grief work, with the purpose of letting go through grief work. She thought death had been hijacked by the medical profession; that it was not talked about (especially not with the patient who was dying) but removed from normal life; to be treated in hospitals (Kübler-Ross, 1975). She
wanted to bring about change for palliative patients and began giving seminars which consisted of her interviewing, behind a two-way mirror, terminally ill hospital patients (Kübler-Ross, 1975). It is through these interviews that Kübler-Ross (1973) identified various stages that people seemed to work through before death, that is, denial, bargaining, anger, depression and acceptance. Her model outlined responses/emotions that people might expect to go through, with the final stage of acceptance being in line with Freud’s notion of decathexis (Kübler-Ross, 1973).

Similarly, other theorists have built on these ideas of letting go and moving on, by outlining various phase and task models (Worden, 2003; Parkes, 1998; Raphael, 1990). Kübler-Ross’s ideas of letting go through grief work have permeated popular culture and shape how we perceive bereavement (Breen & O’Connor, 2007). See for example, her five stages of grief featured in an episode of the Simpsons (accessible on YouTube 30/11/2017 https://www.youtube.com/watch?v=1tHy1IbJLrg). I highlight her model as people may think they have not grieved properly when they have not ‘let go’. In this situation, people might judge themselves as having normal or abnormal reactions to bereavement (Breen & O’Connor, 2007), which could be relevant to my research.

Notions of letting go through grief work still feature in thanatology, including cultural theories that can “constrain, confine, and pathologise the experience of grief” (Moules et al, 2004, p. 99). The experiences of grief often contradict cultural expectations whereby, “complicated grief (CG), also termed prolonged grief disorder (PGD) and traumatic grief described in the published literature is a painful and impairing condition ... people with this condition experience prolonged acute grief symptoms ... persistent feelings of intense yearning or preoccupation with the deceased, shock, disbelief and anger about the death, feeling that it is difficult to care for or trust others and impairing behaviours to try to avoid reminders of the loss or to feel closer to the deceased” (Shear et al., 2011, p. 139). The literature identifies two factors that place people at risk of CG which are relevant to my study: the circumstances of the death (that is, untimely, preventable, violent), and the context (for example, poor social support) (Shear et al., 2011). Recent studies during the COVID-19 pandemic on bereavement confirm the deleterious effects of sudden and
unexpected death (Breen et al., 2022). CG in the pandemic context is exacerbated by unfinished business leading to guilt and regret to prevent death or care for the person with COVID-19 at the time of death (Breen et al., 2022). Although, it is worth mentioning that Breen et al. (2022) found in their research that dysfunctional grief symptoms (CG) were mediated by the capacity for meaning making that is, accessing the back story of the relationship with the person who died with the aim to continue to the bond and address unfinished business. Complicated grief is pertinent to this study given that when someone dies for a drug-related reason, their death is often considered untimely, preventable and judged socially; therefore, care needs to be exercised in the contact with people contributing to this research project.

In direct contrast to the pathologising of bereavement is the contention that most people endure bereavement well, and resilience is a commonplace response (Bonanno, 2004). Breen et al. (2019) normalise the experience of bereavement noting that no one is immune to bereavement. By focusing on resilience means shifting the gaze from deficits to growth (Walsh, 1998). Resilience is defined broadly as the ability to overcome life’s challenges, emerge from adversity both strengthened and more resourceful, and heal and take charge of life to live life well (Walsh, 1998). Resilient people are hardy individuals who possess a self-belief that they have some control over their experience, are involved or committed or connected to activities in their lives that give meaning to their lives, and view change as an opportunity for growth (Bonanno, 2004). Resilience and hopefulness are interconnected, in that those who are more hopeful manifest more resilience, and when people see themselves as resilient, more hopefulness is developed (Weingarten, 2010). So, while bereavement in part represents a hopeless despairing state, Morawetz (2007) contends a realistic hope for the bereaved is not ‘getting over’ the death but learning to live with it. Similarly, Frankl (2006) wrote about hope, saying, “it was a case of getting them to realise that life was still expecting something from them” (p. 79). The ideas of hope and resilience are interesting issues to explore in my research project.

In the preceding paragraphs some of the broad concepts in the bereavement literature are presented, including the concepts of grief work, letting go, pathologising grief, as well as the
alternate literature on normalising grief. Within this broader context lies the specific research literature on sibling bereavement, which has been developing for the past 15–20 years. However, I note that while sibling relationships are one of the major attachments formed during the life cycle, relatively little attention has focused on sibling bereavement as compared to other significant attachment relationships, for example, death of a child, parent or partner. The research that is available makes evident the ongoing nature and significance of bereavement for siblings.

Balk and Corr (2007) show there are negative outcomes for bereaved siblings such as depression, illness, and disturbances in interpersonal relationships. Buckle and Fleming (2011) state that bereaved siblings feel different, have a perception that the locus of control is external to themselves, feel vulnerable in the world and/or have a low self-esteem, that is, a sense of worthlessness. However, what remains unclear is whether these negative impacts are pervasive or time constrained.

In contrast, Batten and Oltjenbruns (1999) found in their research that the death of a sibling is a crisis from which growth is possible, as there is time for reflection; the change is permanent, after a period of psychological turmoil. Balk (1991) came to similar conclusions when studying bereaved adolescents’ coping and adaptation processes. He argues that when an adolescent is mourning the loss of their sibling, the meaning of life and death become prominent issues because trust in the benign innocent universe is shattered. Balk (2004) suggests, after experiencing the death of a person with whom they had a close attachment relationship, there cannot be a return to the previous state; the person is forever altered. Similarly, Buckle and Fleming (2011) reported that bereaved siblings are often perceived as resilient and wise beyond their years by their parents. Resilient adolescents use life crises (that is, a threat to wellbeing which can harm) as vehicles for personal growth (Balk, 1991). Many other young people endure sadness – the adversity of death – and, in doing so, are reported to have the following qualities: an appreciation for life, a maturity beyond their years, more empathetic and able to listen to others, improved problem solving skills, better academic performance and sound moral values; they value life, and therefore are less likely to take risks, especially during adolescence (Balk, 2004; Buckle
& Fleming, 2011; Davies, 1999; White, 2006). Many of these studies occur soon after the sibling’s death. Understanding the longer-term experience of sibling bereavement, in terms of their recollections of the immediate experience and how experiences change over time, will add to the literature in this area.

Davies (1999) is one of the most recognised authors on the topic of sibling bereavement, producing ground-breaking work which still informs current thinking. Using grounded theory methodology, her research focused on sibling bereavement from cancer during childhood, and extended over 15 years. She emphasises both the complexity and lifelong impact of sibling bereavement, identifying that a sibling’s response to the death of a brother or sister is based on three contextual variables that include: the circumstances of death, the characteristics of the individual child and their environment, for example, the family. Davies (1999) noted it was relatively unknown what happens to bereaved siblings in the longer term. Her follow-up research with siblings 7–9 years after death found that siblings often experience sadness years after the death. This experience is similar to that observed in Rosenblatt (2017) reports in his study of personal diaries written in the 19th century, finding “grieving generally is not a constant, but repeatedly wanes and then becomes intense” (p. 622). Oltjenbruns (2007) identified the ‘regrief’ phenomenon that, as children develop, they re-experience the grief and loss associated with their sibling’s death and must renegotiate their relationship with the sibling who died as they move through various developmental stages (Oltjenbruns, 2007; Packman et al., 2006). Davies (1999) identified the far-reaching effects of bereavement for siblings, for example, making significant life choices, results in an appreciation of relationships and life more generally. Across a span of at least 25 years, the potentially negative or positive lifelong impact of sibling bereavement seems evident in this literature. However, it may be possible to develop these ideas further by speaking with bereaved siblings where time from death extends beyond two or more years.

In recent years, Freud’s idea of letting go through grief work has been contested. In 1996, Silverman and Klass applied attachment theory to bereavement, and argued that bonds with the person who died should be continued by constructing ongoing symbolic connections and mental relationships. From this perspective, the goal is to integrate the
relationship with the person who died, into ongoing life in a different way from when they were alive (Klass, 2001). Sometimes, the family interactions help to make sense and attach meaning to the death of their family member (Nadeau, 2002). Hedtke and Winslade (2004) suggest the rationale is concerned with when the person was alive – their absence did not affect love bonds or mean the person was not in our world. Thus, death should not sever the relationship, and the purpose of grieving should not be to ‘let go’ (Hedtke & Winslade, 2004). Forte et al. (1996) explain that if we accept reality is socially constructed, then it is through our interactions with others that we develop understandings of who we are, that is, our identity. Therefore, significant others (that is, those to whom we are attached) in our lives become an ‘extension of our sense of self’ and, if we pursue the idea of disconnecting from the attached person who died, then our understanding of the world disintegrates (Forte et al., 1996).

Packman et al. (2006) drew on the concepts of continuing the bonds in their research on bereaved siblings. They found there are six ways whereby siblings maintain the relationship with their brother or sister. These are: regretting (wanting to have a better relationship); endeavouring to understand (search for reasons); catching up (asking how they are in heaven); reaffirming (loving and missing); influencing (seeking guidance) and reuniting (in heaven). The authors note that many bereaved siblings believe their dead sibling is with them, like a guardian angel, and may extend that connection by wearing their sibling’s clothing or keep their sibling’s possessions present and/or have photos or poems in honour of their sibling’s life. In this way, their sibling continues to travel through life with them (Packman et al., 2006). Another way of continuing the bonds is through rituals such as looking at memorabilia or photos, lighting a candle or having a special dinner to share stories (Ribner, 1998). Ribner discusses the role of rituals, noting they provide a structured and socially sanctioned opportunity for the re-emergence of grief and its expression. He contends that the continued repetition and re-emergence of mourning on an anniversary can help in the mastering of grief over time. All these practices ensure the sibling continues to have a presence and to be connected in meaningful ways (Giljohann & Norrish, 2010).
In the first section of this review, I began with definitions of terms used in thanatology. Given bereavement describes the rupture of a loving relationship through death, I decided to use the term throughout my research. In reviewing the broad literature, I explore how Freud and Kübler-Ross have both shaped, and been shaped, by sociocultural views and research agendas in thanatology. In reviewing sibling bereavement literature, my research is informed by notions that most people endure death well, that sibling bereavement has a lifelong impact with ongoing connections being maintained with the sibling. I conclude that qualitative research with bereaved siblings two years or more after death, focused on capturing their experiences and changes to these experiences over time, could be a useful addition to the thanatology field. I also note that care needs to be exercised when doing research with bereaved siblings where the death is drug-related because their brother or sister’s death is likely unexpected, untimely, and socially may not have been well supported.

Drug use
This section of the literature review focuses on the field of drug and alcohol research and practice. I employ a similar framework as used in the bereavement section above. Hence, I begin by defining the term drugs and then move to explore the varied meanings of drug-related death. I also draw briefly on social construction theory to discuss cause of death and, to a lesser extent, drug and alcohol use. I also consider other models used to understand drug use in contemporary Australian society. Due to the limited nature of the literature on sibling drug use, I review the more general literature on families. The first part of the review looks at the influences from within a family on children to use drugs, and the second part follows with the impacts of the adolescent’s drug use on the family. I also review the available literature on drug-related death and other similar causes of deaths (in terms of ramifications) such as suicide, within the family context.

In the drug and alcohol field, reference to ‘drug use’ does not describe drugs that are prescribed for infections, mental health conditions (such as bipolar disorder) and other physical ailments. The term ‘drug use’ usually refers to the use of chemical substances – legal or illegal – affecting the central nervous system, causing changes in behaviour and/or mood (Muller & Schumann, 2011). This definition is inclusive of the use of alcohol. Drugs in this sense are psychoactive substances which depress, stimulate or cause hallucinations.
Drugs can also be referred to as substances; I have used the term ‘drugs’ throughout this thesis to refer to all psychoactive substances, including alcohol.

Conceptualising this study, I thought initially that the term, drug-related death, was straightforward, meaning what it says – that death occurs due to direct or indirect effects of drug use. In hindsight, nothing is ever straightforward; there is always some unpacking to do. I discovered that ‘drug-related death’ can mean many things. In a United Kingdom study reviewing some 2000 drug overdose registered deaths, the term ‘drug-related death’ is broad and includes six categories: a) death due to drug overdose where the drug toxicity causes death such as respiratory depression, b) death due to accident or trauma where intoxicated behaviour causes death, for example, traffic accident or drowning, c) drug toxicity which impacts on a pre-existing medical condition not related to drug use such as asthma, d) drug toxicity which causes a medical condition such as hepatitis B or cirrhosis of the liver which then becomes the cause of death, e) drug use which causes an acute infection which is the cause of death such as endocarditis, and f) drug intoxication causing hypothermia or aspiration of gastric contents (Webb et al., 2003). These six categories reflect the breadth of the term ‘drug-related death’, alluding to both the direct and indirect effects of drug use, and other factors associated with a drug-using lifestyle and/or intoxication.

In Australia, the Australian Bureau of Statistics (ABS) uses data to produce various reports on drug-related deaths by analysing cause of death and other issues using the International Classification of Disease version 10 (ICD 10) codes (WHO, 2019). However, it is not possible to compare reports as different ICD 10 codes are used for different reports. This makes evident that there are multiple variations in how a death is certified and coded, and which codes are counted or not counted in various reports. Therefore, reports need to be scrutinised in order to understand what the data represents. It also shows there is no simple way to ascertain how many people die for a drug-related reason each year in Australia.

In my study, the definition of a ‘drug-related death’ is deliberately broad, including death due to legal or illegal substance use or a mix of both and/or the direct or indirect
physiological effects of drug use in the short or longer term and/or accidental or intentional drug use. In a sense, the people who contribute to the study and use the social construct of ‘drug-related death’ to interpret their sibling’s death, will further define the meaning of this term. This position acknowledges that ‘drug-related death’ is a social construct that probably goes beyond the cause of death to describe a way of life that may be pertinent for the sibling and/or draw attention to the tensions of having their sibling’s death described this way.

In terms of drugs being a way of life, many Australian drug and alcohol agencies use an instrument with clients called the Australian Treatment Outcome Profile (ATOP) to measure their ongoing drug use, general health and wellbeing (based on various life domains such as physical health, mental health, financial, employment and education, housing, legal and relationships) (Lintzeris et al., 2020). The reason for mentioning the ATOP here is that it confirms that drug use extends beyond just the person using the drugs. The various life domains noted above will likely be addressed by families, such as mental health issues, relationship breakdown and/or financial difficulties and public institutions such as public health system, Centrelink and/or the criminal justice system. Dyregrov et al. (2020) report that “activities related to drug use are given higher priority than responsibilities to family and friends” (p. 416). I anticipated hearing about some or all these issues when speaking to siblings.

Turning to the specific drug and alcohol research produced in Australia, I found a volume of work, but relatively little attention, given to families and even less to siblings. In Australia, research on a person’s drug use and subsequent death as experienced by their sibling, is not available. However, in the past decade a limited number of studies on the topic of drug related death have been published in Scandinavia, United States, United Kingdom and Brazil (Dyregrov et al., 2020). The drug and alcohol research agenda is limited from a family perspective, and more particularly from a sibling perspective.

Given the deficit, I reviewed the literature that refers to family, usually parents, and drug use, followed by a review of literature on drug-related death. Given that drug use typically
begins during adolescence, families, including their siblings, have a lot to contend with (Low et al., 2012). Adolescence is already a time adjustment (physically, emotionally, mentally and socially) and of great change as they individuate from their parents, which can be demanding to navigate (Fuller, 1998). It is during adolescence that parental influence lessens and peer relationships become more important (Low et al., 2012). Fuller (1998) contends there are three types of adolescent drug users: a) experimenter, where the drug use is unplanned and opportunistic; b) the socially disconnected, who use drugs because it gives them social success and friends, and c) the self-medicators, who use drugs to stop unpleasant emotions. That said, more studies focus on social disconnection and self-medication, and less on the experimentation. In a German study, Kirkcaldy et al. (2004) found that ‘trait addiction’, social anxiety and perceived educational failure were predictors of adolescent drug and alcohol use. From a different angle, Brook et al. (1999) contend that adolescents are more likely to engage in drug use when they are more rebellious and non-conforming, have low levels of emotional control and poor impulse control and experience internal distress/discomfort or external stress. Similarly, a Canadian study by Fast et al. (2009) focused on what makes joining the drug-using scene acceptable to the exclusion of the mainstream. In their study, many of the participants decided to move to the drug-using scene because it was safer than other living situations and forms of social exclusion, for example, poverty, crime or parental addiction. Yu and Stiffman (2010) focused on positive and negative predictors of illicit drug use by First Nations peoples in America. They claim that positive family relationships are protective, mediating between negative environments; that is, where there was illicit drug use in the environment, positive family relationships provided a sense of social connection, lowering the risk of illicit drug use (Yu & Stiffman, 2010).

Other studies point to family influences potentially encouraging drug use, such as parents modelling substance use, poor attachment relationships between parents and children, and older sibling substance use, as being direct influences because drug use is normalised and drugs are accessible (Brook et al., 1999; Low et al., 2012). Low et al. (2012) found that older sibling substance use can indirectly influence younger sibling drug use through collusion or conflictual relationships. Similarly, the Fast et al. (2009) study also shows that participants
were often introduced or connected to the drug-using scene by siblings or friends. This is an interesting finding pertinent to my study.

There is another body of literature on how drug use impacts the family. Liddle (2004) suggests that adolescent drug use typically disrupts the family systems. Oreo and Ozgul (2007) concur, saying drug use changes family relationships internally, impacting on family functioning, and externally by impacting on the social lives of the family. To add to the picture for the family Dyregrov et al. (2020) report that after the initial shock of discovery, the drug use not only disturbs family functioning but the view of the family is forever changed. Some families will try to hold the discovery within the immediate family while desperately searching for solutions. In situations where the drug use is unrelenting, family members experience the full gamut of emotional reactions, including shock, guilt, anger, worry, anxiety, panic, stress, dismay, shame, resentment, confusion, self-doubt, uncertainty, helplessness, hope and hopelessness (Oreo & Ozgul, 2007). Denning (2010) contends there is a sense of duty to their drug-using family member which is juxtaposed against public shame experienced by having a family member who is a drug user, or the shame which emerges from naivety when their loved one has duped or taken advantage of them again. In this roller-coaster of emotion, families may experience a sense of loss, that is, a loss of the person they knew or a loss of a particular type of relationship (Oreo & Ozgul, 2007).

There are differences in how a family responds to the individual and their drug use. Orford et al. (2013) acknowledge the worry and disruptive nature of drug use in the family and contend that family members respond by either putting up with the drug use, withdrawing, or standing up to the drug use. Dyregrov et al. (2020) highlight constant agitation, hypervigilance, worry, unpredictability and the lack of control as common family experiences when a family member is using drugs. How the family responds to drug use is varied and will depend on the model informing their approach, and many approaches are conflicting. For example, one method advocates for a ‘tough love’ approach, usually involving an abrupt behavioural change because the family is perceived as ‘co-dependent’ and perpetuating the behaviour (Haaken, 1993). This approach is couched in the disease model of addiction where the addiction is framed as a family disease. In contrast, another
approach advocates informed decision-making and self-care, incremental change, love and ongoing connection (Denning, 2010). This approach draws more from the psycho-dynamic, social learning and social connection theories (Denning, 2010). Families look towards treatment services to solve ‘the problem’ but this is often a long-term process filled with periods of doing well, followed by lapses or setbacks (Denning, 2010). This is further compounded by a treatment system that focuses on the individual drug user, often keeping families at bay, on the periphery of treatment and/or blaming families for the individual’s drug use (Liddle, 2004). In a sense the family are often pathologised as a part of the problem, made responsible for the problem they seek assistance for and ignored by services (Dyregrov et al., 2020).

In the few articles referencing the sibling relationship in the drug and alcohol field, I note a recurring theme where the drug-using child consumes parental energy, as well as time and resources which can detract from parenting of other children in the family. Siblings often react in either a critical or supportive manner (Oreo & Ozgul, 2007; Trimmingham, 2009). Siblings report increased family conflict, a breakdown of trust and communication in the family and can feel denied of attention and affection (Oreo & Ozgul, 2007). An interesting study considered the impact of illicit drug use on non-using siblings in the Vietnamese community. It reports that siblings of an illicit drug user may experience resentment, deprivation of parental attention, jealously, fear of discovery, grief, stigma, fear of violence and financial hardship (Webber, 2003). Even though initially there may have been a reciprocated loyalty between the using and non-using siblings and some protectiveness, Webber (2003) notes that this usually diminished over time. All these studies shed light on what I might expect to hear from people contributing to this study in terms of what it is like to live in a family situation and have a sibling who engages in drug use.

I now turn to review the literature on drug-related deaths in the family. Guy and Holloway (2007) contend that normal expected deaths are where the person dies in old age or from an old-aged-related condition. They contend that because we have an image of young people as fit and healthy, when a young person dies it is premature, not following a predicted pattern, outside the norm and disturbs the organisational system. In Australia
there are approximately 1,800 deaths are induced by drugs (drug-related) each year (AIHW, 2021). Guy (2004) contends when young people die for a drug-related reason, the focus remains on the cause of death, which is judged harshly, resulting in diminished focus on those left to grieve. In a similar view, Feigelman et al. (2011) studied parental grief, comparing the differences between homicide, suicide, drug-related deaths, accidental or natural death and found that parents of children who died through suicide or a drug-related death were more troubled by grief and mental health problems. They contend that social stigma attached to the death fed uncompassionate public responses and simultaneously interacted with bereavement, thus imposing challenges on healing. Cvinar’s (2005) work on suicide adds depth to the notion of stigma, noting that death by suicide is “complicated by the societal perception that the act of suicide is a failure by the victim and the family to deal with some emotional issue and ultimately society affixes blame for the loss on the survivors” (p. 14). These are powerful words that are also echoed in Guy’s (2004) study where the drug-using person is seen as wanting to use drugs rather than participate in society, and the family is seen as failing to prevent or stop the drug use.

The negative moral/social stigma attached to a drug-related death usually flows through to the family (Guy & Holloway, 2007). There is often moral/social stigma, secrecy, shame, denial and feelings of guilt, anger and helplessness, as well as a sense of being cheated and feeling guilty by failed attempts to assist (Dyregrov et al. 2020; da Silva et al., 2007). The stigma attached, and the value judgements, can lead parents and siblings to judge themselves harshly and their memories may be uncomfortable; this is something I have been mindful of in my study. Da Silva et al. (2007) also report in their pilot qualitative study that family members recount a sense of both pain and relief, that is, “relief from his suffering as well as ours” (p. 305). Due to the stigma attached to the type of death, the bereaved family may also feel as though they do not have the right to grieve or that their grief is not legitimate (Guy & Holloway, 2007). In essence, these views serve to stigmatise the death by blaming the person who died and their family.

From the family’s perspective, the drug-related death of a loved one is usually unexpected, considered preventable, stigmatised and socially censured because the person was too
young to die (Trimingham, 2009). Due to a lack of understanding and stigma surrounding drug-related deaths the family are often unsupported and distanced by their social network (Dyregrov et al., 2020). Often too, drug-related deaths occur in the family home and/or when the person has a lowered tolerance to the drug because of a period of treatment and/or abstinence. Such times of abstinence or treatment engender hope for the individual and family, making death even more unexpected (Guy, 2004). When the person is young, there is often a corresponding secondary loss of dreams and expectations attached to that person’s life (da Silva et al., 2007). For some families, it is only after the death that the family find out for the first time about the person’s drug use, thus spoiling their loved one’s identity — another secondary loss. Fundamentally, the news shatters ideas about ‘knowing’ the person because how can they know them if they did not know about their drug use? (Guy & Holloway, 2007). As a drug-related death is untimely, sudden and unexpected, it can also be traumatic (da Silva et al., 2007).

A traumatic event is where a “person experienced, witnessed, or was confronted with event(s) that involved actual threatened or actual death or serious injury, or threat to the integrity of self or others” (Norman, 2000, p. 304). Responses to traumatic events include “intense fear, helplessness or horror” (Norman, 2000, p. 304), a sense of “disempowerment and disconnection from others” (Rowe & Liddle, 2008, p. 132). Siblings can experience a traumatic grief reaction – like post-traumatic stress disorder – if the death of a sibling is violent and/or stigmatised (Shear, 2012). Intense reactions to traumatic deaths are not uncommon. When this is combined with lack of empathy, distancing, stigma and a lack understanding and acknowledgement then the grief reaction can be worsened (Dyregrov et al., 2020). Traumatic grief ostensibly falls into the same definition of complicated grief as discussed earlier. Accordingly, when death of a family member is drug-related, the effects on family can be intense and long-lasting (Guy, 2004).

In this section I provided a definition of the term ‘drug’ that includes alcohol and decided to use the term ‘drug’ throughout the thesis to refer to all psychoactive drugs including alcohol. I also considered the many ways there are to define drug-related death. I have offered a more inclusive definition, determining it is important that I hear from the people
contributing to my study about how they define the term. After reviewing the literature available in the drug and alcohol field, I note it is expansive but relatively little is available relating to family experiences. This is perplexing given the identified far-reaching effects of drug use in multiple life domains including family relationships. The literature is devoid of the sibling relationship and drug use. Therefore, I reviewed what is available on family and drug use and see that most of the literature is concerned with drug use during adolescence. There are two main themes in the literature: parental and sibling influences on an adolescent’s drug use, and the disruptive and worrying nature of a family member’s drug use in the family and the varied responses family might have toward the member using drugs. This section concludes by considering the literature on what it means to die for a drug-related reason. Bereavement in this circumstance is characterised as unexpected, untimely, shocking and at times traumatic. The social stigma attached to drug-related deaths and the perceived failure by the family to intervene in the drug use can intermingle to cause long-lasting traumatic grief effects. In summary, this section shows that very little is known about experiences of living with a sibling who uses drugs, and I could find no Australian research capturing the bereavement experience when their sibling dies for a drug-related reason.

Family

In this section of the literature review, as with the previous two sections, I deploy a similar framework in presenting ideas and information from different sources. I begin by defining the terms family and sibling, in the context of this research project. I draw attention to the sibling relationship being one of the significant attachment relationships formed in our lifetimes. From there I take a deeper look at the application of Bowlby’s work on attachment, as well as the relevance of both family systems and structural family therapy when thinking about the sibling relationship. Then, joining these concepts, I consider bereavement in the family system by reviewing some specific information on this topic (which is quite different from the first section that was more singularly focused on bereavement for the individual), and then move back to the sibling bereavement in the family context. I do not review literature on drug use in the family context because that has already been addressed in the previous section.
The definition of a family, at any given time, is more likely to reflect the purpose of defining the family rather than there being one universally agreed definition. Lindsay and Dempsey (2012) draw on the work of Gilding to describe three main ways to define family: a) objectively as a specific set of people as determined by demographers and government organisations (for example, legally and biologically); b) as a social institution fulfilling functions and roles (such as raising children), and c) subjectively, based on personal meaning (including intimacy, kinship, privacy, connectedness) (pp. 3-6). Boss et al. (2017) look further than subjective meaning and social institutional functioning to define family as “a continuing system of interacting persons bound together by processes of shared roles, rules, and rituals, even more than shared biology” (p. 4). This definition takes into account the family system, important from a family therapy perspective. In this study I settled on an older definition offered by Brown (1993), that a family is “the group of people consisting of one set of parents and their children, whether living together or not; any group of people connected by blood or other relationship” (p. 913). In adopting this definition, I acknowledge connection through relationships and interactions occurring in the family group, subjectively and objectively, as well as the social role given to family.

The term ‘sibling’ is more straightforward and is defined as “one or two individuals having one or both parents in common, a brother or sister” (Davies, 1999, p. 1). However, as Davies (1999) continues, “this definition, however, does not begin to capture the many meanings associated with the word” (p. 1). The sibling bond is influenced by factors such as “gender, birth order, closeness in age, time spent together, the quality of relationship and perception of its importance” (Kissane & Kasparian, 2017, p. 5). The older sibling often protects, teaches and models while the younger sibling learns and imitates such things as: values, knowledge, skills, secrets, taboo subjects, family solidarity and games (Ainsworth, 1989; Cicirelli, 1994; Davies, 1999). Many contend that the relationship between siblings is a special bond; there is a longevity and uniqueness to the relationship with an often rich and detailed shared history (Kissane & Kasparian, 2017; Marshall & Davies, 2011). The sibling relationship usually features elements of protection, caring, security, intimacy, support and companionship which are integral components of attachment relationships (Davies, 1999). As Marshall (2013) says “siblings know each other in ways friends and other blood relatives
do not. We have shared bedrooms, bathrooms, holidays, school days, family milestones, meals and ways of growing up that people outside the family cannot ever fully understand. The bond is intense, complicated, sometimes difficult, often wonderful, and absolutely irreplaceable” (pp. 14-15). Considering all this information, I believe the sibling relationship is one of the four significant attachment relationships formed in our lifetime, along with child-parent, parent-child, and the partner relationship.

Attachment and loss theory was developed by Bowlby in three volumes produced in 1969, 1973 and 1980 (Harris, 2009). Bowlby saw attachment to others was a fundamental motivation (Parkes, 1986). Attachment theory was initially concerned with an infant’s bond with its caregiver(s), separation anxiety, grief and mourning in infancy, and early childhood (Davis et al., 2003; Howe, 1995; Worden, 2003). Harris (2009) draws on Bowlby’s ideas, noting that a person’s life revolves around their intimate attachments, and it is from these relationships that we draw strength and enjoyment of life, thus contributing to the strength and enjoyment of others. Weiss (2007) discusses that attachment theory characterises grief in terms of protest (yearning and searching for the absent person) and despair (the withdrawal of attention from ongoing life and sense of hopelessness). These two states can be accompanied by guilt, anger, fear and anxiety, with guilt and anger suggesting that someone is at fault, and fear and anxiety suggesting the relationship was a source of reassurance (Weiss, 2007). Bowlby and Parkes in 1970 jointly published a paper on the four phases of grief during adult life, which essentially built on the separation anxiety response that had previously been used for children (Parkes, 2002). They believed that attachment behaviours remain significant throughout the life cycle. As Kissane and Kasparian (2017) state, the nature and depth of the attachment relationship determines the intensity of the grief. Therefore, people will experience a lower intensity of grief for affiliative relationships such as with friends or work colleagues, and higher intensity of grief for significant attachment relationships, that is, with partners, children, parents and siblings (Shaver & Tancredy, 2007). The relevance of drawing attention to the attachment and loss theory, is twofold: it drives home the significance of the sibling relationship, and illuminates the significance of the gap in the literature on sibling relationship in terms of drug use and bereavement.
Along with attachment theory, sibling relationships can be understood in the broader context of the various family therapy theories, which is relevant as the sibling relationship only exists within a family. Most family theory draws from systems theory, with a system described as, “a set of interacting units with relationships among them” (Goldenberg & Goldenberg, 1985, p. 28). With this premise in mind, the family system is seen as a living organism, with interdependent parts where each family member is influenced and influences others in the family (Boss et al., 2017). One of the key concepts of systems theory is that the whole system is organised through a series of relationships, and therefore parts of the system cannot be understood in isolation from other parts of the system as a whole (Goldenberg & Goldenberg, 1985). By applying systems theory to families, there is a focus on patterns of communication and interaction, behavioural sequences, as well as relationships in the family, and individual experiences are explained in relational terms, that is, within the context of interpersonal relationships.

Minuchin’s structural family therapy is useful for a study centred around the sibling relationship as well because he saw families as organised and connected around complementary and reciprocal roles, routines, expectations, rules and functions through subsystems and transactional patterns between its members (Lindblad-Goldberg & Northey, 2013). For Minuchin (1974), the family is a psychosocial system, embedded within wider social systems and hence one of his foci was the boundaries between the internal family system and external social environmental systems. For example, when boundaries within the family and the outside world are too permeable then, “the system loses its integrity and identity” and, if too rigid, “the system is cut off and isolated” (Goldenberg & Goldenberg, 1985, p. 29). These ideas are useful in terms of how families might manage drug use and seek help. Families are also organised around internal subsystems, that is, coexisting smaller groupings of family members who meet and interact within the family environment; one such subsystem is the sibling subsystem which has its own distinctive functions (Minuchin, 1974). Other subsystems could be organised according to generation, gender, power, hobbies, parents or function – subsystems are not static (Colapinto, 2019; Tadros & Finney,
2018). It is through membership of various subsystems within the family that children develop a sense of identity and learn relational patterns (Minuchin, 1974).

Subsystems and generations require clear boundaries (imaginary lines) in order to function effectively; therefore, members of one subsystem (for example sibling subsystem) should not intrude on the functions of another subsystem (parental subsystem), yet these boundaries also need to be permeable enough for exchanges across the subsystems and problem-solving to occur (Colapinto, 2019). Minuchin’s (1974) focus was on the person within the family, the organisation and connectedness of the family, as well as the possibilities; therefore, he might work to alter the structure in the family knowing that through such an alteration everyone’s experience within the family would also alter. Minuchin and Nichols (1993) contend that individuals within the family are constantly adapting through interactions with others, and that the individual is constantly influenced by and influencing the family social system.

Packman et al. (2006) emphasise that siblings can often spend more time together than any other family member. The sibling relationship, as stated above, is varied, changing over time, with brothers and sisters sharing a family history. Kim et al. (2007) found sibling relationships are considered an important part of child and adolescent development and adjustment, providing innumerable opportunities for social learning. Relationships between siblings have both protective and risk factors, that is, siblings can learn prosocial or antisocial behaviours through supportive or conflictual interactions and be exposed to positive or negative sibling role models (Kim et al., 2007). Understanding the structure of a family and thinking about the sibling subsystem (with its own boundaries, relationship, rules, functions, and roles) existing within the broader family system emphasises the relational nature of being a sibling – shaping and being shaped, by one another. The family therapy approach is quite different to studies on the sibling relationship which focus on issues like identity formation, developmental and clinical issues, or measuring the relationship quality based on warmth and conflict (Zerach & Milevsky, 2020). The sibling relationship is unique, complex, and imbued with a depth often not given attention in research or practice.
Above, I have looked at the family therapy literature broadly and then literature specifically on the sibling relationship. Continuing with my focus on family, I now review what the literature says about family and bereavement for the family as a whole and for the individual family members. Overall, the views are mixed. Death of a family member is a part of the life cycle usually bringing with it changes to the entire family (Bradach & Jordan, 1995). Norman (2000) states, “each death is not a solitary or private event, for each death, serious wounding, maiming, or deprivation, there are survivors” (p. 304). Therefore, bereavement as a phenomenon can impact on individuals, families, and whole communities simultaneously. Packman et al. (2006) contend that death disrupts family functions, communication patterns, and changes the expectations of each other. Boss et al. (2017), in their work on family stress (which could include both bereavement and drug use), contend there is a family perception, that is, the way the family views the world, where the family, “have unique systemic characteristics and this unit produces a family perception” (p. 11). This approach suggests the family thinks collectively, in a sense, seeing and coping with the stressors in the same way. However, Gilbert (1996) is adamant that families do not grieve, rather individual family members grieve within the family context. This individual grief often manifests as a form of silent bereavement and is common in families, especially when family members experience or express feelings differently. For example, they may be at different ages or stages of development and therefore there can be a mismatch in their grieving (Gilbert, 1996; Oikonen & Brownlee, 2002). A person’s response to bereavement is based on a range of factors including: the level of disruption; the individual’s own past experiences with loss; the social context; the person’s resilience, and the ability to cope (Weiss, 2007), as well as the attachment relationship (noted above). In this respect, a systems view is helpful in making room for both collective and individual responses to bereavement; as individual family members are interconnected in the family system, there will be an interplay of grief responses within the family context, with each member affecting and being affected by the others in a circular manner, even when there is a mismatch in grieving responses (Oikonen & Brownlee, 2002).

Nadeau (2001a), in her grounded theory study, was particularly interested in how family structure and dynamics intersect in family meaning making, and what stimulates or inhibits
the family’s ability to make meanings when a family member dies. She collected information
from cross-generational individual family members of the same families, interviewing them
alone and together which allowed for constant comparisons to be made. As stated above, a
death in the family is a disruptive event for the family to navigate; individual family
members must regain a sense of order, control or purpose in life, and the family, as a whole,
has to restructure and readjust (Packman et al., 2006). How families have typically managed
disruptive experiences, buffered stress and effectively reorganised when needed in the past,
note the benefits of talking in families, as it is through talking to one another that the family
can make sense of the death, create a shared story of the death and of the time after the
death. Nadeau (2001a) concurs, contending that families construct meaning, create their
own worlds (similar to the idea above about family perception) and maintain their own
reality through everyday conversation. Dyregrov et al. (2020) concurs explaining that the
family is usually a source of support, helping with coping and healing processes, the “family
strengthens the most natural form of support through dialogue” (p. 422). However, when a
family member dies for a drug-related reason family bereavement processes can be
complicated as a ‘taboo-laden’ and stigmatised death. This led me to wonder what happens
in families where there is already drug use before the person dies. As noted in the previous
section, Orford et al. (2013) suggest that families usually respond in one of three ways: they
put up with the drug use, withdraw, or stand up to the drug use. I note that these
approaches may help or hinder meaning making in the family context.

In her research with families, Nadeau (2001a) used techniques derived from family therapy
which I have used in my study. For example, she used genograms to develop an
understanding of all family members and family structures. She also used circular
questioning to reveal systemic patterns of interaction in the family. Circular questioning
allows for differing perspectives and realities to be heard by family members, illuminating
the inner and outer worlds of each, linking emotions, relations, meaning and actions
together (Bertrando, 2002). Specifically, circular questions draw out differences or
connections between people, across various situations or time, about feelings, behaviours,
beliefs, meaning or relationships (Brown, 1997). Examples of other-based circular questions
I used are: “what do you think your mother thought about your sibling’s drug use?” or “if your father were here and I asked him ‘what happened for you when your son died?’, what do you think he might say?” help make visible the various relationships in the family, therefore, allowing for a deeper understanding to be established about the experiences. The use of both genograms and circular questioning are included in this study.

Drilling down further to look at sibling bereavement in the family context, White (2006) raises an interesting point in stating that sibling rivalry can often go on after the death of a brother or sister. From a different angle, children can become upset by their parent’s ongoing grief. They may want to protect their parents and, therefore, they may not mention the dead child’s name and, for a time, feel as though they are parenting their parents (Packman et al., 2006).

Many authors also draw attention to the notion that siblings are secondary mourners to parents (Horsley & Patterson, 2006). Bereaved siblings are told to look after and be strong for their parents; sometimes interpreted as messages to deny their own grief (Dyregrov & Dyregrov, 2005). Hence, in the family context, the literature suggests that bereaved siblings often experience their grief as ignored, postponed, invalidated or unacknowledged (Horsley & Patterson, 2006). Again, it seems that how a sibling will experience bereavement will be shaped by interactions in the family, and on an individual level can be quite varied.

In this section I provided a definition of family that sees social connection through relationships and interactions within the family group. Based on the application of Bowlby’s theory, I define the sibling relationship as a significant attachment relationship which carries with it a wealth of meaning and richness in experience. Further review shows that sibling relationships have been understudied in both drug and alcohol, and thanatology (as shown in the above sections), in comparison to the other significant attachment relationships. The benefits of family systems theory and structural family theory are useful in promoting concepts of family organisation and relational interconnectivity. From this literature base, it becomes apparent how we are shaped and indeed shape one another in the family context, and there is an interplay of grief responses with each family member affecting, and being
affected by, the others in a circular manner. Nadeau’s (2001a) study focused on family meaning making to draw attention to the utility of both genograms and circular questions in understanding the family context and have direct relevance to my study. Maintaining a focus on the relational nature of the sibling relationship, I also note literature identifying issues such as sibling rivalry (even after death), protection of parents and the idea that siblings are secondary to parents as mourners. However, Nadeau’s work resonates; it makes me appreciate the depth of family relationships and wonder how family members, and more specifically siblings, construct meanings around both drug use and drug-related death, within the family system.

Gaps in the literature
Undertaking the literature review illuminates what is known and establishes where the gaps in the literature exist. The purpose of reviewing the literature when doing research is not just to identify the gaps in knowledge, it is also to inform the research design, show how the research project will relate to others’ work, and how the research will add to the current literature available (Murray, 2002).

In terms of the bereavement literature, I noticed that much of the research is temporally located around the time of death or soon after, and it is relatively unknown what happens to bereaved siblings in the longer term. It would be useful to have a longer-term view. However, I also understand that retrospective studies are often criticised from a positivist perspective because memories lack accuracy and longitudinal research designs are expensive. That said, longitudinal studies do capture change in a controlled manner allowing for a ‘motion picture’ effect to develop (Balk & Corr, 2007). From a qualitative perspective, these same concerns are not problematic, as the focus is more on the interpretation and meaning of past memories.

In qualitative research there is recognition that narratives help to organise the memory, and that memories are continually being constructed and reconstructed, as the perception of reality changes (Gilbert, 2002; Norman, 2000). This perspective allows the past to be shaped by the present, recognising the interpretative nature of memory which could help illuminate a variety of experiences and understandings after the death event (Norman, 2000). As I am
interested in capturing depth of experience for bereaved siblings when death is drug-related, within the family context, it makes sense to use a qualitative methodology.

Kellehear (2008) argues that how we describe death is often decontextualised, and for that reason, recontextualising bereavement using a methodology that reflects the experience of the bereaved, could add a new dimension to the thanatology field given the plethora of quantitative research already available (Carverhill, 2002; Currier & Holland, 2007; Neimeyer, 2000). I concluded that qualitative research with bereaved siblings more than two years after death, focused on capturing their experiences and changes to these experiences over time, could be a useful addition to the thanatology field.

As stated above, in Australia there has not been a great deal of attention given to researching families in the drug and alcohol field, especially family experiences, and I could find no Australian research specifically focused on the sibling relationship. This is against a backdrop of a vast drug and alcohol research literature tending to focus more on specific drug use, treatments and interventions for individuals. The information that was available highlights the disruptive and worrying nature of the drug use in the family, and the varied responses parents and siblings might have to the family member using drugs. The social stigma attached to drug use and a person’s drug-related death is also contemplated as another layer of understanding, and how social stigma might also intermingle with bereavement arising from an often sudden, untimely and unexpected death. Due to the gaps in researching families and specifically the sibling relationship in the current drug and alcohol literature, a study focused on understanding the experiences of having a sibling who uses drugs and dies for a drug-related reason would enrich the field.

In much of the thanatology literature, bereavement is typically located within or inside the individual. This notion has also generated many grief theories that have an intrapersonal orientation, concerning the inner world, and uniqueness of individual experience (Allan & Harms, 2010). However, when the view is shifted to see bereavement relationally, then the relationship with the person who died and the impact on family relationships can be considered. Death in a family is complex and disruptive, and impacts on family in a
A multitude of ways (Packman et al., 2006). Nadeau (2001a) recommends looking at the family as a system and grief from a meaning making perspective. She also recommends using this perspective for further studies to understand the long-term consequences of family bereavement and how meanings change over time.

Finally, as a significant attachment, the sibling relationship carries with it a wealth of meaning and richness in experience. However, this review shows that sibling relationships have been understudied in both drug and alcohol, and thanatology (as shown in the above sections), as compared to the other significant attachment relationships.

In summary, and based on information in this literature review, I am not aware of a retrospective qualitative study seeking out the experience and meanings that siblings attribute to the death of their brother or sister for a drug-related reason in the longer term. The experience could include recollections of drug use, the experience immediately after the death and changes occurring over time to the sibling and their family. As there is a lack of research on this topic, little is known about the meaning attached to the death of the sibling, the ongoing presence of their sibling or indeed stories of growth, hope or resilience which may be present. This research project aims to address these gaps in the literature.
Chapter 3: Theoretical orientation

Introduction

The purpose of having a chapter on theoretical orientation is to clearly articulate the research tradition from which I am drawing as the researcher. This is in recognition that the various research traditions are based on different research paradigms comprised of research communities, concepts, systems, values, language and practices used to generate knowledge (Levers, 2013). Further, each research tradition/paradigm also represents a philosophy of science which embodies different world views (Varpio & MacLeod, 2020). It is the philosophy of science that incorporates the researcher’s ontology, epistemology, axiology and methodology (Ponterotto, 2005). For example, research using a positivist theoretical orientation will take a quantitative research approach and be concerned with the objectivity, reliability, validity and statistical analysis, whereas research using an interpretivist theoretical orientation will take a qualitative research approach and will be concerned with subjectivity, meaning, reflection, in-depth interviews and thematic analysis (Welford et al., 2011). My interest is in the qualitative approaches to research. I note that some authors do not delineate between the notions of a research paradigm and philosophy of science and instead use such terms interchangeably with ‘research tradition’ (Welford et al., 2011). Ultimately, the theoretical orientation, informed by both the research paradigm and the philosophy of science, provides the lens through which to view and accomplish an investigation (Welford et al., 2011).

There are some other important considerations for articulating the research tradition informing the project. Zaidi and Larsen (2018) posit that doing so is a means of understanding the strengths and limitations of different research paradigms, noting one is not better than the other; however, one may be more suited to answering particular questions than the other (p. 6). Varpio and MacLeod (2020) argue for multidisciplinary research collaborations as a productive and generative endeavour, remarking to do so well, it is important to articulate the disparate paradigms so they can interface effectively. These are important factors but possibly the most important is that the research tradition will inform all aspects of the project and, therefore, requires significant contemplation to ensure
there is internal coherency, consistency and flow throughout the entire research project (Zaidi & Larsen, 2018, p. 6).

As such, in the following three sections of the chapter, I make explicit my theoretical orientation by unpacking my ontology, epistemology and axiology as fundamental elements influencing choices around the research tradition used for this project. In the next chapter, I will detail Gadamer’s philosophical hermeneutics as the methodology underpinning every decision made during this empirical study. In each section, I follow the same structure, initially defining the term for clarity, then progressing to contemplate the meaning for me, both professionally as a social worker, and personally.

**Ontology**

In order to understand what shapes my ontological framework, I first explore what ontology means and how the term is applied. Wilson (2001) asks, “What do you believe is real in the world?” and goes on to say, when you answer that question, you then, “know what your ontology is” (p. 175). Therefore, our ontology questions what the real world is and what can be known about it (Welford et al., 2011). In a similar vein, Rosenberg (1995) suggests that one of the ways to understand what you believe is to look at what you are interested in researching, what questions you ask philosophically and what methods you are drawn to (Rosenberg, 1995). Bell (2012) defines ontology as “ways of being or worldview” (p. 410). Taking the idea of worldview further is Gadamer’s thesis that “language ‘discloses’ the world to us” and that “it is only through language that we can be said to ‘have’ a world” (Hekman, 1984, p. 212). Here, he draws our attention to language as ontology which I will explore in detail in the next chapter. Suffice to say that our ontology comprises our beliefs about being in the world and influences what we research, what we consider to be knowledge and how we practise in the world.

At any given time, our ontological framework may be determined by our professional work and experiences. Bell (2012) discusses the idea of having multiple ontological positions because, “humans negotiate and experience the world in multiple, self-determined ways” (p. 415). She elaborates by discussing the idea that social work is about people existing within complex systems which are both interdependent and interrelated. This notion is
supported by Ornellas et al. (2018) who posit that social workers draw on at least four different ontologies to inform their practice, including an interpretivist-therapeutic one. I note the interpretivist-therapeutic ontological framework specifically because this framework emphasises relationships, client centredness, meaning development, an inward focus and growth, which are all important aspects of my work and, therefore, contribute towards making up my ontological position as a social worker.

My ontological framework has taken on layers of being in the real world. When I think about my own ontology, I am not sure I can separate myself into my personal, professional or research worlds. My beliefs have been formed through my own experiences; informed by the various roles I hold (for example, being a student, wife, and mother) as well as the roles of social worker and researcher. When I think about being in the world, numerous things spring to mind. I can identify core beliefs that operate across the various roles I have, and I think these are relevant to the research project.

I am endlessly curious and fascinated by people, and sometimes perplexed too, as I endeavour to understand how people interpret their world and what shapes their interpretation. Ontologically, I have my own truths or understandings about the world based on my experiences and interpretations, and I know some of my understandings have changed with new experiences and/or interactions with others. Therefore, understandings are not static or finite, and multiple interpretations of the same event are possible. In this respect, there cannot be the one right interpretation for everyone, and I have to make room for multiple views. Understanding Gadamer’s (1975/2004) horizons has helped me to articulate this concept simply. When I work with couples, the idea of more than one interpretation of a situation being possible is critical to achieve understanding by making room for two ways of seeing the same situation (Gottman & Silver, 2012). Working within this frame is also the notion that people are inherently good. This is similar to Rogers’ (1978) idea that people are trustworthy and capable of making constructive choices although people definitely do unhelpful things; I find there is usually an explanation that brings forth positive intentions. As I reflect, I can see that this belief positions me to listen, be open, curious, genuinely interested and think positively about people. When I link all of the above,
it makes sense that I would be interested in *understanding* the *experiences* of bereavement for siblings when their brother or sister dies for a drug-related reason.

Another aspect of my work that features strongly is that our thoughts are just thoughts – conceptual and fragmented – until we speak or write them, at which time the thoughts become sentences, with form and structure, and these sentences have real meaning that can be understood. Gadamer’s (1975/2004) views on language again influence my thinking here, where meaning is achieved through the expression of words and rules of language. Willig (2012) describes this well, noting “language is the medium through which we humans construct meaning ... required for us to know ourselves in particular ways” (p. 63). Elements of Acceptance Commitment Therapy, which suggest that “thoughts are merely sounds, words, stories or bits of language” (Harris, 2007, p. 41), also inform my thinking. As a social worker in direct practice, the idea of putting words around thoughts is helpful because it is through a counselling conversation and/or writing activity, that making sense of what happens in life can occur.

The idea of conversing and interacting with people links to my next belief – about the relatedness of all people. We all belong to the human race; we are not islands. As Johnson (2019), who draws on Bowlby’s attachment theory, says “we are first and foremost a social, relational, and bonding species” (p. 5). We are also more similar than different to others in that we share universal facial expressions as identified by Darwin (1872, in Watson, 2005) such as surprise, anger, despair, contempt, joy, shame, sadness. We are also hardwired, through neural pathways, for social engagement and to connect with others in trusting relationships in order to coregulate (Porges, 2017). To me, this translates into people being able to connect in neutral and respectful ways irrespective of sociocultural context. As people, we live in an interpersonal world, within the context of a series of relationships and interactions shaping who we are in the world and how we see the world (Minuchin, 1974). For me this means that it is through interactions and exposure to differences and similarities, especially when we genuinely listen, that we learn about and from others, about ourselves. Said in a different way, I see people as fundamentally interpersonal beings and,
therefore, understand and explain “individual experiences in relational terms” (Vertere & Dallos, 2003, p. 7).

In summary, multiple understandings of the same things are always possible as we interpret events based on where we are and with whom we are interacting at a particular point in time and context. Just as we are relational beings, the concepts of ontology and epistemology are also linked and shaped by one another, with ontology being about what we know to be real, and epistemology being about how we know what we know.

**Epistemology**

I have already introduced the idea of epistemology being inextricably linked with ontology. I now define and describe my epistemology. Wilson (2001) defines epistemology as concerned with, “how you think about that reality” (p. 175) (where reality is what one believes is real in the world – one’s ontology) and, therefore, showing a direct connection between ontology and epistemology. Rolfe et al. (2011) suggest epistemology is the philosophical theory of knowledge and from where it originates. Rosenberg (1995) adds to this idea saying, “the house of knowledge has many mansions” (p. 213). Hence, we have choices to make and there are many legitimate ways of expanding our knowledge. Bell (2012) says simply that our epistemology constitutes our “ways of knowing” (p. 410). When I reflect on my epistemology and what are my ways of knowing something, I am instantly aware that my response is broad. Knowledge comes in a variety of forms and from a variety of sources; for example, some knowledge has come to me informally from others or in the shape of cultural traditions, which Gadamer (1975/2004) would refer to as my historicity of understanding. Other forms of knowledge have been formally learned at university or through other training courses. Also, as a social worker, I continue to learn from interactions with the people with whom I work, and therefore have developed both practice wisdom and experiential knowledge through reflective practices (Rolfe et al., 2011). However, the things that can be reflected upon and learnt at any given time will be shaped by the person’s horizon, that is, their situatedness and the standpoint of their view (Gadamer, 1975/2004).

To develop the idea of a horizon influencing our knowledge, I reflect on how different workplaces have changed how I understand client situations. Fook (2002) discusses this very
notion, referring to it as the situatedness of our work and influences over practice.

Consistent with Gadamer, she acknowledges that different contexts can help us have different views of the same situation, so our view is determined by our position at a given time (Fook, 2002). For example, when I worked at Relationships Australia, if a couple attended for counselling and one person was drinking excessive amounts of alcohol, the focus of work would be on the impact of the alcohol consumption on the relationship and family. This differs to the approach at a community health drug and alcohol service where the approach would be on what the person will do about their drinking, that is, through withdrawal, reduction or control options. Our situatedness – our standpoint – shapes what questions we ask and how something is interpreted, and therefore what can be known (Willig, 2012).

Reflective processes, such as my previous reflections on my workplaces, are encouraged in the social work profession. As a profession, social work draws from a broad knowledge base including formal theory and more subjective forms of knowledge such as practice wisdom and experiential knowledge (Bell, 2012). Experiential knowledge and practice wisdom are valuable forms of knowledge arising from reflective practices, recognising that the relationship between knowledge and practice in social work is circular in nature, moving from specific practice to reflection on the whole interaction and back to the situation of practice. This process is similar to the hermeneutic circle describing how understanding is achieved by moving from the part to the whole and back to the part again (Gadamer, 1975/2004). Fundamental to these subjective forms of knowledge development are the practices of reflexivity and critical reflection. To be critically reflective is to assess, analyse and question experiences, meanings, practices and ideas, and then challenge the critical thinker’s thinking and the implications of their thinking (Rolfe et al., 2011). In social work, critical reflection is often about “uncovering power relations and questioning dominant structures and relations” (Agglia et al., 2010, p. 56). Participating in critical reflection is a good way of “generating data, constructing knowledge and applying it to practice” (Rolfe et al., 2011, p. 6). In doing so, practitioners effectively conduct research on their own practice to develop an evidence base, that is, practice wisdom. In contrast, being reflexive is to reflect and act at the time, for example, to test ideas with the person by asking questions.
and then using the feedback to modify thinking or direction of conversation; going back to the person with new reflections, theories or hypotheses (Rolfe et al., 2011). Fook (2002) says reflexivity recognises presence and the capacity to influence the immediate situation. Therefore, reflexive practice helps a social worker gain experiential knowledge. For social workers, the relationship between knowledge and practice is circular, facilitated by reflective practices, along with other theoretical forms of knowledge.

The process of developing knowledge through reflective practices is primarily subjective, with understandings and meanings developed through conversation with other people within certain contexts and at particular points in time. Valuing this type of knowledge is evident of a leaning towards the qualitative research tradition. As Willig (2012) advises, qualitative research attends to relationships, sense making, meaning and understanding of what goes on, “for people and between people, as they live their lives” (p. 22). This is quite different to the quantitative research approaches designed to demonstrate cause and effect or predict future outcomes. Quantitative researchers ontologically are concerned with what is the external, independent and objective, and seek knowledge derived from scientific method where the variables are controlled, data results are objective and able to be repeated and validated. Gadamer (1975/2004) challenges the ability to be objective in the human sciences claiming that to understand something, there is a need to project from what is already known (pp. 269–273). Hence, qualitative research is much more context dependent and concerned with finding meaning and, by necessity, the researcher is inextricably involved in the process, although endeavours to be sufficiently self-aware so as not to impose their experiences on participants’ accounts (Rolfe et al., 2011). As Finlay (2011) notes, the qualitative researcher is expected to draw on their own understanding throughout the research process. They are “a central figure who actively constructs the collection, selection and interpretation of data” (Finlay & Gough, 2003, p. 5). Qualitative researchers view people as knowing something, being curious and interested to know what they know, and how they live in the world, while making room for the possibility of multiple understandings.
In summary, my understanding of what constitutes knowledge – my epistemology (ways of knowing) – is broad. I avoid adhering to ‘one’ way of knowing, choosing instead to value various forms and sources of knowledge, including subjective knowledge and knowledge gained through reflective practices. Where the goal is to understand a human phenomenon, I privilege knowledge arising through qualitative research methodologies, as this type of research is often focused on understanding the subjective meanings of experience. The knowledge derived from the more subjective sciences are consistent with my interpretivist ontology which allows for multiple understandings and meanings to exist.

**Axiology**

To finish this section, I consider how my ontology and epistemology are influenced by, and influence, my axiology. The word ‘axiology’ originates from two Greek words, axios, meaning worth or value, and logos, the meaning of logic or theory. When combined, they form “a theory of value” (Biedenbach & Jacobsson, 2016, p. 140). Therefore, at its most basic level, axiology is concerned with values. I reviewed articles from other fields of practice (for example, cardiology and art-based research) to broaden my understanding and it is apparent that axiology extends to ethics as well (de Hoyos et al., 2013; Viega, 2016).

Biedenbach and Jacobsson (2016) contend that a researcher’s axiology is interwoven with, and will influence, research choices, questions, interests, choice of methodology, data gathering and analysis and who will benefit from the study. This notion is supported by Zaidi and Larsen (2018) who conclude that “good-quality research attends to paradigm, methodology, and methods and demonstrates internal consistency between them” (p. 6). Therefore, as the researcher, it is important for me to clearly articulate my axiology as well as my ontology and epistemology; doing so removes the reliance on assumptions and promotes an overall coherency in the research endeavour.

The values of the social work profession are well aligned to my personal values – my axiology – which I will articulate for the purposes of this research project. I came to work in the ‘helping profession’ decades ago and was trained in counselling techniques underpinned by theory developed by Rogers (1978). I think that because I have worked in various roles (for example, as a welfare worker, drug and alcohol clinician, social worker, counsellor,
family therapist and clinical supervisor) within the profession for so long, the principles of Rogers’ humanism theory have become an inherent part of who I am, what I believe and value – so, both my ontology and axiology. Humanism influences, and is present, in almost all my communications, connections and interactions with others, whether this is with my family members, clients, colleagues or people contributing to research. Many of the key tenets of humanism can be found in the Australian Association of Social Workers (AASW) Code of Ethics, for example, self-determination, empathy, informed decision-making, autonomy and respect (AASW, 2020) and, therefore, there is a consistency between the personal and professional. That said, I am also aware that over time, ways of thinking can change and for that reason, it is always useful to revisit the formal theory, the source, in this case Rogers himself.

Rogers (1978) described his work as person-centred. He was concerned with neutralising, as much as possible, the power imbalance between the therapist and the client. The work with others was focused on developing a greater independence so that people could assume responsibility for their own problems and, as their self-efficacy grew (through the management of one problem), they would develop capacity to manage other problems (Rogers, 1978). He advised there were three conditions needed for the counsellor: be congruent, have an unconditional positive regard for the person in front of them and have an empathic understanding (Rogers, 1978). His premise is that “the human being is basically a trustworthy organism, capable of evaluating the outer and inner situation, understanding herself in its context, making constructive choices as to the next steps in life, and acting on those choices” (Rogers, 1978, p. 15). I have adopted many of the values espoused by Rogers, as noted above, into my personal and professional life.

Valuing Rogers’s theory translates to holding human interaction in high regard as a way of learning about myself and others in the world. I am keen to understand what others think, how they cope and see the world, and feel privileged to do the work I do. While interacting with others, I am both reflective and reflexive. There is a constant internal dialogue like this: What am I thinking? What leads me to think that way? What leads me to react that way? How is the other person responding? Do I need to change what I am doing? This type of
reflective practice – reflexivity – is about evaluating all aspects of my work and ongoing learning (Fook, 2002). Through working reflexively with others in direct practice, I have also come to value the transformative powers of language, as it is the major way that thoughts, feelings and experiences can be expressed and communicated and thus made accessible to the person concerned and others (Willig, 2012). The use of language in human interaction – exploring thoughts, feelings and experiences – is consistent with Rogers’ values around creating the conditions for the person to avail themselves of their vast resources which are accessible through self-understanding. Here, I draw attention to the value placed on language and interaction in understanding. These values are also consistent with Gadamer’s (1975/2004) views about the role of language when conversing with others, where no-one really knows in advance what understanding will come out of a conversation, and where it is our willingness to hear something new that allows something to emerge from the conversation. Both Gadamer and Rogers hold that interactions, and our approach to these interactions, are key to understanding.

While Rogers’ theory and Gadamer have both influenced my values, family therapy theory has underpinned much of my thinking around the work with other people, since formal training in the late 1980s. Family therapy offers ways of thinking and working with others, focused on interactions, language and understanding. The approach is relational, considerate of structures and circular patterns of interaction. Many of the techniques for working with others are useful, for example, making connections within the system such as lifecycle transitions, relationship patterns, or family structures (Goldenberg & Goldenberg, 1985). Practising in this way means the family therapist does not adhere to one explanation that becomes prescriptive, but instead, will test multiple ideas until an understanding emerges that fits for the people concerned (Vertere & Dallos, 2003). Family therapy is also congruent with my belief that people are inherently good as evident by the technique of positively connoting others’ behaviour. This is where a behaviour displayed by one person in a family is not individualised, pathologised or psychologistised, but identified as probably serving a helpful function within the family system (Byng-Hall, 1990).
Social work has a strong ethos of helping people by focusing on the social environment in which they live, by taking a person-in-context, rather than a psychological approach focused on personal traits (Fook, 2002). As a social worker, I draw from Bronfenbrenner (2005) and his bioecological model or family therapy model approach. The model is both humanistic and optimistic, emphasising the human capacity to grow and adapt to many different life circumstances including the person’s ability to shape their own development.

Bronfenbrenner (2005) contends that at the heart of the social system is the family. Using a model like Bronfenbrenner’s offers the flexibility to view a person’s situation through different lenses, in a multifaceted way, thus understanding them in context (Fook, 2002).

In summary
My ontological beliefs are around people being inherently good and trustworthy (Rogers), the utility of language (Gadamer) and the relatedness of all people living within different contexts and systems (family therapy and Bronfenbrenner). My ontology informs my epistemology, shaping what I think is knowledge and from where it originates. For me, I am interested in engaging with others as a means of learning, interpreting and co-constructing multiple understandings (knowledges), through reflective practices and qualitative research. My axiology includes values and ethical behaviour (AASW) that are aligned to, and consistent with, both my ontology and epistemology. In this way, I value theoretical approaches that aid communicating, understanding and encouraging self-determination and autonomy in others. I also value the ability to engage in reflective practice and qualitative research as other means of informing practice wisdom and acknowledge experiential knowledge as being useful in my interactions with others. Overarchingly, Gadamer’s philosophical hermeneutics has also greatly influenced my values around engaging in conversation from a position of curiosity and collaboration, having a willingness to learn something new with other people and openly recognising that multiple understandings will become apparent.
Chapter 4: Gadamer introduced

As stated in the previous section, my ontology and axiology mean that I value and am curious about how people understand their world. Epistemologically, I value qualitative research methods where an interpretivist methodology is used (Welford et al., 2011). My interest for some time has been in understanding the experience of sibling bereavement, especially when the sibling dies for a drug-related reason. The study of experience is a phenomenological study and, when the study is about understanding, it falls into a hermeneutic inquiry. Given this, I began by reading Husserl (in Moran, 2000) and then moved on to Heidegger but quickly realised that Heidegger handed hermeneutic phenomenology over to Gadamer to further develop ideas in plain language (Gadamer, 1996/2007). In doing so, Gadamer emphasised interpersonal communication as the primary means of determining meaning, therefore highlighted the role of language in all understanding. Once I started reading and truly understanding Gadamer’s work, I became engrossed, seeing application not only in my research but in my work and personal life as well. Now Gadamer’s philosophical hermeneutics largely shapes my worldview; it is a part of me, so much so that it is imperative that I dedicate an entire chapter explaining his philosophy. Doing so will also ensure clarity in all research decisions I have made under the governance of Gadamer’s philosophical hermeneutics.

To understand Gadamerian hermeneutics, it is useful to understand first his ontology and second his epistemology, as both are foundational to understanding the research methods that fit with his philosophy. Wilson (2001) says, “what you believe is real in the world: that’s your ontology” (p. 175). Gadamer (1975/2004) believes that “the world is verbal in nature and that languages are worldviews” (p. 440). Gadamer’s focus on ontology sets him apart from other 19th century hermeneuts (Gadamer, 1992/2001a). He takes his lead from Heidegger who introduced the ontological perspective of hermeneutics by exploring the meaning of being – Dasein – and the facticity of Dasein (Gadamer, 1993/2001a). Gadamer develops the facticity of Dasein further and simplifies it, by talking about the concrete factual existence of human beings as encompassing traditions, historicity, prejudice, situatedness and the capacity to project (Gadamer, 1995/2001a). He says that language
‘discloses’ the world to us. Gadamer (1975/2004) contends it is through language that the world is revealed and therefore, it is only through language that we can be said to have a world.

Hermeneutic sciences make use of language to elucidate (make visible) the meaning of the subject matter within a given context (Gadamer, 1975/2004). Moules et al. (2015) say that hermeneutics has been referred to as the science of examples. Gadamerian hermeneutics concerns the condition of man in the world. To Gadamer, “the nature of things” (p. 401) and “the language of things” (p.411) have the same meaning and, therefore, by studying one, we effectively study the other (Hekman, 1983). He argues that understanding is always interpretation and “interpretive language and concepts are recognised as belonging to the inner structure of understanding” (Gadamer, 1975/2004, p. 306) and “hermeneutics helps us realise there is always much that remains unsaid when someone says something” (Gadamer, 1996/2007, p. 417). He emphasises the universal phenomenon of understanding as a dialogical, practical, and situated activity (Malpas, 2003).

Gadamer’s ontology links to his epistemology; again, noted by Wilson (2001) who says, “how you think about that reality is your epistemology” (p. 175). We use our epistemology to gain more knowledge about the world. Gadamer stated in an interview with Dutt:

So, one of the most essential experiences a human being can have is that another person comes to know him or her better. This means, however, that we must take the encounter with the other person seriously, because there is always something about which we are not correct and are not justified in maintaining. Through an encounter with the other we are lifted above the narrow confines of our own knowledge. A new horizon is disclosed that opens onto what was unknown to us. In every genuine conversation, this happens (Gadamer, 1993/2001a, p. 49).

When Gadamer placed language at the centre of hermeneutic ontology, he effectively moved the epistemology of hermeneutics from simply interpreting to how understanding occurs; to identifying the conditions needed for understanding to occur. This is because Gadamer is always concerned with application. At the core of his philosophy is that human
beings learn from each other, which sits well with my own axiology where I believe we influence, and are influenced by those with whom we interact. In many interviews, Gadamer talks about trying to hold himself open, ready to listen to the other and respond because it is only through listening that there can be understanding (Gadamer, 1993/2001a). At the heart of these statements is the fact that there can be no grandstanding, no elitism, no arrogance because, in Gadamer’s terms, that would make you a sophist, that is, someone who maintains he or she is right and, therefore, does not want to understand what others have to say (Gadamer, 1996/2007). Hermeneutic work occurs in the ‘in-between place’, either between two people or a person and a text. He describes understanding as a fusion of horizons where this fusion is an event in its own right. He describes the process of fusion as analogous to a game or play (Gadamer, 1975/2004, p. 109). The conditions of understanding are to listen and be open, to question by projecting from what we know and reflect on what we hear, have goodwill towards hearing something new, and be prepared to risk what we have previously known about the subject matter (Gadamer, 1975/2004).

Now, with a clear understanding of Gadamer’s ontology and epistemology, it is possible to consider the research methodology for the project. Wilson (2001) defines research methodology as, “how are you going to use your ways of thinking to gain more knowledge about your reality” (p. 175). The title of Gadamer’s magnum opus – Truth and Method – is a little misleading because no method for doing hermeneutic phenomenological research is provided. Instead, Gadamer (1975/2004) states that hermeneutic interpretation is, “not to develop a procedure of understanding but to clarify the conditions in which understanding takes place” (p. 295). A significant part of his endeavour was to show that method is not a way for the humanities and social sciences to achieve legitimacy alongside the natural sciences because both have a different relationship with their subject matter (Gadamer, 1993/2001a). The humanities and social sciences essentially complement the natural sciences by having a focus on what is shared and participated in, rather than what is objective and tested. With no specific method per se to guide my work, except having clarity about Gadamer’s ontology and epistemology, I endeavoured to use language as a means of questioning and reflecting on my traditions, historicity, situatedness, and prejudices, and to
manifest the conditions of understanding through all aspects of the project, as I worked towards developing concrete and practical understanding of sibling bereavement when the brother or sister dies for a drug-related reason.

**Gadamer in context**

In the subsequent paragraphs I aim to clearly articulate Gadamer’s philosophy to promote a deeper understanding. First, I consider the sociocultural context of his situatedness (essential when working hermeneutically) because Gadamer’s situatedness informs – in part – his philosophy. Then, I progress to look at those philosophers who came before Gadamer, prompting his thinking (also important hermeneutically). After setting the scene, I untangle and present the various interwoven elements of Gadamer’s philosophy. Sometimes when I explain Gadamer’s approach, it seems as though I am repeating myself. It is not the case; rather the whole of Gadamer’s hermeneutic philosophy is informed by multiple parts which are related and build on each other to form the whole.

Gadamer was born in Germany in 1900 and died in 2002 (Barthold, 2017). He lived through two world wars but did no military service due to a limp, incurred after contracting poliomyelitis. His mother died when he was young. She was inclined towards literature, arts and religion. His father was the professor of pharmaceutical chemistry at the University of Marburg and, therefore, Gadamer grew up in, as he called it, a ‘scientific milieu’ and was exposed throughout his life to the rigour of the ‘natural sciences’ (Gadamer, 1992/2001a). His familiarity with the natural sciences, coupled with his mother’s influence around the arts, would later assist him when extending his epistemological ideas about what constitutes knowledge (Grondin, 2003). Gadamer studied with many well-known philosophers of the 20th century including Natrop (1854-1924), Bultmann (1884-1976), Hartmann (1842-1906), Klein (1899-1978) and Strauss (1899-1973) (Gadamer, 1992/2001a). He had a distinguished academic career, retiring in 1968 (Grondin, 2003). During his fifties, he wrote *Truth and Method*, first published in 1960 (Barthold, 2017). It was not until after his retirement from university, and his magnum opus was translated into English, that he was recognised internationally.

As a person, Gadamer was a humble man who had lived and breathed hermeneutics for more than 70 years. Earlier in his career, Gadamer taught Plato and Socrates philosophy, both of whom are “masters of dialogue”; these experiences likely shaped his purported enjoyment of a good debate (Palmer, 2001, p. 10). In line with Socrates, Gadamer would strengthen the other’s debate, trying to see from the other’s point of view, with the goal of learning something new. During an interview with Grondin (2003), he said words to the effect that he was not a person who could use bravado to wing it and, therefore, he wanted to concretise learnings to make them applicable in everyday life. This is his gift to readers. Throughout his life he continued to reflect and engage in conversation, to listen, study, and sharpen his own philosophical hermeneutics (Palmer, 2001).

To understand the development of Gadamer’s philosophical hermeneutics, it is useful to look at who came before him and, therefore, to reflect on both Husserl (1859-1938) and Heidegger. What all three philosophers (Husserl, Heidegger, and Gadamer), and others around their time, were concerned with was progressing philosophy, a general methodological doctrine, in the Geisteswissenschaften, that is, the social sciences and humanities (Gadamer, 1978/2007). In the following paragraphs, I provide a summary of each philosopher’s theory and briefly consider the application of their theory to research in the humanities and social sciences, beginning with phenomenology.

The notion of phenomenology first appears in the works of Plato and Aristotle (Logan, 2016). Kant (1724-1804), Hegel (1770-1834), and Mach (1838-1916) expanded the theory later in the 18th century (Logan, 2016). Kant used the word phenomenon to mean ‘that which shows itself’ or thing-in-itself (Regan, 2012). However, it was Husserl’s work with the
Frankfurt School in Germany that brought phenomenology to the fore in the 20th century (Groenewald, 2004).

Husserl was concerned with the study of everyday lived experience (Munhall, 1994). He argued that how objects appear to an individual’s consciousness is certain or real (Converse, 2012). When a research project is underpinned by a phenomenology methodology, the research is explorative and descriptive, aiming to capture rich detailed information of people’s lived experiences of the issue being researched (Dietsch, 2003). The research findings serve the purpose of understanding a phenomenon for a group of people who have had the experience (Logan, 2016). Husserl’s stated aim was ‘to get back to the things themselves’, that is, the pure phenomena as known by the individual, which could only be done by ignoring everything outside the immediate experience including that of the researcher (Moran, 2000). Husserl did not believe in the Cartesian split between mind and body (Laverty, 2003), that is, where the body (object) is studied by science while the mind (subject) is studied by philosophy and religion. To prevent the subjective interpretation of phenomena by the researcher, Husserl introduced the idea of bracketing, where the researcher suspends their beliefs around the phenomena being studied (Moran, 2000).

Gadamer criticises Husserl for perpetuating the split between body and mind by incorporating the need for certainty and objectivity because, in doing so, he believes that “relegates the whole of its own historicality to the position of prejudices to be freed from”, in the humanities and social sciences, which is not possible (Gadamer, 1975/2004, p. 283).

Heidegger, like Husserl, was interested in the lived experiences and studied with Husserl. He was also influenced by other philosophers such as Schleiermacher (1768-1834) and Dilthey (1833-1911) and their work around hermeneutics (Gadamer, 1975/2004). Hermeneutics, some would say, is a school of phenomenology concerned with uncovering the hidden meaning, that is, interpretation (Logan, 2016). The term hermeneutic is derived from ‘Hermes’, the Greek messenger who communicated between the gods and mortals (Jones, 2001). Gadamer says the term ‘hermeneutic’ covers many different levels of reflection, but primarily refers to the practical art of understanding required when something is unclear or ambiguous (Gadamer, 1977/2007). In the 17th century, hermeneutics focused solely on the
interpretation of biblical texts using methods to objectively determine the intended meanings of the authors (Dowling, 2004). Two philosophers are credited with extending the context of hermeneutics. Schleiermacher is acknowledged as the founder of modern hermeneutics, by moving hermeneutics from biblical interpretations to human understanding (Gadamer, 1977/2007). He also promoted the notion of the conversation being 'an event' of understanding, which was very relevant to Gadamer’s work (Gadamer, 1993/2001a). As his focus was on psychology, he was interested in what conversations revealed about the person, that is, their inner subjective consciousness (Gadamer, 1993/2001a). Gadamer also credits Schleiermacher with unifying the processes of understanding and interpretation, thereby identifying the universal role of language (Gadamer, 1993/2001a). The other philosopher is Dilthey who broadened hermeneutics beyond a focus on the individual to include cultural systems and organisations (Dowling, 2004). Gadamer contends that Dilthey and others provided the stimulus for Heidegger “to further develop and reshape Husserlian phenomenology” (Gadamer, 1993/2001a, p. 39). Today, hermeneutics refers to the science/theory or art/practice of interpretation (Smythe & Spence, 2012).

By combining hermeneutics with phenomenology, Heidegger shifted the focus from the descriptive (pure phenomenology) to the interpretative (hermeneutic phenomenology) (Gadamer, 1977/2007). Heidegger contended that what influences interpretations is not necessarily within the consciousness of the individual (Linge, 1977). He believed we are influenced by what is already present in our society and taken for granted, that is, our history, societal structures, our culture, laws and expectations (Gadamer, 1975/2004). Heidegger contended that we forget about being in the world. This notion of forgetting and just existing is fundamental to Heidegger’s argument against bracketing, as suggested by Husserl; remembering it is the interpretative nature of hermeneutic phenomenology that makes it different to phenomenology alone. Therefore, according to Heidegger, it was not possible for researchers to know and bracket everything that may influence their interpretation due to the nature of forgetfulness of being-in-the-world (Barthold, 2017). Instead, Heidegger argued that the researcher should approach the research from a position
of openness, and document as much as possible, their preunderstandings, thereby not
discounting them in the interpretive process (Dietsch, 2003).

The other major contribution that Heidegger made was to shift the direction of hermeneutic
phenomenology from an epistemological problem to an ontological one, with the
introduction of ‘Dasein’ and the hermeneutics of facticity (Gadamer, 1995/2007). The
hermeneutics of facticity concerns “the concrete, factual existence of human” (Gadamer,
1995/2007, p. 362). To elaborate further hermeneutic facticity knows that “one would like
to uncover what is still shrouded in darkness, and yet one finds that it continually escapes us
and yet, for all that, it is always still there” (Gadamer, 1995/2007, p. 364). Said differently,
Regan (2012) says Heidegger’s Dasein captures the duality of both ‘being in the world’ and
simultaneously ‘forgetting we are in the world’ in our daily lives. The idea of forgetting we
are in the world essentially foregrounds (brings to the front) our historicity which is defined
as the “horizon of the past, out of which our culture and our present live, influences us in
everything we want, hope for or fear in the future. History is only present to us in light of
undertook to interpret being, truth, and history in terms of absolute temporality” (p. 247).
Therefore, the term Dasein – ‘being-in-the-world’ – concerns the structural unity of the
world, the self and the world-self relation at a point in time (Sembera, 2007, p. 47).
Heidegger links the fundamental ontological question in phenomenology, “what it is to be?”
(descriptive) to the hermeneutical problem of “what is the meaning of being?”
(understanding). In linking the two, Heidegger’s “radical ontological reflection” transitions
hermeneutic phenomenology to have an ontological rather than epistemological focus and,
as such, Gadamer (1975/2004) contends that, “the concept of understanding is no longer a
methodological concept” (p. 250). Understanding in hermeneutics occurs in the place
between two people or a person and text. Gadamer (1975/2004) says it is not possible to
separate our history, traditions, situatedness or to know which prejudices will be productive
or hinder understanding and lead to misunderstanding. The endeavour to understand
anything begins with what we already know. Therefore, there cannot be a procedure or
method of understanding – there can only be clarity on the conditions in which
understanding takes place (Gadamer, 1975/2004).
As stated above, Gadamer was taught and mentored by Heidegger (Leiviskä, 2005). He was inspired by Heidegger’s philosophy, as well as Heidegger the person. Gadamer (1992/2001b) says during an interview that Heidegger was a gifted speaker, but his writing was elusive and trying to understand Heidegger was equivalent to learning another language. Heidegger encouraged students to find their own words for what they wanted to say (Gadamer, 1992/2001b). In the spirit of Heidegger's encouragement, Gadamer used the term ‘tradition’ to encompass the same meaning as Heidegger’s term ‘thrownness’, to “underline the facticity of Dasein” (Gadamer, 1992/2001b, p. 111). Gadamer ostensibly became an expert in Heidegger’s earlier works and, in doing so, was able to develop hermeneutic phenomenology well beyond many of Heidegger’s initial concepts (Gadamer, 1977/2007).

While interviewing Gadamer, Grondin (2003) enquires about a quote – “hermeneutic philosophy? Oh, that is Gadamer’s thing” written by Heidegger – to which Gadamer concedes that Heidegger stopped using the term ‘hermeneutics’ in his own work (Gadamer, 1996/2007, p. 412). In progressing his own philosophical thinking, Gadamer (1975/2004) emphasised the concept of application in hermeneutics which provided the impetus to use simple language and examples to concretise the understandings he was trying to convey. Therefore, Gadamer’s philosophical hermeneutics is both comprehensible and practical (concrete) (Gadamer, 1993/2001b).

In the preceding paragraphs I set the scene for the development of Gadamer’s philosophy. First, there was Husserl who was interested in the phenomenon of everyday lived experience. Husserl valued people’s experience as a way of knowing about the world, rather than the knowledge arising from scientific method. Heidegger subsequently linked phenomenology with hermeneutics – interpretation – and saw lived experience as an ontological situation rather than an epistemology problem. He saw understanding as existential and belonging to Dasein. Gadamer explicated Heidegger’s hermeneutic phenomenology further. He contends that language is the central ontology, meaning that philosophical hermeneutics is concerned with both understanding the phenomenon and
knowing how that understanding comes about, which he calls the phenomenology of understanding.

**Gadamerian philosophical hermeneutics**

In the following section, I present the key tenets of Gadamer’s philosophical hermeneutics, which has multiple interconnected parts. Ultimately, Gadamer’s philosophical hermeneutics focuses on both understanding the phenomenon and the phenomenology of understanding; therefore, I explain these concepts in detail. Then, I provide a detailed explanation of how Gadamer tackled the scientific method in relation to truth and the aesthetic experience. The next part covers the two universals in Gadamer’s philosophy – the universality of understanding and the universality of language – followed by describing what a horizon is and what informs our horizons (that is, our view of the world) and how understanding occurs through the fusion of horizons.

The difference between phenomenology and Gadamer’s hermeneutic phenomenology is that phenomenology is concerned with what is ‘immediately given’ from the research material, the lived experience, or ‘the thing itself’ (Hekman, 1984). Gadamer contends that to work phenomenologically is to work “descriptively, creatively-intuitively, and in a concretising manner” (Gadamer, 1992/2001b, p. 113). Hermeneutic phenomenology differs in that it is more than describing and is more active, incorporating understanding, interpretation and application (Gadamer, 1993/2001a). Gadamer was interested in how interpretation happens in the everyday world and the nature of understanding (Hekman, 1983 & 1984) which is how his philosophical hermeneutics comes to focus on both the phenomenon and the phenomenon of understanding.

**Truth is not reducible to scientific method**

In *Truth and Method* (1975/2004), Gadamer argues that the phenomenon of understanding precedes all methodological discussions; therefore, he does not offer a specific methodology for conducting research (Logan, 2016). His argument is so strong that he dedicated one part of his three-part magnum opus to issues of objectivity, prejudice, historicism, truth, scientific method and their role in the humanities and social sciences (Gadamer, 1975/2004). Gadamer (1993/2001a) shows “that the concept of method was not
an appropriate way of achieving legitimisation in the humanities and social sciences” (p. 40). He goes on to say that anyone can use a method and a tool for research, but it is those who use their “hermeneutical imagination that distinguishes truly productive researchers” (Gadamer, 1993/2001a, p. 42). While he does not provide a method for humanities and social sciences, he does provide a philosophy of interpretation (Gadamer, 1993/2001a).

To understand Gadamer’s position on scientific method, it is necessary to understand his view on the truth of experience and how, as individuals, we come to know that what we know is true. While he does not reject scientific method outright, he does think the Enlightenment philosophers were erroneous in thinking that all truth must be in the form of ‘objective knowledge’ and thus should be produced by the scientific method. He contends that objective knowledge derived from scientific experiment is not the exclusive ideal of knowledge, rather it is a special case of knowing, not a universal model of all knowledge or truth (Gadamer, 1975/2004).

Gadamer challenged scientific method as the only way of knowing because it excluded knowledge that falls outside the parameters of scientific experiment. His examination shows that drivers of scientific method (such as quantifiability, objectivity, repeatability and the scientific experiment itself) result in other forms of knowledge – including all human experience – being excluded from the realm of truth (Hekman, 1983). As the study of the experience studies the subjective meanings of those experiences, it falls beyond the parameters of the scientific model because these phenomena cannot be quantified (Gadamer, 1975/2004). He contends that faith in method and drive for objectivity are not possible in the humanities and social sciences stating, “people who believe they have freed themselves from their interwovenness into their effective history (wirkungsgeschichete) are simply mistaken” (Gadamer, 1993/2001a, p. 45). What Gadamer means by effective history is that, in living, we are conditioned by our history – it determines our interests and yet, we forget it is there (Gadamer, 1975/2004). Further, he argued it is not possible to repeat the human experience. Scientific experimentation is a methodical procedure and for the experiment to be verifiable, it must be repeatable for checking purposes. Scientific method objectifies experience by removing historical elements. In accordance with the scientific
model, an experience is only valid if it is confirmed; therefore, to be repeatable, the history must be eliminated, but doing so also eliminates the experience (Gadamer, 1975/2004). To Gadamer, methodically conducted experiments have step-by-step procedures; these scientific method controls serve to stop hasty conclusions being reached but, in doing so, Gadamer thought the controls stifling (Gadamer, 1975/2004). He argued that research is not just about applying methods, it is also about the creative mind of the scientist (Gadamer, 1975/2004). He identifies that the natural sciences forget their own historicity, even though it is their history that dictates the need for method and procedure (Gadamer, 1975/2004). Based on Gadamer's analysis, it is apparent “that the closed, ahistorical, ‘truth’ of the scientific model, far from representing the universal form of all knowledge, is appropriate to only a very narrow range of situations” (Hekman, 1983, p. 211).

Not only did Gadamer argue against the application of scientific method in the humanities and social sciences, but he argued the humanities and social sciences are not inferior because they use a different methodology. Gadamer (1975/2004) contends that hermeneutics legitimises something completely different from modern science and there is no need for tension between the two. Central to this critique is his analysis of an experience of truth, the aesthetic experience that embodies “a claim to truth which is certainly different from that of science, but equally certainly is not inferior to it (1975, p. 87)” (Hekman, 1983, p. 208). Gadamer sees the humanities and social sciences and natural sciences in complementary terms.

He describes how truth is experienced when we engage with the aesthetic such as a work of art, a piece of music or some poetry. The meaning obtained from the aesthetic cannot be transferred to another; we cannot paraphrase or repeat our experience. As Gadamer says, it is an event that “jolts us, it knocks us over, sets up a world of its own, into which we are drawn, as it were” (Gadamer, 1993/2001a, p. 71). This ‘knowing’ experience does not fit with the scientific model of knowing (Hekman, 1983). Elaborating further, in the aesthetic experience, the knower is an active participant in the process. This contrasts with the scientific model where the knower is a passive recipient of knowledge and removed from its object (Hekman, 1983). For Gadamer, the truth of the aesthetic is that when we look at a
work of art, we know how it appears to us, and this is our truth. Truth in this context is something that opens up to us, it opens our eyes to new ways of seeing and future possibilities. It is not possible to make the knowing experience, the recognition of truth in the aesthetic, objective or create an existential distance. The knowing experience of the aesthetic is something we are drawn into in such a way that one’s own being is altered (Barthold, 2017). The truth experienced in this context is much more than just the reduction of things down to objects to be tested. Gadamer says there is a deeper, richer truth that goes beyond scientific method.

Hekman (1984), in her précis of Gadamer’s philosophical hermeneutics, summarises his position on scientific method:

Gadamer’s extensive examination of the relationship between truth and method, then, leads to two conclusions: first, that truth is not strictly the province of scientific method, nor is that method the universal model of certain knowledge, and, second, that the understanding which is sought in the human sciences provides the foundation or precondition for all knowledge and, hence, for the knowledge of the natural sciences as well (p. 340).

By focusing on the truth of the aesthetic experience, he validates other truths such as the “encounter with the work of art itself” (Gadamer, 1975/2004, p. 87), while simultaneously obviating the need for methods and scientific experiment.

It is important to grasp fully what Gadamer means when he talks about horizons and the conditions of understanding because these are key concepts in his philosophy, and consequently, key concepts to my research project. A horizon by a different name is the same as our frame of reference or our world view. Numerous elements form our horizons, including traditions and historicity, which are passed to us through language and inform our prejudices and situatedness. Gadamer (1975/2004) uses the term prejudice in a neutral literal manner, to include both positive and negative values. When trying to understand something, we are open to new experiences. In the act of understanding, we project from our prejudices, thereby testing them, opening the prejudices to revision in the context of the new experience. It is not possible to know which prejudices will hinder or help with
understanding the subject matter, “we have to think with them and we situate them in our understandings” (Moules et al., 2015). Gadamer (1975/2004) says, “the horizon of the present can’t be formed without the past” (p. 305). The ‘past’ refers to the cultural historicity and linguistic tradition of our time, all of which we are born into and to which we belong.

As we exist within our historicity, then our historicity is effective – operative – in the act of understanding as well. In a similar vein, Gadamer discusses the situatedness of hermeneutics. A situation necessarily limits our vision because our situatedness is the standpoint from which we view the horizon and the horizon has everything that can be seen from a particular vantage point (Gadamer, 1975/2004). To Gadamer, a horizon allows us to see what is up close and what is far away without excluding either position (Gadamer, 1975/2004) (See Diagram 1). Therefore, we can see what is relevant now and what is happening in the broader context, but we cannot be outside of our situatedness (Gadamer, 1975/2004). What is important to grasp at this point is that our effective historicity and traditions – our prejudices and situatedness – are active in the act of understanding but are not necessarily known to us (Gadamer, 1993/2001a). Gadamer contends that, even with reflection, we can never really know the entirety of our prejudices and cannot stand external to our own situation no matter how much reflection we do. However, we can try to open and expand our horizons and continually question what supports our standpoint and interests (Gadamer, 1975/2004). Of course, this is an endless process, as our understanding develops and our situatedness changes. Therefore, our horizons are not static, rather they are continually changing when we are open to new experiences (Gadamer, 1975/2004).

The diagram below shows how the standpoint – our situatedness – changes our view of the horizon.
All understanding reflects the ubiquity of language

Gadamer argues that hermeneutics and language are intricately entwined with, and are fundamental to, our very existence and human practices (Logan, 2016). He contends that language (like tradition, historicity, situatedness and prejudice) is given to us, we do not seek it out; we learn it because we exist (Hekman, 1983). Language is the medium through which we perceive the world, informing our horizons without our knowledge (Regan, 2012). Our tradition, historicity and shared existence is all verbal in nature, carried and enclosed in language (Gadamer, 1975/2004). Hidden in the forgetfulness of language (that is, taken for granted) are our prejudices and situatedness (Gadamer, 1993/2001a). Therefore, language shapes our orientation and relationship to the world and has “its real being only in the fact that the world is presented in it” (Gadamer, 1975/2004, p. 440). Gadamer claims language is the universal horizon of hermeneutic experience and the hermeneutic experience is itself universal (Malpas, 2003).

We do not just learn or use singular words to communicate, we use sentences, and it is through the entirety of language – a system of words and linguistic expression – that we are able communicate with others (Gadamer, 1993/2001c). There is a shared acceptance and common understanding of the meaning in words and the rules of language (Gadamer, 1975/2004). Words are symbols that allow us to conjure an image (Regan, 2012). There is also an openness in language where we can create new words and, in a sense, new worlds belonging to those words (Barthold, 2017). For Gadamer, it is not about choosing powerful words to project in language, it is that language is the reply (Gadamer, 1992/2001b).

Diagram 1

Scope of the horizon from close up and with more distance
Language in this context belongs to the ‘we’; it is relational and concerns our interconnectedness (Gadamer, 1993/2001a).

In terms of the written word, Gadamer says, “all writing is a kind of alienated speech, and its signs need to be transformed back into speech and meaning” (Gadamer, 1975/2004, p. 394). Gadamer states that writing is essential to hermeneutics because it is the detachment from both the author and the reader that gives text a life of its own (Gadamer, 1975/2004). When we read text, we come to the text with our own tradition, historicity, situatedness and prejudices, which constitute our background understanding, that is, our horizon. The text itself “addresses us with its meaning, with its claim to truth”, that is, its horizon (Vilhauer, 2009, p. 361). In the process of trying to understand, we engage with the text, our prejudices come to the foreground for examination and questioning (Vilhauer, 2009). As our prejudices are foregrounded, we come to understand better our own ideas about the world and the situatedness of our horizon. If we are really understanding the text, then we necessarily apply what we have understood to our world and, therefore, overcome the limitation of prejudice (Vilhauer, 2009). In a sense, to understand the text, we must be able to translate it into our own language, question and examine it and henceforth apply it, thereby projecting a new horizon (Gadamer, 1975/2004).

Understanding events are possible with the right conditions
When Gadamer describes an ‘understanding event’, he emphasises that the conditions of understanding need to be in effect. These conditions include being open to the meaning of the other person, aware of one’s prejudices as they become apparent, have goodwill towards hearing something new, question what lies behind what is said and “put at risk” previous ways of understanding, in order to be transformed (Gadamer, 1975/2004, p. 299). These conditions make possible the understanding event.

Gadamer (1993/2001a) says an understanding event occurs through language. Therefore, it is language that makes understanding, interpretation or translation possible (Logan, 2016). Since all interpretation is linguistic and all understanding is interpretation, it follows that “all interpretation takes place in the medium of language” (Gadamer, 1975/2004, p. 390).
Consequently, language is also the medium of the hermeneutic experience, making understanding possible (Hekman, 1983).

The locus of hermeneutic work occurs in the ‘in-between’ place (the intermediate position), that is, between two projected horizons of either two people, or a person and a text (Malpas, 2003). All interpretation involves exchange of the familiar and unfamiliar and movement from the part to the whole and back to the part again (Gadamer, 1975/2004). To understand the foreign, we must build on what we know; therefore, we begin by projecting parts of what we already know to try to grasp what the other is saying (their whole) with the aim of finding common ground on the subject matter (Gadamer, 1992/2001b). We anticipate a shared meaning will be achieved in the hermeneutic circle which is why we project from what we know (Gadamer, 1975/2004). Through this process, our traditions, historicity, prejudices and situatedness – although these may be hidden from us initially – become apparent and open to revision, as understanding emerges (Gadamer, 1993/2001a). There is the notion of dynamic reflexivity because, as we try to understand, thinking is provoked, questions asked, and understandings achieved, but these are a work in progress, never finite (Smythe & Spence, 2012). This dynamic reflexivity goes to the notions of distance, reflection and application as understanding occurs (Gadamer, 1975/2004). We work through the process, developing familiarity with the strange, until understanding is achieved, and there is an agreement on the subject matter which is the thing in dispute. As Gadamer (1975/2004) says, in order to understand, the interpreter “must not try to disregard himself and his particular hermeneutic situation. He must relate the text to this situation if he wants to understand at all” (p. 321). He emphasises the participatory and reciprocal nature of understanding and the necessity of application.

Gadamer (1975/2004) says that understanding is an event that happens to us where we lose ourselves, like in the experience of play. Play has a life and meaning of its own, its own essence. When we are immersed in play, we lose our ‘I-ness’, we become a part of something that is bigger and more expansive; the subjective self is lost as we experience being in the game (Regan, 2012). The activity of play engages all players in a dynamic relatedness with a reciprocal back and forth movement that is open to varied possibilities.
and experiences (Vilhauer, 2009). Gadamer (1975/2004) says, “you cannot have a game by yourself. In order for there to be a game, there always has to be, not necessarily literally another player, but something else with which the player plays, and which automatically responds to his move with a countermove” (p. 106). He concludes the point by saying, “there is a primacy of the game over the players” (Gadamer, 1975/2004, p. 106). One place where understanding events occurs is where we lose ourselves, in conversation.

Gadamer (1975/2004) says authentic conversations are not things we conduct, but rather we fall into them; they take their own directions and reach their own conclusions around the subject matter. The conversation is the game of language, not under the control of either person, but determined by the agreement around the subject matter as “no-one knows in advance what will come out of a conversation” (Gadamer, 1975/2004, p. 385). Every conversation has a spirit of its own. He concluded that conversing is not about sophism (that is, asserting being right all the time), but rather the conversation is about risking, challenging and questioning our traditions, situatedness, prejudices and historicity, to come together in understanding on the subject matter (Barthold, 2017).

Understanding in conversation, and understanding text, involve the same process. Gadamer (1975/2004) contends that all understanding is interpretative and multiple interpretations are possible, rather than having one objective meaning, because interpretations will change depending on questions asked by the interpreter and their situatedness. It follows there is no one correct interpretation and all interpretations are subject to revision because the interpreter’s horizon will vary over time (Hekman, 1984). Gadamer (1975/2004) says, “understanding text and reaching an understanding in conversation have in common that both are concerned with the subject matter placed before them” (p. 370).

Gadamer (1975/2004) refers to the understanding event as the fusion of horizons. As we understand a part of the other’s horizon, the whole of our own horizon is changed, deepened or made broader. The process involves us moving from a part to the whole, and the whole to the part (that is, the hermeneutic circle) which is the iterative nature of understanding. The interaction becomes something of its own, quite separate, as an event
of understanding. Gadamer (1975/2004) states that every conversation and subsequent understanding or misunderstanding is an event which allows for something to emerge and, therefore, to exist.

Below in Diagram 2, I show how the various elements of the phenomenon of understanding come together.

Diagram 2
The phenomenon of understanding

Diagram 2 is a visual representation of the phenomenon of understanding, based on my interpretation of Gadamer’s (1975/2004) philosophical hermeneutics, and which was used to guide my research. The phenomenon of understanding is depicted in the centre of the diagram as it occurs when two horizons cross over. Gadamer refers to the event of understanding as – the fusion of horizons – which occurs on specific subject matter at a space that is in between either two people in interaction or one person interacting with text. The text or the person each have their own horizon shaped by language which passes on traditions and historicity, all of which inform the situatedness and prejudices and the view from the horizon. The conditions of understanding are projected towards the other.
The conditions include being open, listening, questioning, reflecting, and having a willingness to learn something new. These conditions are present in the hermeneutic circle, moving from a part to the whole again in space between the two, as the fusion of horizons is achieved.
Chapter 5: Methodology – application to research

This study is underpinned by Gadamer’s philosophical hermeneutics and, as such, his conditions of understanding and hermeneutic circle must be present in the research project as both are essential for a fusion of horizons to occur. Recapping, Gadamer’s (1975/2004) conditions for understanding are to be open to the meaning of the text or person, aware of one’s own biases as they present during the process of understanding and have goodwill towards hearing something new, question to test possibilities of meaning, discover what lies behind what is said and put at risk previous ways of understanding, in order to be transformed. The hermeneutic circle aids understanding because we are constantly moving from a part to the whole of the subject matter in the conversation.

Gadamer (1975/2004) contends that language mediates past knowledge with the present, representing one’s situatedness and prejudices, both operating unnoticed, and only becoming apparent when provoked in conversation. He argues it is not possible for a researcher to foreground traditions, prejudices, historicity or situatedness before undertaking the research because not all are evident. He says traditions and historicity “come down to us by way of verbal tradition” (Gadamer, 1975/2004, p. 391). Gadamer does not view prejudices as either positive or negative, stating, “the radical Enlightenment declared war on all prejudgments whatever” (Gadamer, 1993/2001a, p. 43). Further, he says, “the prejudices and fore-meanings that occupy the interpreter’s consciousness are not at his free disposal. He cannot separate in advance the productive prejudices that enable understanding from the prejudices that hinder it and lead to misunderstandings” (Gadamer, 1975/2004, p. 295). He contends we do not try to rid ourselves of our prejudices; rather, the approach must be to engage fully and test our prejudices and, in doing so, risk our prejudices and prior understandings. To achieve understanding of another person or text, Gadamer says we must allow ourselves to be affected, to be changed; that by being open and listening, we ready ourselves to hear something different and, in hearing something different, become aware of our situatedness and prejudices (Vilhauer, 2009).
Both the conditions of understanding through language and the hermeneutic circle must be maintained in any research project underpinned by Gadamerian philosophical hermeneutics. However, they do not represent a procedure or method for research (Gadamer, 1975/2004).

**Methods**

My initial readings of Gadamer gave me a level of understanding that was sufficient to guide the development of the research design with the aim of addressing the research questions. Gadamer would say we are always in a hermeneutic process and this is true for me. As I continued to read Gadamer’s magnum opus – *Truth and Method* – my interpretation of his philosophy deepened in true hermeneutic style.

In the following section, I detail all aspects of the research project, including qualitative research, ethical principles, processes for recruitment and interviews, as well as analysis of the information gathered. This section discusses each part of the research journey with reference to Gadamer’s philosophical hermeneutics. I begin with the research questions and aims generated from the literature review.

Based on the literature review, I am not aware of a retrospective qualitative study seeking out the experience and meanings that siblings attribute to the death of their brother or sister for a drug-related reason in the longer term. The experience could include recollections of drug use, the experience immediately after the death and changes occurring over time to the sibling and their family. As there is a lack of research on this topic, little is known about the meaning attached to the death of the sibling, the ongoing presence of their sibling or indeed stories of growth, hope or resilience which may be present. The experience of sibling bereavement and drug use within the family context is an unexplored phenomenon and the gaps revealed in the literature review are one of the motivating factors for undertaking research in the area. This research project aims to address these gaps in the research.
Research questions and aims
This research has two aims: to develop a rich understanding of the participants’ experiences of sibling bereavement when the brother or sister dies for a drug-related reason and to inform social work practice theories in bereavement, drug and alcohol use and families. The following broad research questions address the aims by capturing:

- What are the reflections on initial experiences and meanings of sibling bereavement and any changes to these experiences and meanings over time?
- What are the stories of connection to the sibling who died, family processes around meaning making and experiences of growth, hope and resilience?
- What are the bereavement experiences when the sibling’s death is drug-related, including the experience of living with drug use?

Qualitative research
My research project is a qualitative study underpinned by Gadamer’s philosophical hermeneutics and, therefore, is focused on both experience and the interpretation (or understanding) of experience, which encompasses the phenomenon of understanding. The key tenet of Gadamer’s approach to research is that the phenomenon of understanding precedes all methodological discussions and, therefore, there cannot be one specific methodology for conducting research (Regan, 2012). In addition, scientific method is useful in the natural sciences but does not offer a universal model of all knowing. In the humanities and social sciences, a different type of knowledge can be ascertained. That is, shared and participated, descriptive and interpretative, and concerning the human experience, in which there exists multiple truths of what it is to be human (Heckman, 1983). The study of experience (phenomenology) is rich in meanings and understanding (hermeneutics) is “carried within language” (Gadamer, 1993/2001a, p. 37).

The focus of research guided by Gadamerian hermeneutics includes both how we come to understand and what we understand about the phenomenon (Turner, 2003). Gadamer (1975/2004) is clear that the conditions of understanding are necessary for the fusion of horizons to occur. The conditions for understanding place the researcher in a humble position because I must assume there is always something – concerning a prejudice (positive or negative) or my situatedness – about which I am not correct and not justified in
maintaining (Gadamer, 1993/2001a). The event of understanding – the fusion of horizons – is not possible if a person seeks to maintain a sophistic position which by its very nature features a closed subjectivity (Frankowska & Wiechula, 2011). Therefore, notions of subjectivity and sophism need to be guarded against to prevent making hasty conclusions and taking a position of just being ‘right’ (Gadamer, 1975/2004).

One of the major criticisms over the years of phenomenological-type studies is that the philosophical theory does not permeate all aspects of the research project because the depth of understanding by the researcher is inadequate or the research project is inconsistent with the philosopher (Koch, 1999). What this meant for me was that Gadamer’s philosophy must be apparent in every process and decision I made throughout this project (Fleming et al., 2003).

The first decision was whether I should be guided by my interpretation of Gadamer’s philosophy of hermeneutics or what textbooks on research refer to as the ‘hallmarks’ of good qualitative research. These hallmarks include credibility, transferability, dependability and trustworthiness, or the broader issues of trustworthiness and authenticity (Logan, 2016). The concern I have with these ‘hallmarks’ is that some parallel quantitative research markers of validity and reliability (Bryman, 2008). They resemble what I refer to as ‘positivism creep’, a term I use to describe how dominant and pervasive scientific method is in influencing our ontology and epistemology and shaping our prejudices about research, including how to define the quality of research, or how we may go about doing our research (Bell, 2012). Consistent with Gadamer’s philosophy, the objectives of scientific method for objectivity and detachment using processes, tools or measures have no place in the assessment of qualitative research. In fact, Gadamer (1975/2004) argued research is not just about applying methods, it is about the creative mind of the researcher. In subsequent interviews, Gadamer says that methods, like tools, are good to have but “it is the hermeneutic imagination that distinguishes truly productive researchers” (Gadamer, 1993/2001a, p. 42). He says that the hermeneutic imagination “is the sense of questionableness of something and what this requires of us” (Gadamer, 1993/2001a, p. 42). Ultimately, my intention is to produce research that has integrity, whereby there is an
internal coherence flowing from the underpinning philosophy – Gadamer’s philosophical hermeneutics – that is sustained and rigorous (Crowther et al., 2017).

**Ethics approval**

The ethics submission was completed and submitted to the Charles Sturt University (CSU) Human Research Ethics Committee (HREC) for consideration on 13 June 2013, with approval granted on 18 July 2013, issued under the approval protocol number 2013/133 (Appendix 1). Accountability processes to ensure the continuity of ethics approval have been maintained for the duration of the project. Below, I expand on the key principles of non-maleficence, informed consent and participant confidentiality and privacy, as applied to the research project.

*Ethical principles – non-maleficence*

When doing any research in Australia involving people, the national standards on ethical principles in research insist on maintaining respect for human beings, producing research that has merit and integrity, promotes justice and ensures beneficence and non-maleficence for all concerned in the project (National Statement on Ethical Conduct in Human Research, 2007, [Updated May 2015], p. 9). Given that the research topic – sibling bereavement – could potentially evoke strong feelings (potential harm), it was important to mitigate against and/or manage any potential risks posed to participants in the study (Walker, 2007). I also had to remain mindful that the circumstances of the siblings’ deaths, in terms of being considered untimely and preventable, and that the associated drug use may have resulted in poor social support, placing people at risk of complicated grief (Shear et al., 2011).

Therefore, the research design incorporated three strategies to ameliorate any distress. I routinely sent a list of community resources available to people in the community that could be accessed for support. I followed up with every person 48 hours after the interview to ask what the experience of doing the interview had been like and to see if there was anything they wanted to add or delete from the interview. I developed a guide for these conversations and proceeded, with permission, to record and transcribe these conversations. These follow up calls went for 10–45 minutes. I also ensured that all people contributing to my study were advised they could withdraw consent and, therefore, cease participating in the project at any time. All these strategies were intended to provide people with choice, facilitate informed decision-making and maintain their welfare while engaged

**Ethical principles – informed consent**

After making contact with people who were potentially interested in participating, I sent the introductory letter on the research project (Appendix 2), plus the consent form (Appendix 3) to the person, via email. I also sent an example of the list of topics to be covered during the interview (Appendix 4) and the list of community services (Appendix 5).

Prior to commencing the interview, I checked routinely to ensure I had a signed consent form from each participant and, if not, verbal consent was digitally recorded. I also outlined the process for the interview with each person and clarified any issues around the research project. I emphasised that participation in the project was voluntary and consent to participate could be withdrawn at any time (Walker, 2007).

**Ethical principles – participant confidentiality and privacy**

Information gathered through in-depth interviews is by nature detailed; therefore, it is important to protect the identities of people participating in the project. Holloway and Wheeler (1995) argue it is common practice to de-identify research material by changing, removing or making vague, references to any ‘identifying’ information such as places of residence or places of work and to use pseudonyms instead of actual names. This approach is also consistent with the principle of non-maleficence where the intent is to do no harm to people contributing to the research (Bryman, 2008).

I interviewed some people from the same family and, assuming they would be able to recognise each other in the report, therefore, I have removed references to one another (Walker, 2007). My decision for doing so was twofold. First, there was no way for me to know the sensitivities in each relationship or, to assess if comments made would help or hinder those relationships and, second, the focus of the study was on the relationship to the sibling who had died, rather than on existing relationships within families.

Confidentiality and privacy were definitely important issues and expected by many of the people in the study; I know this because I had to reassure quite a few people about this
issue. However, one person had a very different view. She was respectful of other people who were participating and their desire for privacy and confidentiality; however, regarding her own participation, she requested her name be used. She said her rationale for doing so was, “I’m really aware of the stigma … the more we silence it, the more we sort of stigmatise it ourselves”. I made the decision to honour Kathryn’s request after we discussed what this meant to her and she provided informed consent with the caveat around her name being used. Her perception that being de-identified in the study would further stigmatise her brother’s memory was cause for concern for me – a guiding principle is do no harm. Also, her desire to contribute to the study was in part to raise awareness of the damaging nature of stigma that occurs when someone dies for a drug-related reason. She was well informed and clearly articulated her rationale for the request. She also knew she could withdraw her consent to participate in the study at any time.

Strategies to recruit people to the study

Holloway and Wheeler (1995) state that qualitative researchers will gather information from a small number of people because the purpose is to gather rich and detailed information, often referred to as ‘thick descriptions’, of the phenomenon under investigation. Interviews can be lengthy, generating a vast amount of data and often providing depth and breadth in the information gathered (Hycner, 1999).

The aim for this research project was to recruit 20 to 30 people to participate in the study. As Moules et al. (2015) say “hermeneutic research is not validated by numbers, but by the completeness of examining the topic under study and the fullness and depth to which the interpretation extends understanding (p. 90). I recruited 21 people. Originally, I had thought recruitment would be a simple process as I am aware that many people have experienced the death of a sibling for a drug-related reason. Around 1,800 deaths are induced by drugs (drug-related) in Australia each year (AIHW, 2021). When I combined that information with the average number of children per family in Australia at 1.7 (Qu, 2020), I know that around half the people who die each year for a drug-related reason will have a sibling – meaning there is a large pool of people (900 per annum) from which to draw. After much reflection, I realised later that my own prejudices influenced my expectations.
I used two sampling methods incorporating purposive sampling and snowball method of sampling. Bryman (2008) describes purposive sampling as “essentially strategic and entails an attempt to establish a good correspondence between research questions and sampling” (p. 458). Purposive sampling means to seek out only those people who have experienced the phenomenon, to participate in the study (Alston & Bowles, 2003). In other words, participation is restricted because it is a very specific study aimed at deepening an understanding of the phenomenon under investigation. To this end, I developed a set of inclusion criteria to help reveal what the experience means to a particular group of people (Crist & Tanner, 2003). The criteria were: a) over the age of 18 years, b) English-speaking, c) not affected by a cognitive or intellectual disability or mental illness, d) have experienced death of a sibling five years or more years ago, and e) describe their sibling’s death as drug-related. These criteria were informed by the literature review which identified that much of the bereavement research occurs with people within 0–2 years of the death. I wanted people to have greater distance from the death because I was interested in the longer-term bereavement experience and possible stories of growth, hope or resilience, if these were indeed present. The term ‘drug-related’ was not defined as such, although the term ‘drugs’ was defined in this research project as incorporating all psychoactive substances that depress, stimulate or cause hallucinations; therefore, it includes alcohol. I was open to hearing how people defined drug-related death. Hence, I was not being prescriptive. The following terms are those that people in my study used to describe their siblings’ drug-related death: drug overdose, drug poisoning, accidental overdose, drug-related illness, drug assisted suicide and homicide.

Another recruitment strategy was to use the snowball method which means asking those who participated if they could recommend others with similar experiences. A snowball strategy is a ‘convenience sample’ method where initial contact with a relevant group of people is used to make contact with others (Bryman, 2008). This strategy can also be used when access to the target group is limited (Alston & Bowles, 2003). By using this strategy, I was able to interview siblings from the same family. The aim was that recruitment processes would conclude once I had exhausted all the current ‘contacts’ and had no other useful ‘leads’ to pursue (Alston & Bowles, 2003).
I developed various strategies to recruit people such as contacting key organisations, for example, peak organisations, support or self-help groups such as Family Drug Support, Family and Friends for Drug Law Reform and The Compassionate Friends and provided information on the study. I sent an introductory letter about my research (Appendix 2), offered to talk at meetings of these organisations and/or requested the letter be published in organisation newsletters. I also engaged Charles Sturt University (CSU) Media Unit to help promote the study publicly and generate interest regarding possible participation.

By November 2013, I had written to all the agencies and, for those agencies that responded positively, I had information published in their newsletters. I also talked about my research at the annual general meeting of a local Canberra group. One person came forward to participate in the study. In correspondence with the Chief Executive Officer of Family Drug Support (a national organisation), I asked if he knew why no-one had volunteered. He then offered to approach people who might be interested in participating and provide my contact details. I recruited one other person. Neither person suggested others who may be interested in contributing to the study.

Difficulties in recruiting people
On reflection, I realised that siblings do not form the bulk of the membership for these groups; they are represented, but membership is primarily comprised of parents. In this instance, my own prejudices had led me to think that siblings, like parents, would access these groups. However, my prejudices had not been foregrounded until I questioned why no-one was volunteering to participate in the study.

I had also thought the snowball recruitment strategy would be pivotal, as I assumed siblings would know other siblings who had had the same experience because, as a bereaved parent myself, I had reached out to many other bereaved parents. Again, this reflects my own prejudices and situatedness, although I also acknowledge that to understand anything, we begin by projecting from what we know. Interestingly, this was not the situation for the people I recruited. Only one person knew other siblings and that was because she had joined a self-help group specifically for siblings. While most of the participants had other brothers and/or sisters who would also be eligible to contribute to the study, most declined...
to pass on the information about the study, primarily out of concern that doing so would upset their siblings. In the end, I did recruit three siblings using the snowball strategy, with most people participating in the study saying they did not know anyone else who had had this experience. For the duration of the project, I have pondered the question of why siblings, who have had a brother or sister die for a drug-related reason, do not seek out and/or talk to other siblings with similar experiences. This observation has helped inform some of my key findings that are presented later in the thesis.

I promoted my study whenever I had the opportunity, for example, presenting to different groups. It was during a presentation to the mental health professional network in Yass, New South Wales, that colleagues suggested I should be approaching other generalist professionals, professional peak groups and service agencies. As a group, they advised they all had clients who had had a sibling die and, while the clients may not be in counselling for that reason, some may have fitted the criteria and been able to participate. Based on their advice, I advertised in the Australian Association of Social Workers’ National Bulletin on 18 June 2014 and, as a result, recruited a further three people.

The CSU Media Unit issued a media release on 25 February 2014, resulting in three radio interviews and an article on page three of The Canberra Times, with a photo of me in my private practice counselling room. An organisation based in Melbourne – International World Overdose Awareness Day (IWOAD) – picked up the story, tweeted a link to The Canberra Times article and put a link to the article on their Facebook page. The founder of the organisation contacted me via email and offered to put me in contact with people who fulfilled the inclusion criteria for the study. I continued to pursue all leads and all possible recruitment strategies until all avenues were exhausted and no other potential participants came forward. Publicity via the media was the most fruitful recruitment strategy deployed.

I interviewed 21 people over a nine-month period between November 2013 and August 2014. There were another four people who fitted the inclusion criteria for the study but ultimately withdrew before the interview.
People who were not eligible to contribute

I was also contacted by people who did not meet the criteria in that their sibling had died within the five-year period. For these people, their grief was very fresh and palpable, even via email. I ensured that I responded compassionately and empathetically, acknowledging their grief. I also sent them the list of community resources that I had developed. Another two people were from overseas. Both contacted me via email, also wanting to participate. It had not occurred to me that people may want to participate from overseas. I did consider whether to expand recruitment to have a multi-country focus but decided against this for ethical and logistical reasons. The logistics concerned developing another list of community resources for a range of countries and the costs of phone calls. Ethically, I was unfamiliar with other countries’ service context and, therefore, would not be able to mobilise support if needed. Again, my responses to the people approaching me were empathetic and compassionate and I encouraged access to supportive services.

Interviews

The qualitative interview is an “interchange of views between two persons conversing about a theme of mutual interest”, where the researcher attempts to understand the world and the meanings of experience from the person’s view (Groenewald, 2004, p. 47). The interviews were semi-structured and conversational in nature; this is acknowledged as a valuable approach when collecting information on a sensitive topic (Walker, 2007). The duration of the interviews was 60–150 minutes. I developed a guide on topics to be covered during the course of the interview focused on the research questions which I also sent to the people beforehand (Appendix 4). Moules et al. (2015) note that a hermeneutic enquiry is by nature interpretative and it is “not possible to determine a way to proceed without being guided by the topic” (p. 5). My intention was to allow each person to speak about their sibling’s drug use, relationship and death, and for this information to unfold during the conversation.

Gadamer’s philosophy places language and understanding at the centre of philosophical hermeneutics. Guided by his philosophy, I had in-depth conversations (interviews) with the people contributing to the study. My approach to the interviews was informed by principles of Gadamer’s hermeneutics and, therefore, I had the expectation of hearing something new
or different, developing insights previously not in my awareness, thus expanding my horizon (Regan, 2012). We rarely know what exists in other people’s minds unless we ask a question (Regan, 2012). This was true for me when I interviewed the people in my study. Gadamer (1975/2004) contends one must understand the questions to be asked and, in order to do this, one has to develop a hermeneutic horizon of the questions.

As the researcher, I had to be aware, as much as possible, of what was in my horizon (traditions, historicity, prejudices and situatedness) guiding my understanding on the subject matter. I needed to use this awareness in a reflexive manner during the conversation, recognising that full awareness of my own prejudices is not unattainable (Gadamer, 1993/2001a). I endeavoured to maintain the conditions of understanding during the interview as well as to engage the hermeneutic circle. During this process, my goal was to understand and to achieve the fusion of horizons. To that end, I listened intently and reflexively, projected from what I knew and asked questions that allowed for the subject matter to be illuminated (Gadamer, 1975/2004).

Throughout all interviews, I drew on my counselling skills to engage with the person and aid the flow of the conversation. My approach was tentative, sensitive and gentle (Bryman, 2008). I checked my understanding by paraphrasing and reflecting, used empathy as needed, paused if the person was upset, summarised to wrap up a topic and then move on to another. I used a range of different questions including closed, open and forced-choice questions, ‘other’ based questions including circular questions, to help people explore the topic thoroughly and ensure I was understanding their experience. I often sought to locate things in time and place and listened for other issues such as developmental stages of life, family relationships and interactions, as well as living arrangements, and this contextual information helped me form a broader understanding. This is informed by a social work approach when working with others, concerned with the notion that all people exist within a broader context and is based on the process-person-context-time model (Bronfenbrenner, 2005). Bronfenbrenner’s (2005) model espouses that there are four interrelated components of the developmental process, including the person, the context comprised of family and social systems, and time. Consistent with this model, I place emphasis on the
chronosystem, where I could explore developments at a certain age but also order “events in their historical sequence and context” (Bronfenbrenner, 2005, p. 83). My approach and questions all assisted in developing deeper understandings of the person’s thoughts and reflections on the subject matter (Paterson & Higgs, 2005). Ultimately, the overall aim was to ensure the conditions of understanding were present in the conversations, by asking questions based on shared insights, so that new understandings could be revealed (Gadamer, 1993/2001a).

The interviews were conducted over the phone and face-to-face. Of the 21 interviews conducted, 10 were by phone. Interviewing by phone was done by necessity when people lived interstate and distance prohibited a face-to-face meeting. A phone interview for some people was more convenient due to the flexibility in time, but also there was a greater sense of anonymity because I could not see them and more comfort as they could be in their own space while doing the interview (Bryman, 2008). For those whom I interviewed in person, it was necessary to find a suitable space to do the interview, either my private practice counselling room or their home. Going to people’s home was a different experience – people could show me photos and mementos rather than just talking about these things. In terms of choosing a venue or time for the interviews, I left this decision with the person being interviewed; therefore, interviews were done during business hours, after hours and on weekends.

For all interviews I recorded the conversation directly onto my computer using Windows Media Player. When I was interviewing by phone, I would put the phone on loudspeaker to allow for recording to occur. I checked with all people that they consented to being recorded, explained that the interviews would later be transcribed (as outlined in the introductory letter (Appendix 2) and also told them when the recording function was turned off.

The beginning of the interview was similar to establishing clear expectations and boundaries in the counselling setting (AASW, 2020). I set the scene so the person was clear about expectations. For example, the interview could be stopped at any time, the interview was
being recorded, it was going to be more of a conversational style of interview and the flow of the interview which allowed us to establish rapport and for them to feel comfortable (Mishler, 1991). I wanted people to feel comfortable as soon as possible for two reasons. The first was in recognition that doing an interview about such a sensitive subject could generate some unease and I wanted each person to feel as comfortable and relaxed as possible. The second reason was to be respectful of each person I interviewed, recognising they were in unfamiliar territory so, in a sense, helping them to make informed decisions and be self-determining (AASW, 2020). These reasons became even more important as I realised some people had only spoken to one or two people about their sibling’s death.

Next, I gathered demographic information and completed a genogram. I have included basic demographic information in Appendix 6. I explained the purpose of the genogram was to develop a visual representation of their family. The genogram was helpful throughout the interview because I could refer to it, as well as later when analysing the information. By doing the genogram, I had a good sense of each person’s current life situation as well as a detailed understanding of their family of origin, including family structure, position in the family and relationship to the sibling who had died (see Appendix 7 for an example genogram). I would also enquire gently and empathetically about how the sibling had died. Discussing how the sibling had died was a good way to segue into the bigger conversation.

As a means of leading into the interview proper, I would ask a question that would allow the person to tell their story; for example, in conversation with Donna, I said, “Okay. So, do you mind if we ... shift to talking about Ben?” If someone was speaking continuously with few pauses, I would listen and take notes and, after they seemed to exhaust what they were saying, I would ask permission to return to parts of that story.

The people in my study were not passive in the interviews and they all seemed to be comfortable to question or reject what I said if they thought I did not have it right. As Laverty (2003) explains, the interview is, “a co-creative process between the researcher and the participants” (p. 22). The author van Manen (1997) elaborates that the person being
interviewed is invested in the topic being investigated; they care about the subject and research question.

As with other researchers who investigate sensitive topics, I noted that for many of the people, the experience of participating in the interview was helpful to understand their experience in a different way. Walker (2007) suggests that some participants may find the experience of the interview therapeutic, although this is not the intention of the research. This was the case for Tony, who realised during the interview, that the last time he talked to his brother, he gave him a hug and said, “I love you”. Prior to the interview, Tony had not connected this visit to his brother’s flat as the last time he saw his brother alive.

It is apparent that a fusion of horizons occurred during the interviews as each person I spoke to and myself became immersed, almost lost in the conversation, often unaware of how much time had passed. These conversations would gain a momentum, sometimes we would finish each other’s sentences and/or new realisations would be made, as was the case for Tony. The conversation definitely had a life of its own during these moments.

In the research design I included the protocol of following up each person 48 hours after the interview, so they had time to reflect on the conversation and see if there was anything they wanted to add or remove from the interview. One person I interviewed was very concerned about confidentiality and privacy and needed to read and remove certain elements from the transcript, such as places, names or any pieces of information that could identify her and/or her family members (Holloway & Wheeler, 1995). We did this together. I am aware she had not spoken to anyone about the death of her sibling, in any detail, for nearly 30 years and there had been times during the interview when she had become teary. Guided by the ethical principle of non-maleficence, I wanted to do whatever was needed for her to feel comfortable in contributing to the project and maintaining her welfare, even if this had meant that she withdrew from the project (Holloway & Wheeler, 1995). We worked through this process by email until she was satisfied with the final version of the transcript. Two other people said to me they did not wish to have elements included about their family, because in hindsight, they did not want to portray a family member in a negative light. After
a short discussion about their concerns, they decided on alternative words and I edited their transcripts accordingly.

**Transcripts**

According to philosophical hermeneutics, the interview transcripts are an “enduring and fixed expression of life” (Regan, 2012, p. 292). The transcript is a record of a conversation – an event in and of itself – that had already occurred (Grondin, 2002). The fusion of horizons happens when new understandings are manifested during the conversation; these same new understandings cannot be new again, as they are quickly assimilated and form part of the participant’s and the researcher’s horizons (Grondin, 2002). Therefore, the need for the participant to check the interpretation and accuracy of the transcript is obviated (Crowther et al., 2017). In line with the philosophical hermeneutics, the reading of a transcript for accuracy is a superfluous activity since the conversation (of which the transcript is a recorded version) is not an event that can be repeated because, by its very nature, it was unique at that point in time. That said, I often read the transcript while simultaneously listening to the interview, for the purposes of listening deeply but, in doing so, I knew the transcripts accurately represented the conversation.

Guided by hermeneutic phenomenology perspective, I decided to edit what was said (edited verbatim) when transcribing; for example, spoken as “it was, it wasn’t, um, like, that bad actually” was typed as “It wasn’t that bad actually”, as emphasis was on interpretation and understanding. This proved to be a good decision because the actual meaning of the experience was more focused, not crowded out by extraneous words or phrases (Crowther et al., 2017).

The transcripts are the written form of the interviews. I recognise that interpretations I gleaned from the people when I interviewed them, are located at a point in time in each person’s history as well as mine. Further, when speaking together, interpretation was aided by tone, manner of speaking, tempo and context. When these interviews were transcribed, there was a temporal distance from the original conversation and original event of understanding. As Hekman (1984) says, the transcript of an interview is fundamentally different to the interview, in terms of what originally transpired in the moment between
two people. Gadamer (1975/2004) says the transcript of the interview has a different quality as the horizon of understanding cannot be limited to the original conversation; therefore, the transcript is, in a sense, free for new relationships to be made (Gadamer, 1975/2004). Further, with temporal distance, Gadamer (1975/2004) says there is time to reflect, think, read and listen/read more. Also, with distance comes the fact I am no longer the same as I was at the time when I did the interviews; I have had new experiences, my understandings have changed (Regan, 2012). Temporal distance is also consistent with the hermeneutic circle as, at the end of the entire interviewing process, the interviews influenced how I read each transcript in the new present and, while I tried to remain ‘true’ to the meaning from the participants by listening and re-listening to the interviews and reading and re-reading the transcripts, I noticed that what I heard in the interviews and what I saw and understood when engaged with the transcripts was different (Regan, 2012).

These transcripts still rely on language as the medium for interpretation. The interview transcript is the object of interpretation; therefore, it puts a question to the interpreter – in this case me – as the researcher. When Platonic dialogue is in operation, the thinking person asks questions (Gadamer, 1975/2004). To understand the text, I must understand the horizon of the question, that is, what lies behind what is said in answer to the question. The ultimate phenomenon or “task of understanding is concerned above all with the meaning of the text itself”, that is, the subject matter (Gadamer, 1975/2004, p. 365). Fundamentally, the horizon of understanding is not definitive; therefore, we have the text being re-actualised in new understandings, recognising there are numerous other understandings that could also come forward. A key consideration here is that “understanding is always more than merely recreating someone else’s meaning. Questioning opens up possibilities of meaning, and thus what is meaningful passes into one’s own thinking on the subject” (Gadamer, 1975/2004, p. 368). The notion of “making the text speak, is not an arbitrary procedure that we undertake on our own initiative but that, as a question, it is related to the answer that is expected in the text” (Gadamer, 1975/2004, p. 370). Gadamer (1975/2004) advises that prejudice, situatedness, traditions and historicity are always at play, so we must engage in reflexive practices, and we have a duty to think critically, to question further, in order to understand. Achieving understanding results when we have put
ourselves forward and our point of view has been transformed and we are no longer the same as we were.

Therefore, when I read the transcripts, I had to ensure the conditions for understanding were again present, that I questioned what informs my understanding and to be disciplined to reach not just one interpretation but multiple interpretations (Regan, 2012). In a sense, by applying Gadamerian hermeneutics, I continued the dialogue between the transcript and myself, that is, questioning what is present, applying it to myself through reflection and questioning again (Logan, 2016). As prejudices were foregrounded, I could reflect and question if they should be kept or discarded and if they aid understanding or not (Gadamer, 1993/2001a). It was interesting to approach the transcripts in an interactive manner and observe my own horizons expanding as other understandings became apparent.

Critical decisions in the analysis of the transcripts

In hermeneutics, the aim is not to keep a distance from the ‘I’, rather to embrace the ‘I’ and know that it will influence the research; therefore, it is necessary to thoroughly engage and harness the ‘I’ in the research process (Laverty, 2003). Application of hermeneutics means that the researcher cannot remove, suspend or ‘hold’ themselves separate to the research project (Williamson, 2005), as the researcher cannot know ahead of time all their prejudices or situatedness. Their prejudices gradually become more and more apparent as the research project progresses (Frankowska & Wiechula, 2011). Further, the researcher’s prejudices are needed to illuminate new understandings of the phenomenon under study, as the starting point of understanding is to project what is already known with the aim of finding common ground on the subject matter (Fleming et al., 2003). Turner (2003) says, “Gadamer asserts that understanding involves discriminating among prejudices, not eliminating them” (p. 7). Therefore, the idea of bracketing – the practice of keeping the researcher’s view of the world (horizon) suspended so as not to interfere with the experience of their participants (Norlyk & Harder, 2010) – was not consistent with Gadamer’s philosophical hermeneutics (Williamson, 2005). Gadamer (1975/2004) was concerned with application, questioning of prejudices and being open to another view; useful in leading to a revision and expansion of horizons as understanding occurs (Koch, 1996). Gadamer (1975/2004) emphasises the participatory and reciprocal nature of understanding saying that, to understand, the
interpreter “must not try to disregard himself and his particular hermeneutic situation. He must relate the text to this situation if he wants to understand at all” (p. 321).

At the beginning of this research project, I assumed that I would use a thematic analysis method to analyse my research material, based on reading research articles and textbooks on qualitative research practices (Crowther & Smythe, 2016). However, as I delved into thematic analysis further, I realised that thematic analysis is not a method that fits with Gadamerian hermeneutics. In hermeneutic phenomenology, in order to understand someone’s story, the hermeneutic circle must be in play; therefore, there must be movement from the whole to the part and back to the whole again (Love, 1995). Moules et al. (2015) contend that hermeneutic data analysis is different from other research approaches in that it involves “carefully opening up associations that strengthen understanding of the topic rather than focusing on a single governing theme” (p. 117). In addition, the hermeneutic circle is critical for both understanding and coherence between the parts and the whole; therefore, “you must communicate the parts with the intent of the whole while anticipating the whole” (Grondin, 2002, p. 53). Gadamer (1975/2004) says, “the anticipation of meaning in which the whole is envisaged becomes actual understanding when the parts that are determined by the whole themselves also determine this whole” (p. 291). The process of interpretation is tentative, circular and constantly being revised as more insight and coherency is gained, and understanding ultimately expands (Wilcke, 2002).

When attempting thematic analysis the process was too fragmented for any meaningful understanding to be attained for me, and therefore, was not conducive to my endeavour. I tried using an open-coding technique identifying 400 odd codes (Braun & Clarke, 2006). However, the meaning of the coded (parts) had become segregated from the original story (whole); therefore, this process was not helpful in creating meaning, understanding of the phenomenon or applying the hermeneutic circle. I realised I was fracturing the people’s stories into bits for coding purposes the parts were isolated from their whole context (Moules et al., 2007). I was working ‘on’ the research material rather than working ‘with’ the material (Crowther et al., 2017), a process which is not consistent with Gadamer’s philosophical hermeneutics (Love, 1995). Hermeneutics is about deepening understandings
of a topic so it can be seen differently (Moules et al., 2015). Ethically, I reflected that I had been entrusted with people’s stories and it was imperative that I honour their contributions; with this reflection I came to the realisation that thematic analysis would not maintain the integrity I desired for this project.

I then turned to questioning various methods of analysis used in the qualitative research arena. Hycner’s (1999) paper was useful as he presents “a number of issues that need to be addressed in analyzing interview data” when doing phenomenological research (p. 280). He emphasises, as others do, that there is not one correct way, and to impose an arbitrary method is not appropriate in this area. My research supervisors have been adamant from the beginning of the project that all decisions must be informed by the philosophy underpinning the research. Finlay (2011) backs their position, saying research methods used must be consistent with the intent of the philosophical framework for the project. Groenewald (2004) says, in phenomenology, “the aim of the researcher is to describe as accurately as possible the phenomenon, refraining from any pre-given framework, but remaining true to the facts” (p. 44). However, in a hermeneutic phenomenological study, the goal is to go beyond describing to interpreting the information gathered; therefore, I needed to consider other ways to analyse the research material.

The best way forward was to read others’ research projects, looking specifically at the data analysis processes. I had my own interpretation of Gadamer’s work and how his philosophy could guide my research, but was open to learning more. I read numerous studies (including PhD theses) and articles on qualitative, phenomenological and hermeneutic phenomenological research. I wanted to check my thinking, so I was open to new information, yet critically questioned and assessed what others had done; I was looking at the familiar, fitting with my thinking/prejudices, and the unfamiliar which challenged me as I tried to understand what this meant to my project. I knew I had a duty to reflect on my prejudices and situatedness, to keep those that represent good judgement and to disempower any in the negative form (Gadamer, 1993/2001a). I reflected and thought exhaustively, to the exclusion of anything else. Suddenly, it became apparent I was a hermeneutist. I had just deployed the ‘conditions of understanding’ (listening and being
open, questioning and reflecting on my prejudices and situatedness, through questioning
and being willing to risk what I knew) to broaden my horizon (Gadamer, 1975/2004). The
standpoint from which I could view the topic of analysis was a different one to where I was
at the beginning of the research project and, consequently; the view from my horizon and
my prejudices were very different as well (Neilson, 2013). I also knew I must make a decision
in the present, while I had the understanding, realising that this was not necessarily the
‘final’, the most ‘right’ or the only ‘approach’ I could take, because change is always
immanent when being open (Grondin, 2002). After engaging the conditions of
understanding and the hermeneutic circle, I developed a way forward based on my
understandings at the time.

Hermeneutic contemplation: critical thoughts on methodology and the process of
explication

I refer to the period of deciding not to use thematic analysis without any other way forward
as ‘the great hiatus’. I used both the hermeneutic circle and engaged the conditions of
understanding to progress my understanding on this subject (Turner, 2003). I went back to
Gadamer’s magnum opus and looked again at the transcripts and other research
projects guided by hermeneutic phenomenology. The hermeneutic task is about questioning things,
a process which invariably leads to the replacement of earlier understandings (Turner,
2003). For Gadamer (1975/2004), research is not just about applying methods, it is also
about the creative mind of the scientist. He wanted researchers to be creative, think deeply
about their research and question their prejudices because it is the “hermeneutical
imagination that distinguishes truly productive researchers” (Gadamer, 1993/2001a, p. 42).
Therefore, he does not provide a method per se, but instead provides principles to guide
research practices (Hekman, 1983).

There are numerous decisions and processes I implemented, as follows:
Finlay (2011) conjectures that any research method will work – when no method is
stipulated – as long as it is consistent with the intent of the philosophy (Finlay, 2011).
Crowther et al. (2017) concur, saying, “there is this way and this way”, always showing new
different meanings (p. 829). What is important is to be explicit about how the research
material has been interpreted (Willig, 2012). The ‘how’ for me is influenced by my
theoretical orientation (ontology, epistemology and axiology), coupled with the deliberate deployment of Gadamer’s conditions of understanding and the hermeneutic circle (Willig, 2012). Hence, I reviewed my philosophy chapter and identified all the elements from Gadamer’s philosophy that I needed to keep at the forefront of my mind when doing the analysis. This became the guide that kept me on track.

After some distance, when I looked at the transcripts again, I had a critical realisation. I noticed some transcripts focused more on death and bereavement, whereas others had more emphasis on drug and alcohol use, or the sibling relationship. I realised that I had collected information on three subject matters and they overlapped with each other. Gadamer (1975/2004) says, “the subject presents different aspects of itself at different times or from different standpoints” (p. 285); therefore, different subject matters comprise different horizons. Willig (2012) confirms that the standpoint for viewing the text necessarily directs attention, therefore, what is seen and not seen, and ultimately shapes the understanding of the phenomenon. She explains that we “generate different interpretations by asking different questions of the same material”, bearing in mind that what lies behind the questions we ask is still informed by our various standpoints (Willig, 2012). Given that multiple alternative interpretations are always possible, there cannot be just one correct interpretation (Hekman, 1984). Crowther et al. (2017) say, “no one telling or listening of a story by any one person will ever reveal all there is to know about a phenomenon and claim to provide the whole truth” (p. 828). I have embraced this idea and deliberately interpreted the research material from three different standpoints (horizons), thereby asking different questions of the material. Interpreting in this manner demonstrated that multiple understandings are indeed possible and kept my thinking flexible and unattached to one ‘right’ way of interpreting the material. Simultaneously, my own horizons expanded; therefore, so have my understandings of phenomena. I also realised different prejudices shaped the horizons for each of these subject matters (standpoints). With these realisations I decided to work on the three different subject matters separately using the same explication process as indicated below.
I worked through every transcript to create three independent interpretations from the three different horizons: thanatology, drug and alcohol and family. According to Gadamer (1975/2004), interpretation is an explicit form of understanding and understanding is always interpretation. By interpreting each transcript, I also moved language into the centre of the research project, consistent with the philosophy of hermeneutics (Gadamer, 1975/2004). I actively interpreted the transcripts, guided in part by Crowther et al. (2017) who developed criteria to transform interview transcripts into crafted stories. I used the following criteria: remove extraneous detail that did not add to the story (for example, a comment about the weather); keep details about the story and particular sentences that conveyed meaning; remove repetitions or sentences that expanded in a manner that was not needed; ensure the story flowed by reordering sentences and adding words where sentences had been removed (for example, a joining word) (Crowther et al., 2017). I also removed all identifying content. With each interpretation, I used questions developed by Crowther et al. (2017) to check my interpretation, such as: does the interpretation still show the experience, and does it hold the meaning as given by the person? This process, while time consuming, was exceedingly useful. This part of the interpretation process resulted with me becoming very familiar with the content of every interview transcript; I can now look at a ‘part’ and know the ‘whole’ story. In a sense, “I developed an intimacy with the participants’ dialogue” (Turner, 2003, p. 11). Diagram 3, below, represents the process of explication. One interview is transcribed and then each transcript is interpreted from three different horizons of understanding.
After interpreting every transcript from three horizons, I identified salient commonalities that belonged to, and represented, parts of the whole story. I choose the use of the term commonality to represent repeated phrases or particular ideas expressed by people in the interviews and across interviews throughout the initial analysis. The commonalities incorporated “extraordinary occurrences and exceptional views” in the transcripts “while also noticing points of affinity and relationship” (Moules et al., 2015, p. 127). I then engaged in another layer of interpretation by analysing all the commonalities within the horizon of each subject matter (Crist & Tanner, 2003). In this process, the commonalities were an essential part of the transcript interpretation, allowing me to move from the part to the whole in the hermeneutic circle of understanding. As Gadamer (1975/2004) outlines, when describing the hermeneutic circle, “the single word belongs in the total context of the sentence, so the single text belongs in the total context of the writer’s work, and the latter in the whole of the literary genre of literature” (p. 291). Applied to my research endeavour, contextually the commonalities belong to the interview transcript, as well as belonging to the researcher’s (my) interpretations of the interview transcript, and the latter belongs to
the whole horizon of the subject matter. Therefore, the commonalities facilitated movement in the hermeneutic circle from the part to the whole and back again.

As stated above, I had developed an intimacy with the interpretations; now I needed to develop the same level of intimacy with the horizon of the subject matter. Gadamer (1975/2004) contends that when we are trying to understand something, we have a bond to the subject matter. Full immersion was possible by using Excel spreadsheets. I created three spreadsheets, one for each horizon. I copied and pasted all the salient commonalities (phrases or particular ideas) from the interview transcripts onto each spreadsheet. As I am very familiar and comfortable using Excel, I could move the commonalities around with ease and see each in relation to others; together, the commonalities formed topics of conversation. This process may seem similar to thematic analysis however it is the interpretative process that distinguishes it from thematic analysis. Turner (2003) explains Gadamer well, saying, “we begin with an assumption of familiarity and proceed to listening with openness to the unexpected and a readiness to revise our preconceptions (Gadamer, 1972/1989)” (p. 10). I was prepared to hear something new about the horizon; however, first I had to, “make conscious the prejudices governing our own understanding, so that the text, as another’s meaning, can be isolated and valued on its own” (Gadamer, 1975/2004, p. 298).

I proceeded through another interpretative process by identifying all the commonalities that ‘fitted’, in that they were familiar and expected, with my current prejudices. This process helped me to readily foreground accessible prejudices that shaped my situatedness around the three horizons (Laverty, 2003). I identified these commonalities in each of the respective horizon lists (Appendix 8). These lists were essential in understanding the standpoint for viewing the horizon of each subject matter and making me aware of the prejudices I project from; in the first instance, when trying to understand something new and unfamiliar (Gadamer, 1993/2001a). As Willig (2012) notes, interpretations are an interplay between understanding and not-understanding. The paradox of prejudices from Gadamer’s perspective is that a prejudice has less power to influence interpretation once it has been identified; in fact, he claims it is neutralised. It is the unidentified prejudices – the ‘givens’ in
our world – that wreak havoc because they continue to influence our interpretations unwittingly (Finlay & Gough, 2003). Gadamer (1975/2004) makes two critical points on this issue. First, for us to notice a prejudice, it must be provoked through questioning and being open to other possibilities, and second, foregrounding and acknowledging prejudices essentially ‘suspends’ them because our mind continues to be influenced by prejudices only when we are not aware of them.

Next, I also assessed each commonality that ‘said’ something alien or unfamiliar to me (Gadamer, 1993/2001a). In my mind, these commonalities had the potential to really show me something new. To do this, I had to be open and reflective and keep questioning ‘what is this commonality saying to me’? I read and re-read the commonalities of each horizon multiple times, for days at a time. I came to recognise similarities, differences, interconnectedness, patterns and meaningful links between them (Turner, 2003). My objective was for them to come together in a way that enabled deep understandings within each horizon (Turner, 2003). However, what happens in the process is that what was once new cannot be new again; it cannot become unknown again, so it rapidly gets assimilated into our horizon and becomes a part of the familiar.

I ostensibly ‘played’ with the commonalities until understandings became apparent. These were understandings that made sense to the whole interpreted transcript and the whole horizon. I took notes, jotted them down so I could hold onto the newness. I drew pictures, talked to others who had no idea about the subject matter to see if what I said made sense, and tried to join pieces of information together. This part of the process is difficult to describe adequately. It was organic – a dynamic reflexivity brought about through distance, reflection, and constant application (Gadamer, 1975/2004, pp. 570-1). By its very nature, it was interpretive, that is, I was translating the information into something that made sense to me (Laverty, 2003). When I was ‘playing’ with the commonalities, I was immersed, questioning what each commonality was telling me in the context of the bigger story and in the bigger context of all the stories. Simultaneously, I was questioning myself about what leads me to think what I think or how I see what I see, so much so that I lost sight of ‘me’ in a way (Regan, 2012). As I read and re-read the commonalities and whole transcripts, I made
new connections and relationships with the transcripts which meant the text was being re-actualised and new understandings came forward (Gadamer, 1975/2004). I think this is akin to Gadamer’s use of the metaphor of playing a game in his elaboration of the fusion of horizons (Neilson, 2013). There was an ‘I-lessness’ about this process (Regan, 2012). That is, understanding became possible because it was no longer about me as the individual, the understanding was much bigger; it was an event separate to me, it was something on its own (Vilhauer, 2009).

As I reflect on this ‘I-lessness’, through play, I recognise this was the instance when the fusion of horizons – the event of understanding – occurred (Neilson, 2013). I found it exciting when pieces would come together as loose conceptual ideas to form topics of conversation and gradually form into a coherent whole. Gadamer (1975/2004) says, “the harmony of all the details with the whole is the criterion of correct understanding. The failure to achieve this harmony means that understanding has failed” (p. 291). These moments were wonderful but also humbling because these ‘aha’ moments sit within a context of knowing that there can be endless understandings, endless other ‘aha’ moments, as there is never just one ‘right’ interpretation; these understandings were just mine at a particular point in time (Turner, 2003). This situation creates a degree of arbitrariness around deciding when to stop the explication process. In fact, Crowther et al. (2017) contend that hermeneutic phenomenology does not aim to provide one definitive final description of experience; rather it shows how a variety of meaningful understandings are possible. The explication process, outlined above, represents how I came to understand the subject matter of each horizon.

To summarise: while conversing with the 21 people whom I interviewed, there were numerous ‘understanding events’ assisted by ensuring the conditions for understanding and the hermeneutic circle were present. Following the transcribing of the 21 interviews, I then moved through the following explication process:

- Twenty-one transcripts were interpreted from three different horizons (subject matters) which led to three different interpretations of each transcript, a total of 63 interpretations.
• From each interpretation, I identified salient commonalities from the interview transcripts within the respective horizon.

• In each horizon I identified commonalities that were familiar and expected (as prejudices) and those that were alien and unfamiliar.

• I then immersed myself in each horizon’s topics by ‘playing’ with them; questioning and making connections between them, until deeper ‘aha’ understandings became apparent.

• I developed tables to capture my analysis for each horizon (see Appendix 8).

The process has been guided throughout by Gadamer’s philosophy of hermeneutics using the hermeneutic circle, and the conditions of understanding, in the quest for the fusion of horizons to occur (understanding events) through the sense of play. The new understandings are coherent across the parts and the whole (transcripts), as well as the subject matter, and have expanded understandings.
Chapter 6: Bereavement horizon – findings, analysis and discussion

Introduction

In this chapter the focus is solely on the bereavement horizon. I interpreted all the interview transcripts from the bereavement horizon; in doing so, I identified commonalities and topics of discussion across the conversations. These topics include the experiences around the time of their sibling’s death, rituals around death, duties when someone dies, stories of understanding, grief experiences, connecting with the sibling and changes made after their sibling’s death. As I immersed myself in these topics, I developed an understanding of all conversations. This process is the hermeneutic circle in action; I am moving from the part, which is the topic of conversation to the whole, which is the interpretation of all the conversations in the horizon. The topics were formed by commonalities and there were between two and seven of these commonalities noted in each topic (see Appendix 8).

The next part of my analysis was to question if these commonalities were familiar or foreign to me. Familiarity is represented by common understandings or expected information that already sits within the horizon. Gadamer (1975/2004) suggests that we project from what we already know. These familiar commonalities are articulated in this thesis representing the shared historicity, traditions, situatedness and prejudgments informing the bereavement horizon. By achieving an initial common understanding, it was then possible to become immersed in the interaction and hear something new or different that deepened and expanded the horizon of understanding on the subject matter. A new understanding is indicative of Gadamer’s fusion of horizons. Another aspect of the analysis was to then identify if the new understanding had any overlap with the other two horizons, for example, bereavement and the family horizon, recognising that any overlap was seen from the bereavement horizon. I note also these new understandings are only new once before being integrated into the horizon and therefore, represent a new understanding only at a point in time. Gadamer (1975/2004) says the understanding potential is infinite and I know if I entered a relationship with the transcripts at a future time, I would again see more newness. In the following section, each familiar and new commonality is anchored to the conversation by drawing on specific quotes from the participants, providing some contextual information and, at times, my personal reflections. I then present a discussion on
each topic of conversation and conclude the chapter with an overarching summary of new insights that have deepened the horizon of understanding of bereavement.

**Experiences around the time of death – familiar**

When the people in my study began to speak, we would spend some time reflecting on their experiences when they realised their sibling had died. Some of the experiences discussed were already familiar to me within the bereavement horizon based on, as Gadamer says, my historicity, traditions, situatedness and prejudgments. In this section, I present commonalities within this topic including memories of finding out, notions of disbelief, physical sensations at the time of death and not saying goodbye as familiar aspects of the conversations.

**Memories of finding out**

Being told that your sibling has died creates memories that can be out of focus, for example, Amy describes her memories as “fuzzy memories”; difficult to retrieve specific details. Alternatively, memories can be rich in minute detail including how they were told, who told them, when and where they were and what they were doing – the memory is so clear that it is as if the death happened yesterday. Vera talks about working in remote Australia when she found out about her sister’s death almost three decades ago, before mobile phones made connecting easy. As Vera explains:

> The police came to work and said, ‘You’ve got a phone call’ … I started panicking.
> They said, ‘Sorry, we can’t tell you’ … mum told me.

Sometimes there is a mixture of focused and out-of-focus memories around the time of their sibling’s death. Lorraine says when she found out about her sister’s death, she remembers who told her and where she was but when it comes to other details she says:

> We all came together I think that day … it’s funny, I don’t have very good memory of that time actually … I think I was overwhelmed.

Their responses are reflective of the intensity and overwhelming nature of the situation and their memories are indicative of the assault leveraged by the news of their sibling’s death.
Notions of disbelief
Receiving news that your sibling has died is incomprehensible and shocking and many hear the news with a sense of disbelief. Karen’s statement about her brother’s overdose captures both the normalness of her brother’s drug use and the idea that his overdosing on drugs and dying was not a consideration for her. She says:

   His partner rang saying, ‘Your brother’s really unwell he’s been airlifted to hospital’
   ...
   I just thought he had an appendix problem, and it was like, what do you mean he’s had a heroin overdose ... surely not! He’d used for 20 odd years ... I thought he was invincible ... I never imagined life without him.

Death can be unexpected even when drug use is present and/or associated illnesses; in fact, sometimes this knowledge makes death seem more remote and unlikely and all the more shocking and unbelievable.

Not saying goodbye
Not having the opportunity to say goodbye to their sibling can leave a lasting impression around the “struggle” of “accepting” that your sibling has died. Lilibet describes recognising or seeing her brother in a crowd, after he had died, as she went about daily life; she concludes this was her brain telling her that, “I miss him”.

The effect of not saying goodbye can also influence future interactions with others; for example, Helen’s brother was missing for four days before he was found. Since the time of his death, she says saying goodbye has become important:

   I didn’t get to say goodbye to him so it’s really important for me to acknowledge when someone is going, or I get nervous.

As I listened to Helen talk about the circumstances surrounding her brother’s death, I could readily understand the significance of saying goodbye to people in her life now; this speaks of the enduring nature of these experiences.
Experiences around the time of death – new

In this section I present commonalities within this topic that were new and expanded the horizon. These common aspects include memories of the last interaction with the sibling, the awfulness of their death and, at times, a sense of relief.

Memories of last interaction

It was common among participants to hear very detailed memories of the last interaction with their sibling. Relaying these details provides a context for the unexpected nature of death, the disbelief and tremendous sadness experienced when their sibling died. For many, their sibling was well, the last interaction positive and future plans were discussed. The possibility of their sibling dying was not given a thought.

When Gina describes her last interaction with her brother, she says the day before her brother died:

He was glistening with good health ... I felt unhealthy next to him ... he had a good diet ... I thought he was doing really well ... we had a discussion about ... Christmas ... and then I even said ... I love you, and then off he went, riding his bike down the street – without a shirt on, and lots of sweat dripping and looking good.

Similarly, Sally says when her brother died:

We’d had this perfect kind of family Christmas ... two weeks later he had rang my mum and said he wanted to come down ... and he was waiting for the bus ... I don’t know if he’d just taken some drugs to try and get him through the trip ... but he died on the way to see us, so that was very sad ... it wasn’t that it was unexpected ... I explain it now that he ran the gauntlet and he ran it too many times, because my brother had sort of overdosed before this ... and so even though it wasn’t unexpected that he would die of drugs, the timing was ... a shock. Even though you knew, you never thought it would happen.

What struck me about these memories was how detailed they were and that the memories were more focused on the relationship with their sibling than their sibling’s drug use. The
positive last interaction with their sibling ‘frames’ who their sibling was to them – much more to them than just someone who used drugs.

The awfulness of death
In this study I expected to hear about overdose as a cause of death. After years of working in health, I know overdose from a depressant usually involves the central nervous system being so depressed that breathing stops and the person dies. As I say those words out loud, I hear a very clinical view. It is not a view that has ever led me to contemplate the circumstances of the many people’s deaths from overdose or the plight of their families. I was unprepared for the sheer awfulness and distressing nature of many sibling’s deaths, whether by suicide, homicide or overdose. Some of the circumstances of their sibling’s death were described in vivid detail and obviously had left indelible memories. These circumstances had a disturbing potency, often taking the person back to their experiences at the time, even though considerable time had lapsed, for example, almost 20 years for Alice. She says she remembers “absolutely everything” about her brother’s death. She says he “was in intensive care hooked up to all sorts of bits and pieces”. She explains she couldn’t have time with him alone.

When everybody else had had dinner and gone to bed, I would go up to the ICU (crying) and just sit with him until the early hours of the morning ... I would just put my head on the side of the bed ... I needed some time with him ... quietly and privately”.

Alice says during one of the visits she said to him, “oh dear (crying), he’d had enough, just let go”. Alice believes her father made the decision to turn off the life support. “Someone ... made the decision to disconnect him from the machine and it was done when we weren’t there”. She says, “I can’t reconcile in my brain how we hopped into this car and left my brother”.

These memories have a real potency for Alice; she almost steps back to that time because the memories are so strong.

Krystal refers to the delay in finding her brother:
[He] had gone to his room and overdosed ... he was there for a couple of days. He was found with a syringe in his arm and another full syringe next to him.

The delay in finding her brother meant the family were advised not to see him. Krystal found this situation difficult, and despite the possible physical deterioration of her brother’s body, says she would have preferred to have seen her brother than be denied a viewing, because not seeing him “made it really hard”.

For others there was not only a delay in finding their sibling, but also the realisation that when looking for their sibling, their sibling had been where they looked the entire time, but they did not know; this was the situation for Gina.

Gina had gone to her brother’s flat to look for him earlier in the day; she says:

To know ... that he’d been lying there dead in his flat for a whole day and a bit, or I’d been just up the road. That was pretty hard.

When I reflect on these memories and images, I hear more emphasis on the sibling and the sibling relationship than what caused their sibling’s death.

Lorraine shares the imagery formed by the circumstances of her sister’s death, images that are impossible to push aside. She says, “she was hit by a train ... she was laying down on the tracks”. Lorraine carries an image of her sister’s death and of this imagery, she says tearfully, “I try not to think about it”.

Similarly, Sally says of her brother’s death:

He had injected and was found on a train station ... with a needle in his arm and I think he had a pair of shorts on ... not a lot of clothing.

When someone dies at home from an overdose, the house becomes a forensic scene as police and coroner undertake investigations. This happened for Kathryn. Her brother died at home, at night, from an overdose. Kathryn’s mother woke her to help, and it is Kathryn who
performed cardiopulmonary resuscitation until the ambulance officers arrived. She says once the ambulance arrived:

I was going into shock, and ... the ambulance officers ... starting to monitor me ... it had been like a couple of hours and the police had started to arrive and the ambulance officers were still there ... the house became a crime scene and the forensics turned up, and the photographers ... there was a lot of police ... more of them that could really fit in the house ... mum wanted to go in ... and one of them was ... at the door ... saying ‘I’m not sure if that’s okay’ ... I sort of remember them sort of fumbling around ... that was ... not something that I’d wish upon someone.

As I listened to people describe their memories and the mental pictures of their sibling’s death, I too could be moved to tears, as these recountings were filled with such emotional rawness. Although these accounts are awful, for some there was a sense of relief experienced as well.

A sense of relief
For some people in my study, the family relationships with their sibling were fraught and/or the sibling’s health so untenable that it was almost a relief when their sibling died. This is not to say there was no grief experienced, just that a sense of relief was experienced as well as grief. I had not considered what the experience of living with a sibling who engages in drug use could be like. Isobel says:

For years I thought I was living in volcano. I never knew if I was going to get a phone call from him or someone else ... or if you go home if things would be tense, bad or difficult ... I must admit to a certain point there was relief, because, thank God, it was over, there wasn’t all that tension with going home.

The focus here is on the tension endured by the family and the fact that the drug and alcohol use is over. Carl also used the term relief when referring to his brother’s death; however, the focus was different – the relief was that his brother’s suffering was over. As Carl says:

Well, everybody was really sad and a little bit relieved ... because he was out of misery.
Carl’s brother died at 39 years of age after a long history of drug-related illness. Relief also featured for Donna although the situation is different. She says of her brother’s death, “we had been expecting it”. Her brother had a 10-year history of drug use and he was unwell, physically and mentally, when he died. She says she grieved for her brother 10 years earlier:

Because it was clear that he wasn’t himself anymore. That’s when he really died, as far as I was concerned ... he would hear voices in his head telling him to kill people and stuff like that.

My reflections about this sense of relief lead into the discussion on the topic of experiences around the time of death.

**Discussion on death**

Death in the drug and alcohol field is tragic; people die young and suddenly, in awful circumstances including brutal homicide, suicide and overdose. Some of the siblings in my study were not found for days, some were alone, some on life support in an intensive care unit or could not be resuscitated; others could not be viewed because their bodies had deteriorated to such an extent that viewing was not recommended.

Statutory authorities (police, medical examiner and coroner) are often involved in drug-related deaths with the explicit role of determining cause of death. Ford et al. (2018) notes that police involvement at time of death tended to exacerbate the distress experienced. In my study, Kathryn referred to the intrusiveness of the police presence in the family home. Concurring with Kathryn, Ford et al. (2018) state, “at the scene of death, police officers could take over private spaces … cordonning off rooms and denying family members access” (p. 50). Chapple and Zeibland (2010) explore the idea of different causes of death generating different responses. They report that death from suicide or accident (including death caused by drug and alcohol use) is sudden and can be traumatic. The awful imagery coupled with the suddenness of death and involvement of statutory authorities can make for a very distressing time and create enduring memories.
All of these circumstances carry evocative imagery, so potent that it is always possible to return to this time and invoke similar emotional responses, even though decades may have passed since their sibling’s death. White (2006) calls this the re-emergence of grief. The experience of time collapsing and being back in the grief also resonates with loss orientation, as described in the dual process model developed by Stroebe and Schut (2008). Hedkte and Winslade (2017) use the term ‘elastic time’ to describe this experience. Time is usually thought of in chronological order – like a film strip where each frame moves sequentially, in order, from past to present to future. There is another view which refers to time as Aion – where time is more like an out-of-order slide show; the past is present in the here and now and in the future, and there is fluidity in movement between these states (Hedkte & Winslade, 2017). All of these theories are useful in capturing the experiences of the people in my study surrounding the tragedy of death and the awfulness of circumstances, and their capacity to feel the full force of the emotional response as if it occurred yesterday.

The magnitude of the news of your sibling’s death is so shocking, especially when unexpected, that the initial response can be one of disbelief. Worden (2003) talks about sudden death as causing a shock reaction. He goes on to say disbelief is the state entered before the reality of the death sinks in (Worden, 2003). DeVita-Raeburn (2004) writes about her experiences of sibling bereavement. Her brother was known as the ‘Bubble Boy’, he was unwell and hospitalised for eight and a half years. Her brother’s illness became normal for her. She refers to his death as the “shock of the impossible” (DeVita-Raeburn, 2004, p. 12). The normalness of her brother’s illness is similar in some ways to the normalness of a sibling’s drug use. For some people in my study, their sibling’s drug use went on for two or more decades without incident; to these people, their sibling is almost ‘invincible’. As the drug use became more normal, the possibility of death became more remote.

Again, when someone dies suddenly, there may not have been an opportunity to say goodbye to them which can leave a sense that something is unfinished about the relationship. Kübler-Ross (1978) introduced the concept of “unfinished business” and linked it to saying goodbye. To some extent, Lilibet’s experience of ‘seeing’ her brother
everywhere after he died, is reflective of the internal struggle to accept his death because she was not able to say goodbye. Another response to not saying goodbye when someone dies could be a ‘nervousness’, as was described by Helen, thereby increasing the significance of saying goodbye to others in the present. Worden (2003) describes anxiety following death arising for two reasons: the person fears they will not be able to survive without the loved one and there is a heightened sense of our own mortality (Worden, 2003). Said another way, the death of a loved one makes the precariousness or tenuousness of life a reality; we can no longer take living for granted because the reality of death is now known. In a sense anyone could die at any time – this is the reality – therefore, it is important to say goodbye to everyone, having no unfinished business and no regrets.

For others, interactions with their siblings were tainted with relationship difficulties or the sibling’s health was so poor that relief was the initial response to death, followed by grief. The idea of relief at the time of death was also expressed by those interviewed in the Ford et al. (2018) study, particularly where there had been a prolonged period of drug and alcohol use. Worden (2003) also notes that relief is likely when the relationship is difficult and/or the person suffered from illness. In my study, Donna felt relief when her brother died; however, she also said that the brother she knew had died 10 years before his actual death. People interviewed by Templeton and Velleman (2018) expressed similar views of already having ‘lost’ the person they had known earlier.

Memories around the time of death are indicative of the intensity and overwhelming nature of the experience. Davies (1999) has done extensive research on sibling bereavement in childhood. She quotes 30-year-old Kate whose sister died when Kate was nine. When recalling her sister’s death, Kate says, “I’ll find myself as that nine-year-old girl, those emotions will come back … and I can’t communicate that with anyone” (Davies, 1999, p. 188). This quote is interesting in that Kate not only recalls but ‘feels’ all the emotions and cannot communicate this with anyone; just as a nine-year-old Kate found it difficult to communicate. Kate is thrown back in time. This was reflected in my study, with many people able to recall and/or relive the experience of their sibling’s death as if it happened yesterday. Many of the people I spoke with had detailed memories of their last interaction
with their sibling. These memories were focused on the sibling relationship, more so than the sibling’s drug use. These memories capture the richness of experience including pleasure in their sibling’s company, the love and hope for their sibling, and their expectations of a shared future, all of which contribute to the tremendous sorrow experienced following their sibling’s death. There is a potency to these experiences that leaves indelible memories.

Although painful, these memories become a precious link to the sibling. Memories ensure that “our loved ones continue to exist in our minds” after biological death (Hedtke & Winslade, 2004, p. 8). By continuing to tell stories about them, we recall their influences and make meaning around their lives (Hedtke & Winslade, 2004). Detailed memories form a part of the sibling’s biography which in turn bring understandings, closeness and connection with the sibling. As Attig (2001) eloquently says, “when we think of those who have died in our lives, we notice how an ongoing relationship with them in memory takes place alongside our other relationships. Their legacy in memory consists of their lifetimes, remembered moments, episodes, periods, and stories, none of which is canceled (sic) by death” (p. 47).

This section has discussed all the commonalities identified in this topic of conversation with the people in my study. The experiences around the time of their sibling’s death remain palpable and capable of transporting the person back to that time. The next section focuses on the topic of rituals surrounding the death of their sibling.

**Rituals around death – familiar**

Many of the people in my study also talked about various rituals they were either involved in, or took family responsibility for, when their sibling died. In this section I present commonalities within this topic which are familiar to me, including viewing the sibling, putting items in their sibling’s coffin and the funeral.

**Viewing the sibling**

There are many social rituals to acknowledge a person’s death which can be organised in a variety of ways. One of the ways of saying goodbye can be to see the person who has died, usually in their coffin, before they are buried or cremated. For some of the people in my
study, these viewings were a source of comfort and a means of saying goodbye but, for others, the experience was upsetting and the cause of nightmares. Stan talks about the viewing:

  We saw his body before the funeral, he was laid out in his coffin ... they (the Funeral Director) offered it (the viewing) to us, if we wanted to say goodbye in that way ... that put me at ease ... he looked peaceful, not happy, but peaceful. So that relaxed me.

Krissie also talks about the viewing her brother in an open casket as:

  One of the best things for me. I remember going up ... I gave him a kiss on the head ... said, ‘I love you and I miss you’ ... it’s very vivid ... it’s certainly not a happy memory, but it’s almost something I cling to ... if I can’t sort of conjure his face ... I can always go back to that memory and I see him clear as day.

Connie’s experience of saying goodbye by viewing the body was quite different. It was not pleasant for her and she consequently questions:

  Whether that’s a good thing or a bad thing ... I don’t know if it makes any difference, because it was a bit depressing, because he was all bloated, and ... just didn’t look peaceful ... I had nightmares about it for ages after.

**Putting items in the coffin**

Another way of saying goodbye is to put special items that have meaning in the coffin with the sibling. Of note was writing letters to their sibling. Gina says:

  I wrote him a big, long letter, which I went and bought special paper for, and then I sealed it all up with red wax and put that in the coffin with him.

Karen’s situation was different as she discovered you could put “things in the box with him” after the event and “felt like I didn’t get the opportunity to do that because I didn’t know you could”. Not being given the choice to write a letter or give her brother a special gift was upsetting for Karen. Another ritual around death is the funeral.
The funeral

The funeral can be a time of further distress or can provide an opportunity to do one last special thing for their sibling. For some families, funerals can also be a time to come together and support one another, but for others funerals are a time of anguish and family conflict.

Stan says of his divorced parents at the time of his brother’s death:

they (parents) came over to my place and they were very good to one another ...
they did pull together ... they were good to one another.

Connie says she and her other siblings organised her brother’s funeral; she says, “we wanted to honour him ... we tried to make it special”.

However, some relationship rifts remain or can be exacerbated when organising the funeral. Sally had quite a different experience from Stan and Connie and describes her situation as being stressful. She says:

My mum and my dad weren’t able to communicate ... there was a few disagreements because my dad didn’t want to pay for some things ... I was in a position of saying ‘we will be having music and we will be having flowers and we will not be getting the cheapest ones; we will get the best because your eldest son only dies once’.

Funerals can carry great meaning for family for so many reasons. They are one of the social rituals at the time of death.

Scattering ashes

Another ritual can be scattering the sibling’s ashes. This can be a private family affair as was the case for Isobel’s family:

The three of us (Isobel and her parents) ... we stood there for a few minutes; we scattered the ashes ... he loved the beach ... he loved the ocean.
Scattering the ashes can also be a part of a memorial. The place where the scattering happens can be significant to the sibling or the family and is often a place returned to, to remember the sibling. For Karen, the scattering of her brother’s ashes was:

Important for me to really make sure that the memorial at the beach was something for him.

Karen also describes going to a lot of effort with her family to access her brother’s ashes which also caused some angst; she says, “I had to advocate to have his ashes released ... my brother’s ashes were divided in half”. She explains that the memorial was significant for her; “I kind of felt like we have to make this right” because no-one was with her brother when he died.

In Karen’s situation, the scattering of her brother’s ashes had special meaning for her – it was the last thing she could do for her brother as is sometimes the case in organising the funeral – but doing so can be accompanied by distress, anguish and/or conflict. Isobel’s experience was quite different, as the scattering her brother’s ashes was intimate, shared only with her parents.

Rituals around death – new

Here I present the new commonalities within this topic focused on rituals around death. There was only one new commonality on this occasion – deciding who attends the funeral.

Deciding who attends the funeral

Funerals can be small private affairs restricted only to the immediate family, through to the other extreme where the funeral is a large public event (for example, when a former prime minister dies). Deciding who should attend the funeral was a concern for some people because many of the siblings’ peers were also engaged in drug use. Some wanted to protect other family members or keep separate the drug using part of their sibling’s life, whereas others were reassured by the presence of their sibling’s peers at the funeral.
Janet says her parents “did ask her (brother’s girlfriend) not to come to the funeral”. She goes on, “they did, then they regretted it later”. Stan says very plainly, “junkies weren’t invited”. He goes on:

They rang me, oh, we want to come to my brother’s funeral, and I told them to, go away … I just didn’t want a bunch of junkie skanks hanging around his funeral … I just did not want them there … my grandparents, they were devastated as it was, they had really no idea what had happened.

As I reflect on the words used by Stan in particular, I interpret his desire to keep ‘junkie skanks’ away from the funeral as a means of containing any stigma associated with his brother’s drug use and to keep separate the drug using part of his brother’s life. Such action seems highly protective of both his grandparents and of his brother as it doesn’t allow the drug use to taint memories of his brother or allow for judgements of his family.

For others, the situation was quite different – they were almost reassured that their sibling’s friends came to the funeral. Carl says of his brother’s friends:

It was kind of nice to see that he had friends … good to see these people were sad too. And that maybe he had people around him because we hadn’t been around him.

Connie’s experience is similar; she says:

It was a good turnout … [it’s] always nice to know … there’s a lot of people around who cared about him.

I am aware that people have ‘private’ funerals. I had assumed it was because the family wanted privacy to grieve rather than to do so publicly. I had not contemplated the notion of restricting who attends the funeral, as Janet’s parents and Stan did. As social rituals to be enacted, many are public in nature.

Discussion on rituals around death

There are many social rituals/traditions to guide practices when someone dies to fulfil any cultural and/or spiritual beliefs or obligations, such as funerals, memorials, scattering of the
ashes, writing letters of farewell and viewing the body (DeSpelder & Strickland, 2015). These rituals bring order and predictability at an emotionally difficult time, ensuring people know what to do and what to expect (Nikora et al., 2010). These rituals are social events that honour the person who died, and allow for the death to be acknowledged, memories to be shared, support to be given and sadness to be expressed (Doka, 2016). As Ribner (1998) also says, rituals around anniversaries – the repetition and re-emergence of mourning – can help in the mastery of grief over time. Core to many of these events is also the notion of saying goodbye.

One of the ways of saying goodbye can be to see the person who has died, usually in their coffin, before they are buried or cremated. In English-speaking cultures at the turn of the 20th century, it was common to have the person’s body at home and/or see the body after death in an open casket at the funeral (Chapple & Zeibland, 2010). However, death has gradually become more of a clinical and private occasion for the family where funerals and wakes are brief social affairs. Robbens (2004) describes our current approach to death as the ‘invisible death model’ where death is medicalised, creating distance from death and dying. These social changes coupled with decreased mortality mean there is now less exposure to death and seeing dead bodies (corpses). For many people, seeing a dead body now is an unfamiliar experience and, while viewing the body can be a source of comfort and a means of saying goodbye, for some the experience is upsetting and the cause of nightmares.

Even though there are numerous social rituals around death, governing practices and expectations, this does not mean that a family will come together in an amicable manner. It is not uncommon for differences of opinion and conflict to become apparent in family relations; thus, limiting the ability for the family to be a source of comfort and support for one another (Sands, 2017).

When people die for a drug-related reason, an added dimension that can cause some disruption is stigma. The phrase ‘junkie skanks’ denotes the stigma attached to drug use. The notion of stigma was originally written about by Goffman in 1963, in his work on
‘spoiled identity’. Two types of stigma are described: “public stigma occurs when a group is prejudiced toward another group, and self-stigma is a condition where stigmatised individuals internalise public stigma” (Ventura et al., 2017, p. 712). Stigma occurs because an individual’s characteristics or behaviour are contrary to societal norms (Walter & Ford, 2018). People who use drugs violate society rules and are devalued; they are seen as unsafe, unpredictable, out of control and dangerous, as well as responsible for their own condition (Ventura et al., 2017; Walter & Ford, 2018). This idea of being ‘responsible for their condition’ is framed as a choice where people who are using the drugs actively risk their own life (Walter & Ford, 2018). Public stigma not only shrouds the person using the drugs but can extend to their family and associates (Walter & Ford, 2018). A stigmatised death can bring a lack of compassionate responses by the public (Feigelman et al., 2011). Cvinar’s (2005) work on suicide – another stigmatised death – found that societal perception affixed blame on the family for failing to deal with some emotional issue. For Janet and Stan, the stigma around their sibling’s drug use and subsequent death could potentially colour how the sibling or family is viewed by others and, therefore, the desire to separate the drug-using aspect of their sibling’s life at the time of the funeral. This action serves to shield others in the family from being exposed to drug use and the associated stigma, as well as protect the image of their sibling. Doka (2016) suggests that families face a dilemma; if they disclose, they may fail to receive the support they need, but in doing so, they possibly conceal an important attribute of their loved one’s identity.

Duties when the sibling dies – new
People talked about the many ‘duties’, ‘obligations’ and ‘responsibilities’ required by our society, that must be completed when someone dies. What was surprising to me was how many of these duties fell to the people in my study. All the people – except one – in my study were adults when their sibling died and perhaps this is a common phenomenon for bereaved adult siblings. In some instances, being in close proximity to the sibling was a contributing factor to having these duties, for example, identifying the body. Presented in the following section are only new commonalities, including quotes to exemplify the experiences, in attending to these duties.
Identifying the body

One of the duties performed when someone dies is identifying the body or obtaining dental records so that person can be identified. Many people in my study were responsible for identifying their sibling. While Connie did not identify her brother, she says factually, “yeah, my [older] brother … had to go and identify him” so her parents did not have to do so.

Difficulties can arise when the authorities (other family, police or morticians), with seemingly good intentions, discourage access to the sibling’s body, due to physical deterioration. The lack of choice and expectation of access, that is subsequently denied, can be hard to accept. Others, who did identify the sibling, report being poorly prepared and not supported to do so and having subsequent palpable memories.

Gina says her husband identified her brother’s body. She relays the sequence of events:

I was really upset, and they [the police] said someone has to come and identify the body. And he [husband] said … ‘I’ll go. I don’t think you should go’, and then they were gone … I think they thought it would be too distressing for me. And it may have been, but I would have liked to have had that choice, but that was taken away from me.

Others were advised they could not identify the body because their siblings had not been found for 2–4 days.

Therefore, Helen had to “get dental records organised” so her brother could be identified. Krystal says, “we were never allowed to see him”. She elaborates further:

Because it was summer, and he’d been in his room for two days. The funeral director...said to dad, ‘I’d rather you not see him’.

This duty concerns identifying their sibling’s body. Another duty concerns letting other family members know.
**Telling parents of sibling’s death**

Some people in my study, because of their proximity to the sibling, were the first in the family to be notified of their sibling’s death and then had the responsibility of notifying other family members. Gina says when her husband went with the police to identify her brother’s body, “I had to ring mum and dad and all of that sort of stuff ... by myself”. Helen explains that she had this duty but didn’t realise, “I rang thinking they knew. Oh, it was awful”, because Helen’s family didn’t know, “the police got it wrong”.

The burden of having to tell other family members can be difficult to bear as can other responsibilities/duties around this time.

**Clearing out apartments or rooms**

Clearing their sibling’s belongings out of their apartment or room was a common experience for many of the people in my study. Some considered this an important job that needed to be done well or to protect others in the family from undertaking the task. Whereas, for others, it was a deeply upsetting experience that they were not ready to do but did at the behest of their parents. Helen talked about her memories of clearing up her brother’s bedsitter. She says her older sister:

> Flew down and we cleaned out his room ... his bedside table was still there and next to it was a cigarette with a lighter and a full cup of herbal tea. We just laughed because it was like, fucking herbal tea, you know? It’s like, he’s shooting up heroin, but oh, I’ll have some herbal tea to come down, you know?

For Gina, going to her brother’s flat was an important thing to do. She says:

> We [Gina, brother’s ex-partner and son, mother and younger sister] had gone to his flat and ... found things that they wanted to put in the coffin with him and what they wanted to dress him in.

She goes on:

> They wanted him to have a harmonica, wanted him to have stuff he had written himself. They wanted him to have his best tie on, and his big pointy boots.
Helen and Gina describe clearing their brother’s apartment as a shared activity with other family members, a bonding time honouring their brother. For Stan, clearing out his brother’s room was more purposeful; he describes volunteering to clear his brother’s bedroom the next day. Upon further reflection he says:

Mum couldn’t deal with it at the time ... she was so upset ... he died in that bedroom ... I think for mum ... to shelter her a little bit from ... any real nasty surprises.

Connie’s experience of clearing her brother’s flat is different again. It was not something she and her siblings wanted to do at the time, but they did it for her father. She says:

My dad just had this thing that we had to clean out his flat the next day ... and I was thinking that’s the last thing I want to ... what’s the rush? But for dad … we were thinking he wants this done, so we’d better do it. But that was the hardest thing we did actually ... I found all these things from when we were kids, and we were crying, and I remember thinking this is way too early. But none of us were going to say no.

I noticed how the people in my study availed themselves of this duty so their parents did not have to do it. Another duty falling to siblings in my study involves the statutory authorities.

**Advocating for parents**

When a parent was in a shocked state, some people ended up in an advocacy role. For Sally, this was around the need for an autopsy to be done on her brother. She says:

My mum didn’t want the autopsy ... all she thought about was ... people cutting her little boy up ... and so I was having to listen to them explain to me what they were going to do to my brother and then ... talk to mum about that and explain why that was necessary, and I guess get her to the point where she could agree ... yeah, so I was kind of the interpreter for mum in some ways I guess, or a spokesperson for mum.

Sally also discusses advocating for her mother when organising her brother’s funeral. There is a thread running through this section on duties that is about representing, protecting and/or looking after parents.
Organising the funerals

While most people talked about participating or being involved in organising the funeral, some were responsible for the entire funeral. This role seemed to fall naturally to some and, for others, it was taken on as a means of honouring the sibling’s life, involving the entire family and/or out of necessity, as the relationship between the parents was strained.

When talking about the funeral, Sally describes a stressful situation as her parents were not talking to one another:

Mum was in complete shock, she was barely talking ... and I guess my role then sort of became like a middle person between my mum and my dad ... and ... to help mum to make decisions at that time.

Sally mediated between her parents, in a sense taking control, to ensure that all the family, including her other brother, were also involved in the decisions. Gina’s parents had also been separated for many years when her brother died. She says:

I’d organised his funeral ... and I’ll never forget, I walked out of the funeral directors and there had been skywriters doing lots of skywriting ... and I looked up and they’d written the word, ‘why’ with a big question mark. And I looked up at the sky and saw that and thought, ‘oh God’.

Connie is from a family of eight children and while the parents are still together, neither were involved in planning the funeral. She says she and her sisters organised the funeral. “We did it really nice ... I played a song, my niece and I sang a song together”. She says her mother is “not a very good coper with things ... she was happy for it to be done”.

The funeral often includes someone delivering the eulogy for the person who died. Many siblings in my study did not question having this duty fall to them.

Eulogies

Some talked about having the responsibility to give the eulogy at their sibling’s funeral.
Amy says, while she doesn’t have a good memory of her brother’s funeral, that, “me and my younger brother did his eulogy”. Her rationale for doing so was, “well, I am the eldest and my parents couldn’t do it, and so the ball fell to me and my brother”.

These duties are not new to me; what is new is how many of these duties adult siblings undertook to do for the parents, sometimes out of necessity or to look after the parents, and sometimes because they were asked by others or by the parents.

**Discussion on duties when the sibling dies**

As noted above, there are many ‘duties’, ‘obligations’ and ‘responsibilities’ required by our society, that must be completed when someone dies. It is interesting that there is not a lot of research on these obligations, although attention is given to funerals. Funerals, as with other rituals mentioned above, serve many functions, including marking the loss and facilitating the expression of grief (Imber-Black, 1995).

The best account of these obligations lies in textbooks on death and dying where these responsibilities are referred to as a part of the ‘death system’ in society (DeSpelder & Strickland, 2015). This system includes “preventing death, disposing of the dead, making sense of the death, endorsing socially sanctioned death and sometimes camouflaging the impact of death in our lives” and defining the rules around grieving (DeSpelder & Strickland, 2015, p. 140). The legal system forms one part of a society’s death system. Matters under the legal jurisdiction concern identifying the body, the need for an autopsy and involvement of the medical examiner and coroner. When someone dies for a drug-related reason, it is likely that the legal system will become involved as a ‘reportable death’ defined generally “as unexpected or unexplained; is the result of an accident or injury; occurs in care or custody; is healthcare related; or is a case of unknown identity” (Dunstan, 2019, p. 248). Also, when a person dies and the cause of death is unknown and a doctor is unable to sign a death certificate giving the cause of death, then the death is a reportable death (Hughes, 2013). The legal system can be daunting and hard to navigate as Ford et al. (2018) found; many in their study “were resigned to these being necessary processes which, apart from the funeral, they had little influence over or detailed involvement in” (p. 47). Another part of the death system is the social aspect, such as organising funerals, memorials, obituaries

What interested me was the high level of involvement of people in my study in attending to both the legal and social aspects of their sibling’s death. I appreciate that siblings are classified as next of kin, but did not expect to hear about so much involvement. Marshall (2013) discusses this issue in her research. She interprets her own experience and the experiences of the people she interviewed as protecting the parents. In her situation when her brother died, her father was in hospital following surgery and her mother was in shock. Marshall and her sister-in-law organised the funeral following her brother’s death and then had the role of explaining to the parents how the funeral would unfold. Marshall (2013) captures the roles taken on in the family when a sibling dies, in Rena’s chapter. She says Rena helped organise the funeral, delivered the eulogy and cleared her sister’s belongings. Marshall (2013) says, “Rena was available for every difficult task while her sister was alive and then, even after her death. She took her role and responsibility as a sister very seriously, almost as if by doing these things, she was extending their bond beyond life” (p. 42).

Reflecting on the experiences of people in my study, there were both of these elements present, that is, the desire to protect the parents but also to fulfil their role as a sibling, as a means of honouring their sibling and/or protecting their sibling. I question whether bereavement renders us so vulnerable that the drive to protect becomes heightened. This latter point is something I will continue to reflect on as opportunity presents and is another example of the multitude of understandings that are possible through hermeneutic application, if I remain open to hearing something new and continue to question what I know (Gadamer, 1975/2004).

Among the many possible understandings was the next topic of conversation, about how people in my study and their families came to understand aspects concerned with their sibling’s life and/or death.
Stories of understanding – new

There were two commonalities within this conversation topic that were new and, therefore, expanded the horizon – these were: what to tell others about the sibling’s cause of death, and the need to know more about their sibling’s life.

What to tell others

Some people were very open about what caused their sibling to die; for others, there was discussion in the family about what to say publicly because of the circumstances surrounding the sibling’s death and not wanting the sibling or family judged. Still, others did not talk outside the family about the cause of death; they may even provide a different cause of death. The latter was more of an issue if the family had not talked about the sibling’s drug use and/or mental health issues outside of the family because they may have been managing the situation in private.

Krissie says her brother’s death was so public that “everyone knew he died of an overdose”. Whereas Janet says, “it was interesting because there was a question at first ... should we tell people ... we did decide that we would tell people and we wouldn’t hide it”. For Krystal, it was different. She says:

We told everyone he took his life and some people we told how, but ... we didn’t want people to think he was a junkie. Because yes, he used heroin, but I still believe he wasn’t a junkie. He was a recreational user; he didn’t use every day ... when all this started happening, we didn’t tell anyone ... it was a real shock, and my grandparents were quite devastated ... but it wasn’t ours to share at the time ... if he got through this and got past it, you don’t want people judging him on his past.

Karen’s experience is different again. There was no discussion about what would be said outside the family. Karen recalls an uncomfortable situation when she realised that her parents were not telling their friends how her brother died. Karen describes a situation where she was at her mother’s house, talking to one her mother’s best friends, who asks:

How did my brother die? ... I said he died of a drug overdose, and I was aware, all of a sudden, that mum was at the other end of the corridor, and the look on her face,
they [parents] were telling their friends he’d died in a car accident ... and I had been totally unaware that that’s what they were saying.

Lilibet’s brother died more than 30 years ago. She explains:

When somebody died in those circumstances ... people don’t want to admit their kids have been doing drugs or that their child committed suicide ... we don’t talk about it ... [we] were not allowed to mention his name at home and all photographs were put away ... it was like he’d never existed.

That said, Lilibet has a very clear story about her brother’s death. She says, “he drove into the mountains and gassed himself in a car, he was not discovered for a couple of days”. And while she “doesn’t know a lot of details”, she says, “he was in love, but it was not returned, and he was devastated”. This may or may not be the same story for the rest of her family.

When people die, an explanation about the cause of death usually follows; it is almost expected. What to tell others about the person’s death when the person has been engaged in drug use and that drug use causes their death can make this an issue for consideration. Stigma around drug use can affect how others view the person who died and, by association, their family. Some, like Kathryn, want to challenge the stigma by disclosing about her brother’s drug use. Kathryn says:

I’m aware of the stigma that families face ... a few years ago I wrote a post ... about my brother’s death ... lot of people contacted me ... and people ask me, how do you tell people about your brother, because they feel the stigma and they don’t want to tell people ... the person that died of an overdose was somebody ... it makes me really aware that that person’s life is sort of denigrated by the virtue of how they died, it totally overlooks who they were.

She goes on:

When I say that my brother died of an overdose, that does carry an assumption about how he died ... it was ... Xanax [a benzodiazepine] ... that killed him, and ... the Xanax were actually prescribed to him.
She also says:

People that die of overdoses are people, regardless of their social class or whether or not they’ve had a heavy drug use problem or not. It’s irrelevant.

Kathryn’s position on stigma is a part of her brother’s story now – it determines what she will tell other people and is a part of her understanding.

**Having to know more**

For many to develop an understanding of their sibling’s death, they needed to know more details which is achieved by accessing coronial reports and/or attending the coroner’s court if there is a hearing and/or talking to significant people involved with the sibling, for example, doctor or counsellor. The additional information often contributes to the understanding about their sibling’s death. Sometimes the pursuit for information was discussed openly within the family; for others, it was done independently and not talked about in the family. When Isobel’s brother died, she says his death was not talked about [with her parents]:

I’d actually rung the coroner’s office ... and I’d asked them to send a report to me, so I knew ... then dad said ... your mum doesn’t know. As far as mum was concerned, he died of a rare blood disease and that’s what she told everybody.

**Krissie** was a young teenager when her brother died. Talking about her brother’s death in the family was “definitely off limits”, even though she was “so desperate to know”. She says, “I was told it was a drug overdose”. Krissie describes herself as an “inquisitive young girl” who found out more about her brother by reading the coroner’s report and:

Just listening to conversations, like if dad was talking to somebody ... I’d sort of sit ... behind one of the walls and I could hear everything.

Attending coronial hearings and reading their reports is one way of finding out more about the sibling; other ways include seeing health professionals and friends. Isobel says after her brother died, she went to see her brother’s psychiatrist:
The psychiatrist said, ‘I don’t believe he [brother] was a heroin user ... if he was a drug user then he was like a whole lot of high functioning doctors and lawyers who’d taken drugs’ ... I said ... ‘he had this sort of life with people that take drugs’ ... I thought this guy [psychiatrist] is an idiot.

In a similar vein, Krystal and her parents kept talking and trying to understand what had happened for her brother; they all read his diary and talked to the psychiatrist, and Krystal talked to his friends as well. She says it was “part of the healing”.

Knowing more, having access to more details, can be fundamental to filling in parts of the story that are missing and are necessary when trying to understand what happened to their sibling.

**Discussion on stories of understanding**

When someone dies unexpectedly and prematurely, it is difficult to understand and make sense of what has happened. The developmental life stage may also affect understanding and some people, for example, Krissie in my study, may experience a regrief phenomenon as described by Oltjenbruns (2007). That is, the notion of regrieving occurs where bereaved siblings continue to revisit, renegotiate and re-experience the death of their brother or sister as their maturity develops. In the process of understanding, there can be many questions, some of which will go to the core of existence. There is a drive to make sense and derive some meaning from the death. Neimeyer and Sands (2011) say it well: “in the aftermath of life-altering loss, the bereaved are commonly precipitated into a search for meaning at levels that range from the practical (how did my loved one die), through the relational (who am I, now that I am no longer a spouse?) to the spiritual or existential (why did God allow this to happen?)” (p. 11).

The bereaved desperately want to understand and somehow construct some meaning from the death of their loved one (Neimeyer & Sands, 2011). A part of making meaning is developing or constructing a story. A story structures the experience, because events are ordered according to beginning, middle and end; as the story develops, so can understanding (Rynearson & Salloum, 2011). This is consistent with Gadamer (1975/2004).
thinking, where language is the medium for understanding. Meaning reconstruction is about telling a story to help create meaning of a painful experience (Valentine, 2018). To develop a story that makes sense, some people in the study needed more information; therefore, they may have attended coronial hearings and/or read coronial reports and visited their sibling’s friends or professionals involved in their care. DeSpelder and Strickland (2015) confirm that it is not uncommon when death is sudden for the family, to “want information, often in considerable detail, to help them begin to make sense of the loss” (p. 371).

The process of developing the story begins soon after death, with the cause of death. In my study, some people were open about the cause of death but, for others, a different story was created to protect the privacy of the family and prevent public judgement of the sibling and the family. When the cause of death is drug-related, then what to tell others about cause of death can come into question. The stigma around drug use can affect how others view the person who died and, by association, their family. Drug use stigma typically devalues the person; individuals are attributed with negative behaviours and a flawed character (Ventura et al., 2017). Further, different drug types and means of drug use are stigmatised in different ways, for example, heroin use and injecting drug use are considered worse than perhaps smoking cannabis (Walter & Ford, 2018). Similar to my findings, Walter and Ford (2018) report that many participants in their study did not talk about the cause of death and/or would misrepresent the cause of death to avoid the anticipated stigma and elicit sympathetic responses from others. For others like Lilibet, the stigma and shame were so great that once the funeral was over, “all photographs were put away ... it was like he’d never existed”. In Tony Trimmingham’s (2009) book on family drug use, he describes this idea of erasing the child from the family as one of three ways people grieve from an ‘overdose death’.

Stigmatised deaths, such as a drug-related death, can introduce distance in relationships which is then accompanied by reduced access to social support; this can extend to the family (Ventura et al., 2017). In this context, family are not deemed worthy of support. Doka (2016) introduced the concept of disenfranchised grief in 1989 to refer to losses that are “unrecognised and unsupported by society” (p. 184). These losses are not openly
acknowledged, socially sanctioned or publicly shared. Doka (2016) identifies stigmatising deaths, such as a drug-related death or suicide, as being perceived “as only occurring in families beset by problems”, and/or judged as self-induced (p. 219). One person in particular in my study should be mentioned at this point – Kathryn. Her aim is to challenge the stigma by disclosing about her brother’s drug use. She says, “people that die of overdoses are people”; to Kathryn, the person’s drug use and cause of death is irrelevant. Kathryn’s views are reflected in Walter and Ford’s (2018) study where the person who died was not portrayed as ‘just’ someone who used drugs but “a unique human being, with positive qualities and a loving family”, thereby, challenging the ‘drug use’ stigma by drawing attention to the humanity of the person (p. 82).

This leads me back to the story of understanding. When creating the story, as with any story, some aspects can be emphasised through elaboration, and other aspects downplayed. For Kathryn and others in my study, the relational aspects of the sibling are what dominates their story, therefore, less attention is given to the sibling’s drug use. However, as noted above, this is not the situation for everyone; where more attention is given to the sibling’s drug use, social stigma is likely, and with it, the possible experience of disenfranchised grief. However, the experience of grief is not the same for everyone, as presented in the next section.

Grief experiences – familiar

When talking about their experience of grief, many people in my study shared some memories that were familiar, such as insensitive moments that really stick in the mind at such a difficult time or during moments of kindness with others. They also talked about ways of coping with grief.

In sensitive moments with others or systems

As mentioned above, memories of the time surrounding the sibling’s death can be crystal clear. Many memories include jarring moments of system failures, unhelpfulness, or insensitivity expressed by others. As Isobel says:

- It’s funny the things you forget and the things that stick in your mind. I always remember flying [to be with her parents after hearing news of her brother’s death]
... I was crying on the plane, and I said, could I have a tissue, and they said, no we don’t give out tissues ... I always thought such a mean thing to do.

In a similar vein, Alice recalls her brother being in intensive care:

One of the things that sticks in my mind is a specialist talking to us, in the corridors of the hospital, to say that my brother was basically just a vegetable, and it was the language ... we were standing talking in the corridor and the language – the horror of it.

When I reflect on these moments, I feel dismay with how thoughtless people can be during such difficult times. When a loved one dies, the fragility of life hits home. The harshness of this reality can be difficult to fathom, affecting their confidence and sense of security. Insensitive encounters with others as described by Isobel and Alice serve to reinforce the idea of the world as a harsh and mean place.

Cherished moments of kindness

Again, memories at the time of death can be very clear, and just as there are moments of great insensitivity, some people in my study also talked about cherished moments of kindness. Judy says:

The specialist wrote a lovely letter to mum and dad when he [brother] died ... nice words that were comforting. I thought that’s pretty nice for a specialist to do that.

Just as thoughtless acts can stick in the memory of bereaved siblings, so can thoughtful acts. For Judy, her brother’s specialist taking the time to write to her parents was particularly meaningful at such a time.

Ways of coping

To help cope after their sibling’s death, many in my study found writing useful, whether in the form of a private journal or more public online blog. Sally says, “I actually kept a journal as a way of sort of coping with it at the time”. Kathryn says, “I write a blog ... it was around reconciling the death”. Stan mentioned the benefits of social media:
On the Overdose [International Overdose Awareness Day] website you can put a memorial there, spill your guts ... I think I lot of people do that rather than talk face to face about it.

Krystal’s experience is different; she benefited from in-person contact in the Compassionate Friends for Siblings Group. She says:

I started going to those meetings ... there were other girls in that group who had lost brothers to drugs ... you didn’t feel so odd and alone.

Finding ways to cope or process what had happened and obtain some sense of meaning was done in many ways, with most relying on the use of language; this can be in the form of writing (publicly or privately) or communicating with others who have had a similar experience. Bereavement can be a private, lonely and isolating experience; on one hand, it is not obviated through communication, but on the other hand, communication can at least bring a sense of belonging or connection with others, that is reassuring.

**Grief experiences – new**

There were commonalities in some of the ways people described their grief experiences in this topic, such as the pain of grief, feeling unsafe in the world, their views on grief as an indulgence or something to be lived with and the notion of regret. These new experiences expanded the horizon of understanding of sibling bereavement, emphasising the significance of the sibling relationship.

**The pain of grief**

Many talked about the physicality of grief by locating the pain – the aching – in their bodies. Some talked about initially feeling quite disconnected or detached from reality and just going through the motions. There are also descriptions of enduring intense sorrow, despair, depression, loneliness and sadness accompanied by tears spilling out in public and private moments. About her grief, Sally says:

There was no choice, it [the grief] just spilled out ... I would be in tears ... I ... felt like I was missing a limb ... it was like my heart was wide open and exposed ... to the world and I was in a lot of pain ... I’d never really had that physical sensation and grief ... it
very much felt like someone was just squeezing my heart the whole day ... and that went on for a long time.

So overwhelming is the emotional and physical pain that it is almost unbearable. Amy says:

After my brother died, I wanted to die, so much wanted to die.

Coupled with this physical pain is the difficulty in reconciling how life goes on ‘normally’ when their sibling has died and, for them, the world had stopped. Kathryn says:

I was really in that grief bubble, like going through the motions ... [I] felt like an outsider in the world. I remember just walking ... to work, just staring at the world ... people seem to think that the world is still existing, but to us [family] it had just completely stopped. And that went on for a long time.

The enormity of the grief and associated pain are well captured by Sally and Kathryn who describe the pain as similar to “missing a limb”. While I have heard of people describing grief as a void or missing something/someone, I had not previously heard the pain described in this manner. Other expressions such as those made by Amy about wanting to die, I have heard – it is not the same as expressing suicidal ideation; it is much more a statement about the enormity of the pain and wishing the sorrow away because it is so hard to endure.

Feeling unsafe
When the sibling died, the world as it was, is no longer; your sibling is dead – a person you assumed would be there throughout your lifetime. These disconcerting realisations brought a sense of feeling unsafe in the world for some of the people in my study, with accompanying feelings of fear and a loss of confidence once known. As Krystal says, her brother dying:

Sort of threw everything up in the air. Everything sort of went up and landed maybe slightly differently, you know ... it was still all there ... losing my confidence and I lost a lot of weight, and just felt frailer ... it took me a long time to not be scared of the night and scared of the dark. For a long time, I didn’t sleep. I had to have a light on when I slept ... there was just some fear there that hadn’t been there before, and maybe a knowledge that the world isn’t the safe, nice place that I thought it was.
This is a very honest appraisal by Krystal. She was the older sibling and talks about herself (prior to her brother’s death) as being very clear about her career aspirations, painting a picture of a confident and competent young corporate professional. She sees her fear at night time associated with a night that she tried to intervene in her brother’s heroin use. Her parents were interstate and had been told of his intention to end his life; they were travelling to be with her brother but asked Krystal to find him and stop him. She tried to do so but was unsuccessful in getting him to stop. He did not die then, the family managed to intervene and obtained treatment for him, but he did end his life three months later. I wondered if this experience of fear and loss of confidence was about her inability to change her brother’s decisions.

Views on grief

Many talked about their theories about grief as something to be lived with, not something that goes away. Janet says, “I didn’t need it [the grief] to get easier either because that would be like a betrayal thing”. Similarly, Gina says:

That sadness will always be a part of you ... you don’t want it to completely go because you feel that if it completely goes, then you’ve completely lost that person. It’s sort of that ownership of – that grief keeps the memory alive a bit.

The grief, and its associated pain, is almost an expression of remembering that they don’t want to pass because that would be tantamount to forgetting their sibling. Carl says:

I am glad I am still sad about him too. It’s interesting ... I feel like there is a little piece of him in my heart ... I feel sad, I treasure that it hurts because it’s him.

Isobel’s experience of grief is quite different – she queries if she has the ‘right’ to grieve and considers it an indulgence to do so in her circumstances. She says:

Because my relationship with my brother was problematic ... I didn’t face the issue enough ... I didn’t give him enough time you know. I was getting on with my life. So, I think ... there’s a bit of hypocrisy in grieving, would that be right? Do you have a right to grieve that much if you haven’t actually done enough to support that person...you
don’t have a right to become self-indulgent ... it would be self-indulgent to grieve if you haven’t done enough for the person.

Gina adds to this notion of indulgence but not because she doesn’t think she doesn’t have a right to grieve like Isobel; she is speaking about our social mores around grief. Gina says:

In our society ... you’ve got to get on with it, life’s got to keep going on, people aren’t allowed to just wallow in grief, and they’re made to feel like they’re ... wallowing in their grief.

The idea of grief becoming a part of who you are, serving as a connection or a remembering of the sibling, is a familiar idea. However, thinking that grief is self-indulgent caught me unawares; I interpreted the notion as quite severe, perhaps because I believe that siblings have a right to grieve and to do so for as long as is needed.

**Regrets**

For many in my study, their sibling’s death is experienced with regret, either because of the status of their relationship or the situation before death. Those expressing regret predominantly withdrew or distanced themselves from their sibling and now experience recriminations for not doing more at the time.

Judy grapples with her relationship to her brother before he died:

I just didn’t do enough ... and I’d sort of decided it was too hard ... and if he’d had a bit of support, he probably could have been alive today ... I didn’t spend any time with him, and I think that would have been really hard for him.

When her brother died, Judy says it was “terribly sad, and that’s the time where you need your family”. Judy says about the regret:

I’ve got to work all the time at that regret thing ... just consciously trying to not think – I wish I’d done more – I mean it’s gone. You can’t. It’s in the past.

In a similar way, Stan says, “there’s always that feeling I could have done more”. As Stan reflects on doing more, he says:
It’s more for me than him, it would have made me feel better in hindsight ... I wish I did, but I didn’t.

Carl also describes finding it difficult to be around his brother and similar to Stan, he too withdrew. “I found it really difficult, and to my regret now ... I withdrew”. He goes on, “I think ... the thing that I regret is that I didn’t keep in touch with him more towards the end”. He says now he would “stay connected ... I should have stayed in touch”.

As I ponder this idea of regret, I also wonder how much of the experience possibly concerns the notion of unfinished business where things have been left unsaid, plans have not been fulfilled and the opportunity to make changes has passed.

**Discussion on grief experiences**

Some people in my study talked about their personal theories on grief as something to be lived with, not something that goes away. Some stated they did not want the grief to go away because that would be tantamount to losing the person – again. In a sense their grief is a way of maintaining a connection with their sibling. Grief in a sense keeps the relationship with the sibling going (Moules et al., 2004). Silverman and Klass (1996) contested the focus of bereavement on letting go, detaching and moving on, and instead suggested that continuing the bonds should be the focus. These authors said, “we cannot look at bereavement as a psychological state that ends and from which one recovers” (Silverman & Klass, 1996, p. 18). If I shift back to the people in my study, I think some were saying that their sibling’s death generates an ongoing pain/sadness that will remain with them, which they have made room for, because the pain/sadness represents the ongoing connection with their sibling. Moules et al. (2007) concur that, “grief is not confined with a temporal aspect”, it is ongoing (p. 126). Doka (2016) normalises the idea that there is no timetable for grief, and while intensity of the grief lessens with time, there are still occasions, even decades later, when surges of intense grief can be apparent. He says it is a myth that grieving happens for a finite period of time, for example, 12 months (Doka, 2016). This social myth could in part explain the feelings of indulgence that Gina alluded to in my study.
However, with Isobel, I wondered if the idea of her being indulgent was to do with guilt and her perception of not doing enough for her brother when he was alive, and therefore, not having the right to grieve. White (2006) explores the idea of guilt and sibling bereavement, acknowledging that many sibling relationships are ambivalent by nature. She also discusses regret in the context of guilt and remorse, saying the guilt builds, because “we blame ourselves for having failed the deceased sibling” (p. 28). Similarly, Wray (2003) refers to siblings being plagued by guilt, regret and conflict because of the things they should have done.

The experience of grief can be enduring, centred around unfinished business, regret and/or sadness. There can also be a physicality to grief. As Doka (2016) says, “grief can hurt – physically!” (p. 27). Grief is stressful; there are numerous physical sensations that can occur, for example fatigue, abdominal pain, headaches, weakness and oversensitivity (Worden, 2001). Doka (2016) also says, “grief is not a single process that everyone experiences the same way” (p. 6). He also talks about people having different styles of grieving. He identifies one style as “intuitive” or “heart grievers” (Doka, 2016, p. 85). He describes heart grievers as those who experience, express and cope with grief emotionally; where the intensity of emotion can feel all-consuming, coming in persistent strong waves so powerful as to interfere with thinking clearly (Doka, 2016).

The idea of grief being all-consuming is also represented in the dual process model. In this model Stroebe and Schut (2008) discuss two orientations that the bereaved work through as they cope with grief – loss orientation, and the restoration orientation. They contend that both orientations have stressors. The loss is experienced when occupying the loss orientation; the grief intrudes and is confronted, whereas the restoration orientation is more about attending to life changes, life tasks and, in this orientation, grief is avoided. The dual process model captures well Kathryn’s statement about going through the motions of ‘normal life’ when her world felt so different after her brother’s death (Stroebe & Schut, 2008). In terms of coping, these authors describe the process of moving between the two orientations – the oscillating – as reflective of adaptive coping processes.
Another way of coping can be to seek out personal contact and finding it comforting, supportive and helpful (Lourenco, 2017). Many grief therapists suggest writing, journaling or letter writing as a useful strategy for bereavement (Walsh-Burke, 2006). With the advent of social media, there is the option of making writing quite public, albeit in a private way, that is, without face-to-face or other interpersonal contact. This is a good option for many, with people in my study saying they wrote blogs or posted memorials hosted on various websites. Similarly, Doka (2016) reinforces the utility of social media in terms of memorialising, finding resources and support. DeSpelder and Strickland (2015) also espouse the role of social media in terms of reducing social isolation by providing connection with an online community and, thereby, offering other opportunities to mourn.

When a sibling dies, the world is no longer as it was. For some people in my study, the realisation that a person you thought would be with you throughout your life – your sibling – has died, can be disconcerting, bringing a sense of feeling unsafe in the world with accompanying feelings of fear and loss of confidence. Krystal captures this well; she says her brother dying:

Sort of threw everything up in the air. Everything sort of went up and landed maybe slightly differently ... there was just some fear there that hadn’t been there before, and maybe a knowledge that the world isn’t the safe, nice place that I thought it was.

Janoff-Bullman (1992) writes about loss of the assumptive world due to trauma experiences of which sudden death is one. Her book, *Shattered Assumptions*, is well read and often quoted in the bereavement literature. She contends that we have three fundamental assumptions about the world a) that the world is benevolent, that is, the world is a good, positive place and is safe, b) that the world around us is meaningful and makes sense; there is a distribution of good and bad, so a good decent moral person will have positive outcomes, and c) that the self is worthy – we are good, we are competent and, therefore, we can control outcomes (Janoff-Bullman, 1992). She notes that people generally evaluate themselves positively in terms of ability and personal qualities.
When someone dies, our assumptions are confronted with the knowledge that misfortune is arbitrary and haphazard and bad things can and do happen to good people. Suddenly, the randomness of the world means there is nothing we can do to protect ourselves or loved ones from misfortune and, therefore, there is no way of being safe and secure (Janoff-Bullman, 1992). This can leave people feeling fearful and unconfident. The bereaved are forced to “see the world as it really is”; they “can no longer assume that the world is a good place or that other people are kind and trustworthy” (Janoff-Bullman, 1992, pp. 61 & 62). This theory is particularly relevant when considering the interactions with others. Insensitive moments with others or systems can further contribute to the lack of confidence and/or security already experienced by the bereaved. Alternatively, the theory also highlights the significance of acts of kindness, which in a sense could be quite restorative in nature for bereaved siblings.

Another restorative notion discussed by people in my study was the idea of continuing to connect to the sibling.

Connecting with the sibling – familiar

There were many commonalities in this topic of conversation that were familiar in terms of both theory and experience. The experiences of seeing the sibling everywhere, having memories and a sense of presence can be interpreted as connecting with the sibling.

Sense of presence after death

Many in my study mentioned the phenomenon of recognising their sibling in a crowd when going about their normal business. Whereby, they will see someone who looked similar and then realise it is not their sibling, it is someone else, and assimilate the information as part of their grieving. Krissie says, “as part of my grieving process, I honestly saw him everywhere”. Similarly, Lilibet says:

I remember for a long time, you’d walk down the street … see someone with the same hair … that build … somewhere in my brain it still doesn’t want to acknowledge that he’s gone.
Lilibet says seeing her brother relates to messages of “I miss you” or “I haven’t forgotten you”. With over 30 years to ponder this phenomenon, I think Lilibet describes the internal struggle that goes on very well – there is a part of her (her brain) that doesn’t want to know of the death, and another part that is saying “I haven’t forgotten you”.

**Memories of the sibling**

Everyone talked about memories of sibling, encapsulating what their sibling was like, their relationship and what they did together. Krissie talked of her memories and stories about her brother:

I’ve got lots of memories … I do remember … not long before he died … and he swung into mum and dad’s place … I’ve opened the door and I’ve jumped all over him, and I just remember him … playing with my ponytail while he was talking to mum and dad. And then he was like … alright, enough of this. Come on, Krissie, let’s go and play … he grabbed my hand, took me outside, and that was it.

Connie says after 20 years, her memories of her brother now are predominantly good ones, of fun times from a shared childhood. For many people in my study, with distance from their sibling’s death, the memories are more focused around pleasant times. Alice captures this well by saying:

In the last 10 years or so, my memories of him are a little bit freer of all … the family dynamics … unencumbered … it’s like a purer picture of who he was for me.

Memories are precious fragments connecting us to our past. In the situation when someone dies, memories become even more treasured because in our memories our loved ones are alive.

**Connecting with the sibling – new**

There were many moments when what the people were discussing was foreign to me and challenged me to listen more intently to ensure a fusion of horizons. The new commonalities in this section were regarding mementos kept, and the frequency and duration of thinking about their sibling – both deepened my understanding of sibling bereavement.
‘I think about him’

Most people in my study said they think of their brother or sister daily or a couple of times a week. Some others said they think of their sibling at least monthly, but this can increase in frequency for periods of time. Many mentioned talking to or about their sibling, feeling their presence or having their memories triggered by things associated with their sibling, for example, music or their own children. Krissie says:

There’s not a day I don’t think about him ... there’s not a day I don’t talk to him ... if I’m driving on a really wet, slippery road ... I’ll go, come on; please, just clear the road for me ... it’s almost drawing on him when I need that protection ... he’s like this guardian, he’s always present, and he’s always there.

Carl thinks of his brother “not far off every day, I treasure his memory, I am pretty sure he’s around me”. Judy says, “I’d probably refer to him and think about him far more now since he died”. She says, “I still talk about him all the time, and particularly to my daughter ... who is like my brother”.

Some people in my study said they remember their sibling usually because there is a trigger of some sort; for example, Stan says he “has been thinking about his brother more recently because more people have died from overdose”. Sally says memories of her brother are often “triggered by music, places associated with him”. Now that Connie is a parent herself, she says:

I think about him quite a lot, especially with my own kids, because I think of what we did at that age ... and they’ll ask me about my brother sometimes, ‘Tell me what you did with your brother?’

Janet says, with tears in her eyes and a tremble in her voice, “I still miss him a lot”. Her brother died over 20 years ago. Isobel, whose brother died over 30 years ago, says, “I may not think of him much at all ... but will then think about him all the time”.

Initially, I was surprised by the frequency and duration in thinking about their sibling who had died but this quickly passed. I realised that I was thinking about the frequency of
remembering or thinking as a parent. I still think about my son daily, as I think about my
other children and grandchildren daily and I expect and accept that this will probably go on
for the rest of my life. I possibly don’t think about my sibling (who is alive) every day; hence,
being surprised by this outcome because it didn’t fit with my current prejudices (ways of
thinking about the sibling relationship and attachment). Something Stan says is striking, and
really emphasises the sibling relationship; he says quite adamantly:

I had a brother and he’s dead, but I will always, I have always, I’ve always got a
brother.

Stan’s statement speaks volumes about the enduring nature of the sibling relationship.

Mementos

All the people in my study talked about having photos of their sibling; having photos was not
unexpected – what was unexpected was the locality of photos. Stan says his brother’s
“photo is beside my bed”, and Lilibet has a photo of herself and her brother “on my lounge
room wall all the time”. All of those interviewed also had items that belonged to their sibling
or had been gifted to them by their sibling. Mementos included artwork and musical
instruments. Sally says she has “random gifts he gave her”, Gina has YouTube footage of her
brother’s band playing and Connie says she:

Has some recordings of her brother and herself doing creative things [musical
pieces] together [which she has … played to her … children] … I know it’s there …
it’s still just nice to know it’s there.

Some mentioned that others had presented them with mementos. Krissie talks about a
leather pouch:

Dad put together … a little section of his [brother’s] ashes in it, and it’s got … all
these little pendants that mean different things that associate my brother to me, and
me to my brother. So, I’ve got that little leather pouch.

She goes on to say when travelling she has worn her leather pouch “around my neck … it
was almost like this … the protection thing”.
Krissie has her leather pouch of mementos to remind her of her brother. Karen has a significant memento to remind her of her brother, who drove a VW Kombi; she says:

I’ve got this VW emblem from the front of a Kombi, that someone made a frame for, and it hangs in my kitchen.

Many people in my study also had some of their sibling’s clothing. Helen has her brother’s woollen scarf that she wears every winter; Stan has his brother’s coat. He says when he puts it on, he thinks, “hey, that’s my brother’s coat, he loved it, I love it, it’s a nice connection”.

Krissie says:

I still wear his trackie pants ... they’ve got holes right through them, but I won’t throw them out.

Lorraine also has some of her sister’s clothing; she says, “I’ve got some of her clothes that I don’t wear that are just in my drawers”.

Initially, I was amazed by how many people in my study had items of clothing that had belonged to their sibling. I quickly recognised, that in line with Gadamer’s hermeneutic philosophy, I had to open this prejudice to revision and question what supported my standpoint (Gadamer, 1975/2004). The initial amazement rapidly faded into a ‘past-new’ in my horizon as I raised this observation with other people and heard more and more stories of people retaining articles of clothing belonging to their loved one. Clothing is a strong (possibly powerful) connection to the sibling and could be interpreted as another way of continuing the bond and the significance of the attachment relationship with the sibling.

**Discussion on connecting with the sibling**

It is evident from the statements by people in my study that the sibling relationship is enduring (Marshall & Winokuer, 2017). For many, the sibling relationship is more intimate and longer than any other in a person’s life (Sands, 2017). Doka (2016) describes the relationship as “more equal … you are kin but without all the hierarchy” and “Sibling relationships are fundamental to our identity, we develop, in part, by our place in the family” (p. 172). Davies (1999) notes the various dimensions of the sibling relationship
including sibling as playmate, protector and socialiser. It is siblings who hold memories of “family dynamics and events over an extended period of time” that can be shared and tested (Sands, 2017, p. 151). Davies (1999) puts forward the idea that when one child dies in the family, that the remaining child continues to think of that child as one of their siblings. This is portrayed in Stan’s quote – “I had a brother and he’s dead, but I will always, I have always, I’ve always got a brother”. Godfrey (2017) refers to the day her brother died, saying, “It has been 25 years since the world as I knew it changed in an instant … a day does not go by that I do not think of him or feel him with me in some way” (p. 95). In a similar way in my study, Carl talks about his brother being around him. This experience is noted by others, for example, Doka (2016) writes about his experiences of sensing a deceased person’s presence. He says, “many have an occurrence where they seem to smell, hear, see, or feel the touch of someone who died” (Doka, 2016, p. 40).

Parkes (2016) has similar ideas whereby, “the defining feature of grief, which distinguishes it from all other emotions, is “pining” for or missing a lost person” (p. 5). Worden (2003) uses the term ‘yearning’ to mean the same as ‘pining’ and states this is a normal manifestation of grief. Bowlby (1980) describes the four phases of adult mourning, with the second phase involving a ‘yearning and searching’ for the lost figure that would only be eased if the lost person returned. To Bowlby (1980), the bereaved person is ‘impelled to search’ in order to recover the person who has died. Searching in this context, is looking for the person with reference to memories, but it is not necessarily the physical act of searching for something. Worden (2003) identifies that when people are pining, yearning or searching for the person who died, sometimes they will catch themselves calling the person’s name or catching “a glimpse of the somebody who reminds them of the deceased and then have to remind themselves” that the person died (p. 27). Lilibet describes seeing her brother everywhere.

In this context, memories of the person who died become important. Attig (2001) describes memories as rich and fertile in meaning. He says that memories, although incomplete and partial (more like a slide show than a film strip), contain moments or stories that cannot be cancelled out by death.
As we cherish memories, we return to freshen and deepen our understanding of those who died, attend to them again, bring them closer, embrace them in their absence, reconnect with some of the best in life, feel grateful, feel the warmth of our love for them, sense that they are grateful for our remembering and feel the warmth of their love for us. (Attig, 2001, p. 48).

Attig (2001) contends that it is through memory that we can have an ongoing relationship with the person.

Other means of continuing the bonds have been investigated by phenomenological researchers such as Packman et al. (2006), and Harper et al. (2011). These authors provide examples of how bonds are continued, including viewing the dead person as a guardian angel and someone to be consulted on all matters, and/or maintaining a physical connection such as visiting the grave and/or displaying photos. They also note staying connected by wearing the person’s clothing and/or treasuring memorabilia/other items owned by the person who died and/or looking for symbolic representations, for example, noticing a flower that blossomed on the day of death. Another way is to engage in connecting activities, for example, journaling or writing poetry or listening to music. Other authors identify more ritualised ways of connecting, for example, lighting a candle, having a memorial or a special dinner to intentionally share stories (Giljohann & Norrish, 2010). Recognising the importance of connection, Marshall (2013) asked people in her study to share the stories of meaningful items retained that had belonged to, or been gifted by, their sibling. These mementos (treasured artefacts) – photos, gifts, the sibling’s belongings – act as linking objects as described by White (2006) who defines these as “objects that remind you of the person who died” such as clothing (p. 83). White (2006) goes a step further by suggesting intentionally creating a ‘memory box’ of treasured items to maintain the link into the future. As I have thought and read more about clothing being retained by people who are bereaved, I realise that clothing is an intimate memento to have (a treasured coat, or favourite scarf) and to wear clothing that previously belonged to the sibling, serves to bring them close. As Marshall (2013) notes, retaining mementos is indicative of the ongoing attachment to the sibling.
Changes – familiar

Many people in my study talked about changes they experienced following their sibling’s death. Only two of the commonalities in this conversation topic were familiar as informed by my historicity, traditions, situatedness and prejudgments (Gadamer, 1975/2004). In this section I present the commonalities of how grief becomes a part of you, and changes in the family.

Grief becomes a part of you

Many of the people in my study talked about what happens with grief over time. Most echo variations of Janet’s words, “you don’t get over grief, you learn to live with it”.

The intensity of grief changes over time. Again, as Janet says, her grief is ‘not as raw’ now, more than 20 years after her brother’s death. Similarly, Gina says, “that sadness will always be a part of you”. Helen says:

It’s like it becomes a part of you that you don’t want, but you have to accept and have to learn to live and get on with...you don’t anticipate the feeling of such incredible pain ... it changes you because it gives you an insight into tragedy and ultimately, I think it makes you wiser, or else it would destroy you.

This notion of grief becoming a part of you is something I am personally familiar with and have read about. It represents a time where possibly we recognise that we don’t exist in ‘either/or’ states, that is, either happy or sad – we can have our sadness sitting right alongside the joy that life brings. In some respects, it’s quite complex, in that you stop expecting the grief to leave and allow it to integrate into your being.

Changes to family

Not only are there changes on a personal level but there are family changes as well. The family and its members are no longer the same, Amy describes this well saying, “someone is missing” and there is sadness in the family and while there are happy times, these sit beside “massive sadness”. Parents change and for some there was parental depression, financial hardship, conflict and other losses. Some people in my study said their family could no
longer be together or talk for many years after their sibling’s death. Jacqui says that after her sister died:

   The whole family fell apart ... my brother stopped talking to me for the longest time ... it was horrendous when she was alive, and it was even worse when she died.

Whereas, for others, it brought them closer together, more able to speak. As Judy says, “when he died, I think it opened up the conversation”. Janet has a similar experience, saying after her brother died, there ‘was more talking and reminiscing’.

It makes sense that there are many changes that can occur in a family as everyone tries to cope in their own way. Bereavement can be experienced as isolating and lonely, it can divide, but also help forge stronger relationships. Regardless, the family as it was changes, roles change, as does the structure of the family.

With these changes also come secondary losses, for example, after a sibling dies, how do you respond to questions about your family? Some in my study do not mention their sibling to avoid further questioning about their death and becoming upset. Stan will often say he’s an ‘only child’. Janet says on occasion she has done the same as Stan; however, for her, “I just said one brother (instead of two) and felt terrible afterwards ... it’s not telling the whole story”, so this was not an option for Janet.

Similar to Janet, others always mention all their siblings but do not draw attention to their sibling’s death. Krissie says she talked about her brother in the present ‘living’ tense for 15 years and only stopped doing so recently. Others note their sibling’s death when describing their family but actively discourage and dislike fielding curious questions about the death of their sibling, especially from strangers.

What the people in my study draw attention to is that when your sibling dies, even a simple question about your family can no longer be answered without thought.
Changes – new

Many people in my study talked about other changes within this topic of conversation. Many more of these commonalities were unfamiliar in nature and greatly expanded the horizon of understanding. In this section I will present changes in the self, the meaning that comes from their sibling’s death, meanings about relationship responsibilities, contributing to social system changes, family sadness and the hierarchy of bereavement.

Changes in self

Some of the changes mentioned by people contributing to my study were about being less tolerant towards others’ approach to life, especially when this was judged as wasteful or trivial. Amy says:

I’m probably less tolerant when people are just mindlessly gossipy … and also overwhelmingly intolerant of people wasting their lives … we don’t know how much time we’ve got, so we have got to do something with our life now.

In a similar vein, when Krystal hears of sibling squabbles, she thinks to herself “be grateful you’ve got that relationship that you can have this argument with them”. Both Amy and Krystal have a new perspective in life. There is little tolerance for heated responses about the trivialities in life because in the bigger context of life and death, such trivialities are not worthy of attention. Just as an intolerance develops around trivialities, a much greater sense of empathy develops for others with similar experiences. People in my study also reassess their own lives within this new perspective. New priorities emerge and people can change direction. As Krystal says, her brother’s death “was life changing”. She says:

I’d been planning on finishing my professional qualification and going overseas for at least a year. And when my brother died, that was never going to happen. I couldn’t leave mum and dad … because they would be on their own and I felt they needed me, and I needed them.

There are changes within the self that are life changing. There can be a new perspective about life and new meanings because of the sibling’s death.
Meaning that comes from their sibling’s death

After their sibling’s death, many people in my study talked of new realisations or meanings that became apparent. Past ways of thinking no longer fitted, things could no longer be taken for granted as the ‘brevity’ of life became a reality. For some people, death becomes a reality in the immediate world. Janet says the cliché “she’ll be right mate” is not an option for her anymore, “because it might not be right so don’t put off things”. From a slightly different view, living becomes more of a focus. Carl says when his brother died, “the brevity of life became a bit realer”. Similarly, Connie says:

Try and make the most of life and do as many things as you can ... I could be dead tomorrow ... just try to embrace it as a life experience ... life’s got the good and the bad and you’ve got to kind of rise above, rather than just go down into a tunnel.

Being grateful is similar to the approach Helen takes since her brother died:

I don’t take things for granted most days ... because you don’t know when something will stop, or something will change, and things change in a flash ... so it’s about being ... grateful too.

These sentiments are about taking some meaning from their sibling’s death and bringing a different approach to daily living. Similarly, but slightly differently, there can also be a focus on relationships.

Meanings about relationship responsibilities

For Karen and Amy, the meaning arising from their brothers’ deaths was more focused on relationship responsibilities. Karen’s much-loved brother could have been a better parent when he was alive. She says:

Being there for my kids and being able to provide for them ... give them experiences ... the way he [brother] lived was ok for some people ... but you have to look after yourself and others in the mixture as well.

Karen is “being the parent he [her brother] wasn’t able to be”.

Similarly, Amy states strongly her beliefs around responsibility to others:
My life is not my life, I am responsible for the networks that I am born within, and I’ve got a job to do and that’s my responsibility, my life is not actually my own, and I think that my brother had that belief ... I can do what I want ... ‘I love drugs’, well, no you can’t ... look at the effect on your family, you’ve got a responsibility ... your life is not actually your life.

These are powerful messages from bereaved sisters who have reflected deeply on the meaning of their siblings’ life and death and used these meanings to guide how they in turn live their own life in the present.

**Contributing to social system changes**

Another type of legacy could be to focus on services and perhaps contributing to changes in their relationship with families. Lorraine says:

I think I was angry with the mental health system ... I mean when she [her sister] was released from jail, they didn’t have her medication ... she was literally sent home with nothing.

Lorraine ended up studying social work and did an honours year with a thesis on family experiences with crisis services. She now works in mental health where she “ensure(s) that families are included”. In a similar way Jacqui, whose sister was murdered:

Got involved with the homicide victims support group [and] then I ended up teaching ... at the police college ... I got asked to lecture to the homicide detectives.

Her reason for pursuing this was “so no-one would go through what our family went through ... the way we were treated”.

By drawing on their personal experiences, Lorraine and Jacqui work to change the very systems that let them down. Some people in my study were not able to effect changes within their workplace and, therefore, had to change where they were working.

**Family sadness**

Many in my study also talked about changes in their family, broadly ‘someone is missing’ and more specifically, changes with their parents. They also note the family sadness and
ways of coping by making room for the sadness while focusing on the positives in life. On this commonality, Helen talks more broadly about her family and parents:

It changes the dynamic of the family ... someone is missing ... we’ve had lovely times and they’re very happy, positive people [the parents] ... but they’re not the same, because they lost their child.

Amy also talks about someone missing in the family; she says, “happiness is there but beside this is massive sadness, we all know someone is missing”. She says of her brother’s death and other hardships in life:

You can’t dwell on it ... that shit sucks and every time I look at that shit it still sucks ... we [family] do talk about him a lot, but we try not to talk about all the sad stuff, because ... if there is anything worse that being sad yourself, it’s seeing the people you love sad.

The other great sadness people in my study spoke about was the ongoing sadness associated with their own children missing out on meeting their sibling and their sibling meeting their children. Many also said they talk to their children about their sibling, so they come to know their aunt or uncle through the telling of stories. In this way, the sibling continues as a member of the family. Krystal says:

I’m not only grieving that past of having a sibling, but the future of not having a sibling and grieving the fact that my children don’t have an uncle and they’re not going to have cousins, and we don’t have that family ... it could have been so much more.

Karen says tearfully:

I think for me ... not having him around ... not having that naughty uncle around, that’s the bit I’ve grieved the most. And believe me I have cried.

The sadness in the family is for the family of origin because someone is missing and the future extended family, again because their children are missing out on having an uncle or
There is also a sadness for their parents, as mentioned by both Helen and Amy in my study.

**Hierarchy of bereavement within families**

Many in my study talked about their concern for parents and looked after them following the death of their sibling. Others recall receiving messages from others to look after their parents. Many also talked about how their parents are more affected by their sibling’s death than they are; therefore, their focus is on their parent’s grief, not their own. Amy says, “this is something that affects all of us ... but mum and dad ... I am saying to them I think it affects you two more”. Similarly, Karen says, “watching your parents lose a child, you wouldn’t wish that upon anyone, you know they change”. Connie says when her brother died, “obviously, you’re more devastated for your parents ... thinking what are they going through?”

As some of the people in my study have become parents, their understanding of, and empathy for, their parent’s experience increases further. Helen says:

> Having a son now too, it just breaks my heart ... she [mother] lost her boy ... she just misses him very much ... she still just gets sad.

Similarly, Sally says, “I don’t think a mother ever gets over that sort of thing”. Isobel tearfully explains her parents’ experience:

> It’s worse now being a mother ... I grieve now for my mother ... how horrendous that must have been for her, to have lost her first baby and to have lost her son.

Many also said they were concerned about one or both of their parents at the time of their sibling’s death. Gina says:

> They [the parents] were so fragile ... I felt on a few occasions that I had to be a bit stronger for them ... and keep it together.

Isobel describes what happened when her brother died. She travelled interstate to be with her parents and soon after she returned home, her parents came to stay with her “because they couldn’t bear to see the pain in the other, I was the buffer”. She goes on, “horrendous
time … all you see in the other person is that child, the key to that relationship”.

Of her own grief, she says, “[I] put it aside”.

Janet says she was “told to look after your parents” by some good family friends which she tried to do by staying at the family home. She advises that “siblings put on a brave face for the parents”. Karen says, “parents get the attention at such times [death of a child] because they are the ones feeling the greater loss, therefore, they get more attention”.

Karen, while not denying her own grief over her brother’s death, prioritises her parent’s grief and the social recognition that parental grief is a given. Sally says she went looking for information for siblings who are bereaved at the time her brother died and couldn’t find any material. Sally’s experience is indicative of the lower prioritisation of sibling bereavement, compared to other attachment relationships. The words of the people in my study presented in this section speak to the changes experienced as one component of sibling bereavement.

**Discussion on changes**

White (2006) writes, “I have learned that we never really get over the death of a brother or sister” (p. 2). Morawetz (2007) has a realistic hope for the bereaved to not getting over the death but learning to live with it. These words are reiterated in my study. Moules et al. (2004) accept that grief is a lifelong and life changing experience. Wray (2003) and Marshall (2013) reflect the same sentiment expressed by people in my study – grief becomes a part of you, you are forced to reconsider who you are in the wake of bereavement and you change as a consequence.

Some of the changes mentioned by people in my study were about being less tolerant of matters assessed as trivial or wasteful. These observations draw attention to the fresh perspective that death leaves in its wake. The same ideas are reiterated by the people in Marshall’s (2013) research, with statements such as, “I no longer hold onto minor slights or misunderstandings”, or reminding those with siblings how lucky they are to have one another (p. 107). People in my study and Marshall’s (2013) study also made comments
about being “more sensitive to people who were grieving”, and being more comfortable to talk about grief (p. 49).

For many in my study, their sibling’s death caused them to think about the meaning of life and to no longer take life for granted. Some of the changes included introducing a new approach, for example, being grateful and/or living life to the fullest. Kübler-Ross (1997) learnt about death and dying by talking to those who were dying. She says her dying patients “taught me all of the things that were really meaningful, not about dying ... but about living” (p. 168). For Kübler-Ross (1997), accepting death as a reality means we should live each day as if it is our last. This seems to capture the gratitude expressed by Helen and Sally, living life to the fullest, expressed by Carl and Connie, and not being complacent as expressed by Janet.

For others, actively contributing to system changes can be a way of making some meaning of their sibling’s death; this is one of the key strategies in bereavement therapy. Doka and Martin (2011) introduced the concept of people having different styles of grieving, with one style identified as ‘intuitive’, primarily an emotional experience, and the other as ‘instrumental’ where griever adapt to feelings in an active way. One of the strengths of being an instrumental griever is that it is predominantly cognitive in nature which facilitates meaning making. By way of demonstrating how meaning making might manifest, I provide the example of Tony Trimmingham whose son Damien died many years ago. As a legacy to his son, Tony established Family Drug Support as a means of supporting families dealing with drug use in their family. He says, “with overwhelming tragedy comes some form of healing” (Trimmingham, 2009, p. 152). In a similar way, Marshall (2013), Wray (2003), White (2006) and DeVita-Raeburn (2004) all write on sibling bereavement; all have undertaken studies on the topic, all offer valuable input into the experiences of sibling bereavement by sharing their stories and those of others; collectively, their works on sibling bereavement contribute to changes in thanatology.

Another evident change for many in my study concerned work or aspirational career changes. Again, Marshall (2013) comments on this, stating her brother’s death led her “to a
new vocation and a deeper sense of purpose in my life” (p. 108). Doka (2016) addresses this issue as well; he says the workplace is full of expectations and responsibilities and not much allowance is made for those grieving. I think also the fact that we are allowed three days bereavement leave per annum in Australian Government organisations indicates there is not a lot of room for grieving in the workplace; people are expected to recover quickly and get on with living.

Just as there are numerous individual changes, there are also monumental changes to the family, and simple questions about the structure of the family are no longer straightforward. On this, White (2006) says, “there is now a hole when they visit their other siblings, because it is then obvious that someone is missing. The presence of other family members reminds them forcibly of this fact” (p. 47). Therefore, being with family can bring both comfort and pain. Through bereavement, some families can become closer and talk more. Judy’s family was able to pull together, as her brother’s death opened up conversation in the family. Opening up conversation is advocated by family therapists in the palliative care field (Kissane & Hooghe, 2011). However, for other families, distance in the familial relationships is generated, which is what happened for Jacqui. Possibly this occurs because all the relationships in the family must change – there is a shift in the family dynamics and relationships can become strained (Bussolari & Horsley, 2017). In this situation, bereaved siblings may not only grieve the loss of their sibling but also the loss of the family as they knew it (Gilbert & Gilbert, 2017). Riches and Dawson (2000) refer to the loss of the sibling and “losing important aspects of their parents” as a ‘double jeopardy’ (p. 13). Marshall (2013) says, in her own research, “I have learned that the experience of grief is very personal; it often divides rather than unites families. Nowhere is this more noticeable than within a family as each member copes with the same loss differently” (p. 59). Breen and O’Connor (2011) echo this sentiment, finding that family members were often not supportive of one another. Therefore, surrounding the immediate loss of the sibling are numerous secondary losses (Marris, 1975). Examples of secondary losses are not having an extended family, children not having an aunt or uncle, parents being forever changed, loss of identity as a sibling, loss of a supporter, loss of a friend/companion and loss of a shared future (White, 2006). This latter point was deeply lamented by people in my study; not only
was there no shared future with the sibling, but also, often a loss of the extended family that would have been.

Other dimensions for adult siblings can be the changes in their own parenting or how they interact with their parents. In my study, for some people their sibling’s life and death influenced how they thought about family relationships and how they wanted to be as a family member. Making changes to your parenting or how you are as an adult child because of your sibling’s death, in a sense gives value to the sibling’s life. Again, such changes are a lasting legacy in memory of the sibling (Marshall, 2013). It is also, in another way, finding meaning in the loss that makes sense or makes the ‘loss matter’ (Marshall, 2013).

Finally, I draw attention to the idea that there exists a hierarchy of bereavement within families in terms of which relationship and subsequent grief is socially given more emphasis. Many people in my study expressed concern for, and looked after, their parents following their sibling’s death. Gilbert and Gilbert (2017) also discuss changes for adult children, noting that some bereaved children felt the need to care for, and protect, their parents. The idea of children parenting the parents for a time was identified by Packman et al. (2006); the notion of the surviving children being considered secondary mourners (in the bereavement hierarchy) has been identified by other researchers (Breen & O’Connor, 2011; Dyregrov & Dyregrov, 2005). As those interviewed in my study became parents themselves, their understanding of their parent’s experience expanded. Some say they put their own grief on ‘hold’ or felt the need to be ‘a bit stronger’ for the parents; others say they were told to ‘look after’ their parents. Karen clearly states, “Parents get the attention at such times [death of a child] because they are the ones feeling the greater loss”. It is clear that the parents’ grief is prioritised.

Marshall (2013), Wray (2003), White (2006) and DeVita-Raeburn (2004) recount similar experiences to those in my study. DeVita-Raeburn (2004) recalls standing “at the side of my brother’s grave, being exhorted to take care of the real mourners” – her parents (p. 59). They all use the term ‘disenfranchised grief’ to describe their bereavement experiences. Disenfranchised grief is a concept developed by Doka describing grief that is not socially
recognised; therefore, there is little support or comfort available (Doka, 2016). Wray (2003) clarifies that with disenfranchised loss, the loss has no legitimacy socially. Doka (2016) describes disenfranchised grief as occurring when the relationship with the person who died is not recognised or supported by others – there is an empathetic failure, which can exacerbate grief reactions. In exploring the reach of disenfranchised grief, Doka (2016) explains the role of culture in determining how we grieve; for example, in some cultures it is expected and accepted there will be emotional display whereas, in other cultures, such display of “raw emotion is discouraged or censured” (p. 222). He elaborates that each culture has its own expectation on how you are supposed to mourn, and violations are sanctioned (Doka, 2016). When these social mores are internalised, the sibling’s grief will be disenfranchised (Doka, 2016).

Siblings being protective of their parents could be a manifestation of the siblings disenfranchising their own grief. Marshall (2013) also identifies protecting the parents as a major finding in her research. She notes that this protection takes many forms, from helping out, to filling the gap, being silent and shifting roles, so the bereaved sibling can look after the parents and the parent’s grief (Marshall, 2013). She contends that children of all ages want to fix the pain that their parents feel (Marshall, 2013). Looking after the parents and silencing their own bereavement can lead siblings to feel isolated and alone (Prashant, 2017).

One way to think about the siblings’ protectiveness around their parents is that there is a hierarchy around the grief and, in the circumstance of family, it is the parents, partners or children’s grief that is prioritised by society, not the siblings (Marshall & Winokuer, 2017). Barbara’s brother died in 9/11 World Trade Centre attack; she says her loss was invisible socially in that supportive services were offered to her brother’s family and her parents, but nothing was offered to her and, as a consequence, she began to believe that she was undeserving (Bussolari & Horsley, 2017). Apparently, at the World Trade Centre Memorial Commemoration services, it was not until 2005 that siblings were given permission to read out their brother’s or sister’s name (Bussolari & Horsley, 2017). Another example of society’s approach to sibling bereavement comes from DeVita (2004) who says that she has looked at the bereavement cards for sale in shops; all the cards were for parents, children
and pets but not siblings, and she questions why it is an overlooked experience. Breen and O’Connor (2011) say “siblings reported being overlooked, excluded, and unheard” (p. 104). In the epilogue of their book, Marshall and Winokuer (2017) sum up sibling bereavement as an overlooked experience, stating, “society has no narrative for this loss” (p. 195). The media do not pick up on it and there are few resources or very few services specifically for siblings because it’s never quite ‘the’ loss.

I am inclined to agree with Marshall and Winokuer (2017) that, with no narrative and a general absence of services and resources, the social message is the loss is not as significant as others. The lack of narrative and social recognition of sibling bereavement combined with the prioritising of the parent’s grief means, that bereaved siblings disenfranchise their own grief as well. However, I am mindful that the people I talked to almost willingly prioritised their parent’s grief, often at their own expense. This leads me to conclude that sibling bereavement is not personally or socially acknowledged, that is, the siblings in my study also thought of their loss as ‘less than’ their parents’ loss.

Combining Doka’s (2016) concept of disenfranchised grief with Marshall and Winokuer’s (2017) idea that there is no narrative for sibling bereavement, and in paying particular attention to the idea that the people in my study prioritised their parent’s grief over their own, I have looked elsewhere to broaden the understanding of sibling bereavement. I have explored the sociology and anthropology of emotion, looking for some illumination, for an explanation of what I have noticed. Many articles on emotion referred to anthropologist Levy’s (1984) work on the concept of hypocognised and hypercognised emotions. Levy (1984) considers emotion in relation to the cultural structuring of knowing and not knowing. After a thorough exploration of emotion, he contends that socially hypocognised and hypercognised emotions are a form of social control (Levy, 1984). Culture in this context is a functionally useful system of knowledge and control with rules to guide proper behaviour (Levy, 1984). In his work with Tahitians, he notes that anger is a hypercognised emotion, in that there is a cultural schemata to describe how to interpret the anger and how to deal with the anger, including terminology to describe different types of anger and, in the context of social relations, how the anger is evaluated (Levy, 1984). He describes
hypocognised emotions as those emotions that are under schematised and characterised by nonspecific terms with no identifiable relational cause (Levy, 1984). For example, if sibling grief is a hypocognised emotion in a society, then the experience might be explained as ‘feeling lost’ or feeling ‘fatigued’ rather than sorrow or sadness. When there is no language to describe the emotion, there is no way to think of the emotion, so the experience is not thought of or responded to as an emotion and instead it might be treated as something else, like an illness or something internal that is wrong (Levy, 1984). In this context the felt experience is talked about in general terms and not connected directly to the relational loss experienced. This idea is helpful in explaining how some of the siblings themselves did not acknowledge their own grief and possibly why it was so difficult to recruit people for the research project or why so many in my study have never really talked about their grief with others, as was the situation with Isobel. This new commonality within the topic of changes after the sibling’s death was illuminating. In the next section I summarise all the new commonalities of the topics identified and discussed thus far.

Summary of bereavement horizon

From the bereavement horizon, through the process of interpreting the interview transcripts, I identified commonalities that were expected, which were already prejudices within my horizon and, in doing so, was freed to note other commonalities that were useful in expanding my horizon. In this summary I focus on those commonalities that expanded my horizon and, therefore, my understanding of the experience of sibling bereavement.

For those in my study, many of the memories of their last sibling interaction were often positive, future plans were discussed and there was no thought of life without their sibling. The detail of the memory placed the relationship at the centre, not the sibling’s drug use, and with that the deep sorrow experienced as a result of their sibling’s death. These memories were precious links to the relationship which could not be cancelled by death. These memories were almost necessary in the context of often unexpected, awful and distressing deaths, from homicide, suicide or overdose, where the potency of feeling was palpable, often transporting the person back to the death scenes, decades ago, still capable of causing raw emotion and tears, indicative of the trauma experienced. For others, the
sibling relationship was fraught and/or the sibling’s health was untenable from years of drug use, so much so that the primary emotion accompanying their grief was relief. Their sibling and the family were no longer suffering.

There are numerous social duties that must be attended to when someone dies. The roles assumed by siblings around the time of their sibling’s death were extensive. Some were responsible for identifying their sibling’s body, telling family members, organising the funeral, deciding who can attend the funeral and giving eulogies. Others volunteered or were given the responsibility of clearing apartments, dealing with statutory bodies and/or mediating between parents because of conflictual relationships. While some of these responsibilities were given by the parents, many of these duties were assumed, taken on, unquestioningly, often on behalf of parents without regard to their own experience.

When a sibling dies for a drug-related reason, explaining their death to others is not necessarily as straightforward as is the situation when someone dies from, for example, a snake bite. There is a decision to be made about what will become public information. Sometimes, the family makes this decision together but, at other times, the parents make the decision; sometimes the cause of death is shared and sometimes is not. The reason for keeping the cause of death private was to protect the family and/or sibling from others’ harsh judgements and, perhaps also, to ensure social support during bereavement.

For many in my study, there were questions about their sibling’s life and death, and a desire to know more as a means of understanding. Additional information was sought through coronial reports and speaking to professionals involved in their care or friends. The family might do this together or the sibling might do so individually depending on communication within the family. Sometimes these quests for information were fruitful and, at other times, there remained a sense of dissatisfaction.

Many in my study talked about the magnitude of their grief as an intense enduring sorrow together with an unbearable physical pain, often spilling out in the public and private spheres of life through tears. However, they had to somehow continue functioning in the
world that they no longer felt was quite real. So disruptive was the trauma and intensity of their grief that for some, the world as they knew it ceased to be safe and their life direction and priorities changed dramatically. Some talked about how their grief has softened overtime but is enduring and something they ‘allow in’ and make room for. Whereas, for others to grieve is self-indulgent, either because they didn’t do enough for their sibling or social rules dictate ‘enough’. The extent of grief is mediated through regret and self-recriminations that perhaps they could have done more for their sibling or the notion of unfinished business.

The theory on attachment says when we have siblings, the relationship is fundamental to our identity formation and for this reason, remembering is not just about remaining connected to the sibling relationship, but also about knowing ourselves in the world. Most thought of their sibling regularly, if not daily, then a couple of times a week, with memories being triggered by associated events, talking about their sibling or having a sense of their sibling being near. The connection is further maintained by mementos whether these are photos, gifts, or clothing, usually carrying a special meaning about the sibling and/or the relationship. Many conveyed that they still missed their sibling despite the years that have passed since death and that in their own mind, they still have a brother or sister.

As a consequence of sibling bereavement, numerous changes became apparent for people in my study. A new perspective emerged, changing the approach to life, goals and other relationships, with many talking about increased empathy with others, and a sense of appreciation/gratitude. These changes created meaningful and lasting legacies for their siblings in personal life and/or work life. There were also changes in their family which is to be expected when ‘someone is missing’. A lasting sadness pervaded many families. For some in my study, the sadness was focused on changes in their parents, whereas others expressed sadness for their own children missing out on their aunt or uncle and what could have been with an extended family. Many ensured their own children knew their sibling by telling stories.
Finally, against this life-changing emotionally disturbing experience is the social backdrop, that means their bereavement exists in a hierarchy privileging their parent’s grief. The social context results in many bereaved siblings being protective of their parents and silencing their own grief which can be described as disenfranchised grief, that is, where their bereavement is not acknowledged socially and the concept of hypocognised emotion could deepen the understanding. As a hypocognised emotion, sibling bereavement is devoid of cultural schemata evidenced by the lack of narrative and limited language to describe, interpret and evaluate the emotion in the context of social relations. Instead, as a hypocognised emotion, there is no way to think about the emotion, therefore, many of the siblings in my study did not privilege their own grief in comparison to their parent’s experience.
Chapter 7: Drug use horizon – findings, analysis and initial discussion

Introduction

This chapter focuses on the subject of drug use. In keeping with Gadamer’s philosophical hermeneutics, I actively worked through a process of interpreting each interview transcript, from the drug use horizon. By developing an interpretation based on drug use as a subject, I was able to identify topics of discussion across the conversations. These topics include noticing things, knowledge of the sibling’s drug use, the drug-using world, clashes with the drug-using world, explaining the drug use, response to sibling, interventions in drug use, and death and drug use. The topics were apparent as I immersed myself in all the transcripts and allowed a coherent understanding of all conversations to come to the fore. By engaging in this process, commonalities within the topics could also be discerned to further aid my understanding. There were between three to seven of these commonalities noted in each topic. The next part of my analysis was to question if these commonalities were familiar or foreign (new) to me. Familiarity is represented by expected information shared with the other person that already sits within the horizon. Gadamer (1975/2004) says that we project from what we already know. During the conversations, it was also important to be reflexive, asking questions and listening for something new or different that deepened and expanded the horizon of understanding on the subject matter. Another aspect of the analysis was to identify if the new understanding had any overlap with the other two horizons, for example, drug use and the family horizon, recognising that any overlap was seen from the drug use horizon (see Appendix 8). In the following section, each familiar and new commonality is presented by drawing on specific quotes from the conversations with the participants. I also provide contextual information and at times my personal reflections as a means of explicating and analysing the information. Each topic section concludes with a discussion on each commonality. The chapter concludes with an overarching summary of new insights that have deepened the horizon of understanding on drug use.

Noticing things – familiar

Many of the people in my study spoke about various aspects of their sibling’s life that they noticed. In this section I present commonalities within this topic which are familiar to me,
including not finishing education, having money issues, variable work and changeable living arrangements.

Not finishing education

Many of the people in my study were aware their sibling’s drug use began during adolescence, a period of rapid development and change, of experimenting and taking risks, when peers start to have more of an influence than parents. If drug use becomes a preferred activity during adolescence, school attendance and achievement can decline, which may be noticed by others. Tony says his younger brother went “through year 12, but he didn’t do it particularly well. There were a lot of drugs at high school”. Others in the study commented on their sibling’s further education, for example, Gina says her brother started using heroin:

    Probably his early twenties. He ... went to art school for a while, but he did drop out ...
    ... that’s probably when his heroin addiction really came to the forefront.

Other commonalities noticed by the people in my study were money issues.

Money issues

Many of the people I talked with commented on their sibling not having money or asking for money. Isobel talks about the tension within her family surrounding her brother’s perpetual need for money; she says there would be, “yelling and screaming” about “where’s he going, where’s he been ... what happened to the money?”. Isobel says:

    Every time I’d go home, it would be like living in a volcano ... money would go missing from my wallet ... someone would turn up at home, saying he owed them lots of money.

Isobel says she was not aware of her brother’s drug use at the time; what she noticed were ‘contradictions’ in his life; for example, “you get this other side of things criminality, weird people, phone calls, needing money”; however, she says her approach was to “err on the side of things are okay”.

Tony says he had lent his brother “thousands of dollars” but in the later years when his brother asked for rent money:
I would pull out the cheque book and say, ‘what’s your landlord’s name?’ [He’d say] ‘oh, no cash will be fine and I’d say, ‘No mate’.

Stan says, “[we] were just sick of him rocking up and scrounging for money and food and stuff”. Stan goes on to describe a situation where his brother:

Needed money, he got into trouble ... and he ripped off a whole bunch of heavy duty people and I had to help bail him out of that.

Drug use can be expensive. People often borrow money, hock possessions for money, steal items to sell on and/or sell drugs to pay for their own drug use. People using drugs also often get into debt because they have fines, owe dealers or get behind with loans or rental payments. Often too, there can be issues with work.

**Variable work**
For some of those interviewed, their sibling never worked. Connie says her brother only had ‘odd jobs’ because “he just got into a pattern ... doing his own thing, and he didn’t want to follow ... convention”. Helen noticed over time that her brother “wasn’t doing really well financially and ... he sort of went down the scale in the restaurants he worked at”. Helen relays a conversation with her brother; she says:

He told me that ... he woke up one day at like 4:00 pm ... he’d missed work ... he lost a few jobs from not turning up and just realised he was an addict. He ... lay in bed and just thought, fuck ... what’s happened? I’m addicted to this stuff. This isn’t good.

The vast majority of people I have worked with in the drug and alcohol field over the years have been either unemployed or on a disability pension. This is probably because most people who come to drug treatment services are usually experiencing the negative effects of drug use in various life domains. Another commonality that falls within my horizon is the changeability of living arrangements.

**Changeable living arrangements**
In the drug and alcohol field it is not uncommon for people to be homeless, itinerant, living in environments that are unkempt or to live in housing known to house others who also
engage in drug use. What became apparent in my study was the range of living situations that siblings were in.

Karen says, “mum bought a house ... and within about two to three years ... my brother ... moved in and never moved out”. Donna’s brother, from the age of 18 years, “was either on the streets or living at her mother’s place and ruining it”. Sally says when her brother “died he was homeless”. Tony says his brother, at an early age was, “living in squalor” and “towards the end ... his brother was living in those grotty flats”. He goes on:

I just went into the flat and I could just smell the urine ... I knew what was happening.

By this stage his brother was very unwell physically.

While many of these commonalities were present in my horizon, there were other commonalities noticed by the people in my study that were new.

Noticing things – new

One of my aims in this research was always to have my ear open to hear something new. Given the drug and alcohol field is so familiar to me, I really had to engage in some deep listening and questioning about what I was hearing. In this section I present commonalities within this topic that were new and expanded the horizon on drug use. These two common aspects were about the sibling being unreliable and evidence of drug use.

Unreliable

One of the things that people in my study noticed was that their sibling’s behaviour did not follow social mores or was inconsistent with how they previously knew them. Jacqui says about her sister, when “my husband and I got married and she was supposed to come up for the wedding and she just didn’t turn up”. In a similar way Alice says she noticed her brother:

Would make arrangements to catch up for lunch ... and never turn up ... say, ‘I am just going down to the shops’ and you might see him a day later, so he would just disappear.
Similarly, Helen also talks about her brother disappearing, saying that her brother would ‘disappear sometimes’. In a more extreme way, Lorraine says her sister disappeared for the six months immediately prior to her death. Her sister:

said she was going to Queensland for two weeks but then didn’t come home ... mum made ... a missing person’s police report, they said that there was nothing that they could do.

Lorraine elaborates that she heard that “her sister was overseas”.

As I reflect on these comments about the siblings’ unreliability, I liken it to people not showing up for appointments. I had not really thought about relatives noticing unreliability and what this might mean for them. Based on conversations with people in my study, it was evident that unreliability caused a raft of emotional reactions, from shoulder shrugging to worry. The other commonality was finding evidence of drug use.

Evidence of drug use

Many people in my study talked about finding ‘things’, making possible connections to drug use but then wanting to think the best of their sibling. Isobel captures these moments well:

It’s like – click – when you find something like a tarnished teaspoon in someone’s bedroom ... and then afterwards you think, ‘Oh, he could have used ... for heroin’ ... but then you often want to think the best, ‘Oh, it is an old teaspoon in the bedroom’.

Alice had a feeling “that he was doing more than using dope” but it was not until her brother visited that she “worked out what he was doing, he was actually using my bathroom to shoot up heroin”. She says:

He was asking me for a lid, and a spoon and matches and I just put all that together with all the frantic visits to the bathroom ... it all fell into the place afterwards when I thought about what was happening.

At that point, Alice describes having mixed feelings in that, “I was absolutely delighted to see the pair [brother and girlfriend] – I was just angry that they were using my place to do that basically”.

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Isobel draws attention to the idea of thinking the best about her sibling, perhaps wanting to hold on to the image she has of him. Alice’s experience is different – she was perplexed about what was happening at the time but realised later she felt a combination of being duped and indignant.

Discussion on noticing things

Many noticed slices of information about their sibling’s life, in terms of what they said or did, that didn’t fit with how they knew their sibling. For example, the sibling might need money, not do well in school when they were an A grade student, change jobs frequently or become increasingly more unreliable. These slices of information could be to do with drug use but may also not be. When considered in isolation, these observations or slices of information often don’t make sense; however, when considered together, a picture can form. From a hermeneutic perspective, we have memories from often noticing things and it is through the reflective process that sometimes (even years later with hindsight) we retrieve information, and ‘a penny drops’, and we come to a new understanding. As Gadamer (2008) says, “reflection on a given preunderstanding brings before me something that otherwise happens behind my back” (p. 38). He goes on to say that it is through hermeneutic reflection that, “I learn to gain a new understanding of what I have seen through eyes conditioned by prejudice” (Gadamer, 2008, p. 38). In line with Gadamer’s philosophy, we project from our own horizons and, as understanding develops, our horizon expands. I move on now to discuss this topic of conversation.

Drug use often begins during adolescence (Low et al., 2012). Adolescence is the period spanning about 10 years, beginning with the onset of puberty and finishing when the person takes on adult social roles (Geier, 2013). During this time of demanding rapid development, changes and adjustment must be navigated (Fuller, 1998). Fuller (1998) says that the goal of adolescence is individuation characterised by independence and autonomy. It is during adolescence that parental influence lessens and peer relationships become more important (Low et al., 2012). Some refer to this as a youth culture where young people are influenced by peers and the media (Spooner et al., 2001). Adolescence is characterised by experimenting and risk-taking as young people discover who they are and what their
identity will be (Gottman & DeClaire, 1997). Brook et al. (1999) contend that adolescents are more likely to use drugs if they are rebellious and non-conforming, whereas, others identify trait addiction, social anxiety and educational failure as predictors of drug use during adolescence (Kirkcaldy et al., 2004). Geier (2013) explains that risk-taking behaviour and drug experimentation by adolescents as linked to brain development and the heightened responsiveness of the adolescent brain to the rewarding effects of drugs. In Australia, the national secondary school student survey in 2017 showed that 76% of 17-year-olds had consumed alcohol in the past 12 months (Guerin & White, 2018), as well as other drugs, and that drug use for all drug types, for example, ecstasy and cocaine, increases with the age of the person surveyed (Guerin & White, 2018). Drug experimentation during adolescence is common and has to some extent been normalised in our society; however, most young people will only use drugs for a short period of time (Frye et al., 2008).

There are some adolescents where problematic drug taking can develop (Chaplin et al., 2014; Geier, 2013). Problematic drug use during adolescence is related to academic problems such as lower levels of high school completion (Chaplin et al., 2014) and decreased motivation and reduced cognitive functioning (Lee & Vandell, 2015). The problem with not completing high school due to drug use is that unemployment can result (Marel et al., 2016). Many siblings in my study did not finish their education and had limited options for work.

Drug use can also be expensive. Partners and families of drug users report experiences of stealing and pressure for money, causing discomfort and conflict in relationships (Orford et al., 2010). More expenditure on drugs leads to reduced finances to fund eating well or paying bills, the latter of which can also lead to homelessness. When a young person is using drugs, the family can often bear the financial burden of paying off debts, providing money to buy drugs or enter drug treatment (Frye et al., 2008). Spooner et al. (2001) argue for conceptualising drug use as one of a range of risky behaviours that can have “health and welfare compromising outcomes” (p. 1). Drug use can and often does impact on social aspects of life such as education, living arrangements, finances and work, and these social aspects of life will then often interact and compound one another.
As a person’s drug use continues, it is more likely that a tolerance to the drug will develop, and withdrawal symptoms will become apparent when drug use is stopped for short periods. The resultant urges to use drugs can often take priority over as other aspects in life including work, school and/or family relationships (American Psychiatric Association, 2013). It is not uncommon for family obligations to begin to fall by the wayside with families reporting the person may go missing from home without forewarning, become unreliable and be “either absent or disruptive at important family rituals such as Christmas or birthdays” (Frye et al., 2008, p. 20). Denning (2010) also captures the idea of family members feeling taken advantage of when they begin to put pieces of the puzzle together to form a picture of drug use as described by Alice in my study.

Knowledge of the sibling’s drug use – familiar

People in my study talked about both noticing things possibly related to drug use through to having knowledge of their sibling’s drug use. In this section I present commonalities within this topic including having no knowledge of their sibling’s drug use, through to finding out about the types of drugs used by the sibling and knowledge of drug use that becomes apparent if the sibling overdoses from drug use, engages in suicidal activities, has mental health issues and/or associated physical health issues.

No knowledge of sibling’s drug use

Some people in my study describe themselves as having no or very limited knowledge about their sibling’s drug use. Krystal describes herself as “a bit of a mushroom”. Amy also says, “I was completely oblivious to all that kind of stuff, so I had no idea”. Lilibet says about her brother:

I think he was certainly a social drinker, quite the young man with the boys, kind of thing ... like most ... kids in the 70s, he experimented with marijuana, I don’t know that he ever did anything else.

I should note that Krystal and Lilibeth had both moved out of home and, therefore, had less direct contact with their siblings and, subsequently, less exposure to their drug use.
Find out about types of drugs used by sibling

While some in my study have limited or no knowledge about their sibling’s drug use, others knew multiple aspects of their sibling’s drug use. For example, Helen says:

I knew he smoked pot because ... he’d come home from work and have a bong. I remember him saying he’d be an alcoholic if he didn’t have pot.

Connie’s situation is similar; she describes knowing about her brother’s drug use since their teenage years. She says, “when we were teenagers, we all smoked marijuana”. Janet was less certain:

He probably started ... maybe 15 or 16 ... that was just marijuana ... then he got into speed and then ... the heroin was only a year I would say.

When Janet reflects on how she came to know about her brother’s drug use, she says, “I just kind of knew somehow”.

Lorraine knows her sister started using cannabis and drinking alcohol when she was in about year 6 or 7 – she was a “wild one”. Lorraine recalls her sister “used ecstasy and amphetamines” and she was going to “raves and having trips. She was coming and going”. Lorraine says, “we could see the decline with her, especially after the amphetamines”.

Donna read from her blog as we talked, saying her brother:

Destroyed his life with drug abuse. He’s done it all, starting with marijuana at 12 and heading into heroin, cocaine and alcohol and just about anything. I mean he used to inject vegemite, or he’d get the swabs from the needle exchange program and inject the alcohol from the swabs.

For some people in my study, their sibling’s drug use was discovered and became open knowledge in the family, particularly as their sibling became older and the drug use went on for a longer period of time. Helen says about her brother, “he’d struggled with addiction for a long time”. She describes her parents finding out about her brother’s heroin use in a “dreadful way” from an ex-girlfriend’s mother.
This woman rang ... got really mad at mum and wanted money, and mum said, ‘Why does he owe you so much money?’ ... and [the woman] accused mum of being naïve and was very cruel, which is awful”.

Helen’s parents then rang her brother and said to him, “you’ve got to come clean”.

Many of the people I spoke with did have almost an inherent knowledge of their sibling’s drug use from the time of adolescence. In these circumstances, drug use was a subject that could be discussed openly between siblings, and possibly the broader family – it was not a taboo subject. However, for others the topic of drug use was only discussed between siblings, the information was not shared with the parents. The drug use sometimes became known because the sibling had an overdose.

Overdose from drug use

Some of the people in my study commented on their sibling’s overdose history. Donna said her brother had “numerous overdoses”. Vera says her sister had “overdosed and she ended up in hospital”. Similarly, Gina says her brother “started using [heroin] again and ... he’d OD’d [overdosed] in front of his son a couple of times and ... they brought him around”.

Janet described a difficult situation when her brother overdosed. She says, “he did OD near our house a couple of weeks before he died”. She says the ambulance officers “gave him the Narcan and he came to”. With tears Janet says her brother was:

Down near the shops ... I rang the ambulance and I told them it was an overdose and so when the ambulance got there the police came as well ... and the police just kept asking us [the family] question after question ... I blamed myself for a long time [for the police attending because] I told them [when calling OOO] ... he’d had a heroin overdose because I thought that they needed to know ... It was at the overdose scene ... we should be with my brother and ... they [police] were taking us away from him ... before they came the ambulance were really good ... calm ... the contrast was just so blatant.
Janet says after the overdose, the police “rang him at work and hassled him ... and then he took off ... so he could avoid the police, he went on holidays, on his own and that’s when he died ... by himself”.

When Janet described her brother’s overdose scene, it was evident this was a distressing and lasting memory for her. I was working in drug and alcohol in the 1990s, around the time when Janet’s brother overdosed and, unfortunately, Janet’s situation was not uncommon. Heroin was readily available and overdoses were a frequent occurrence at the time. Tragically, many people who had used heroin in Canberra in the short and longer term overdosed and died.

Suicidality
Many of the people in my study also talked about their siblings and suicidality. Donna says her brother had “quite a few suicide attempts”. She describes an incident when her brother was in hospital. “He got out and ran in front of a car to try and kill himself ... crushing his pelvis and traumatising the poor man and his daughter who were in the car”. Lilibeth’s brother ended his life; she says that her brother “used drugs to dull his pain, so he could die”. Similarly, Lorraine recalls the day her sister died, saying, “it was like 7:30 am ... when she was hit by a train”. Lorraine says her sister’s death was “intentional ... she hadn’t talked to anyone for three days after receiving the phone call” from her boyfriend ending their relationship.

Krystal’s family describe her brother as using heroin to self-medicate for depression and that he intentionally overdosed on heroin to end his life. She says, “we found out later that he’d tried to kill himself again ... from his diary”. Krystal had contact with her brother on the day he died; he had come to her place to fix up the battery in her car. She says:

I think he decided before then ... I’m going to end my life soon, and this is something I want to do for you to say, hey, thanks for being my sister. He was found with a syringe in his arm and another full syringe next to him ... the police thought it was intentional ... and he’d been very drunk.
Many years ago, a psychiatrist told me it is rare for people to end their life through suicide without taking a drug first. This made sense to me. Whether people take drugs to make the planned suicide easier or take drugs and then make the decision to end their life, is difficult to know. All that said, Krystal, Lorraine and Lilibet’s siblings seem to have planned their suicides, whereas Donna’s brother’s attempts were more spontaneous.

**Mental health**

In the drug and alcohol field, it is not unusual for people to also have mental health issues such as depression, anxiety or drug-induced psychosis. Isobel grapples to understand what happened with her brother who was diagnosed with ‘manic depression’. She says she is not clear:

> Whether the drug use was to counteract the manic depression in some way, or whether the drug use brought on the manic depression ... for me, I guess I was rationalising he had this [manic depression] and that’s why he took drugs and now he’s got the tablet from the psychiatrist, who knows everything, life will be wonderful. And I guess, in some ways that’s a simplistic naïve way of compartmentalising it and going, ‘Things will be right now’.

Lorraine talks about the ambiguity regarding her sister’s mental health:

> I know that she was in India and she got very sick ... I don’t know whether she was psychiatrically unwell, or she had a physical illness. And she didn’t have any money to come home.

When her sister came back into the country, the authorities “locked her up, she didn’t know what day it was or anything ... she was very psychiatrically unwell”. Her sister was detained in the psychiatric ward of the jail for three months. Lorraine says:

> We didn’t know what was going on ... didn’t know what to do or how to help her. When she was released from jail, she was not given any medications. She had no money. Her behaviour was strange”.

Lorraine says her sister “was meant to see the mental health service but there was no way to make her comply ... she continued to use substances. There was nothing to stop her”.

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Sally is clear about her brother’s situation. “There was a drug-induced psychosis at first, which was then diagnosed as schizophrenia”. She goes on:

The mental health team would come over ... but ... he never really ceased taking drugs during that time. So, it’s hard to discern what was mental illness and what was drugs.

Donna says by the time her brother was 17 years old:

He was just so off the planet the whole time. He was very difficult. He had delusions ... he was unpredictably violent ... he’d say, ‘I’m going to come and slaughter you while you’re sleeping.

Donna says her brother was held in mental health “[in] a forensic bed ... he was locked up because he was a danger to society”. When he “was in the open area of the place ... he kept absconding and taking drugs again ... so he had to be kept in the secure area”.

Co-occurring drug use and mental health issues can make intervening more difficult in terms of where to focus attention and which services to involve. It creates an added layer of complexity for all those connected with the person, particularly for the family, as Donna, Lorraine, Sally and Isobel have explained.

Associated health issues

There are numerous health issues that can be associated with drug use from overdose, as noted above, to accidents. For example, Tony says his brother’s “tent burnt down, and his brother got seriously burnt on his arms”. Sally says, “because of the drug use, he’d lost some of his teeth and ... generally was not that clean”.

Donna’s brother was held in the secure mental health facility until he died at the age of 27:

He was locked up ... never to be released. And once he was there, his condition kept deteriorating and they said, ‘He’s not a candidate for a heart transplant’ ... that’s what did him in ... heart failure.
Tony recalls the last time he saw his brother:

I actually went to see him at the flat ... and it was just, fetid. I do vividly remember going into that flat, I can see him, he was in end stage of liver failure, he was yellow, he had ascites, he was obviously incontinent, and I just thought I am not going to see him again, and I gave him a big hug when I left and said, ‘I love you’ and walked out. [My brother] survived two lots of bleeding oesophageal varices and the mortality rate is 95% or something heinous, and to survive that and to be 5%, and then to survive it again you are 5% of 5%, the third time got him ... [he] bled out.

Associated health issues can occur from an accident when intoxicated, as a result of the drug use, for example, by using an unclean syringe to inject or failing bodily systems through longer term drug use.

Knowledge of the sibling’s drug use – new
In this section I present only one commonality within this topic that was new and expanded the horizon. The commonality was that the siblings used drugs together.

siblings use drugs together
Some of the people in my study knew nothing, or very little, about their siblings’ drug use. Others were introduced to drugs by their siblings or introduced their sibling to drugs and/or used drugs together. For others in my study, they were put off drugs completely because of their siblings’ drug use.

Helen’s brother introduced her to cannabis. She says, “I’m a terrible pot smoker. It doesn’t agree with me at all. So, I only tried it with him once”. She says at the time she didn’t know about her brother’s heroin use. She also recalls a dance party:

I ran into my brother and all his mates, and I was there with my friends and so my brother said, ‘I’ve never been on drugs with one of my sisters before, this is great’ ... we had an absolute ball together.

Carl and Stan talk about introducing their siblings to cannabis. Carl says he and his younger brothers were all “smoking dope” together. Stan has a similar experience to Carl; he says, “I
introduced him to pot when he was about 13”. Both brothers were also aware of their brothers’ ongoing drug use. Stan says his brother used “heroin ... for about seven years, yeah probably since he was 15–16”. Similarly, Connie says during her early teenage years, “we [siblings] used to smoke marijuana ... it was just normal”. Connie didn’t think of smoking marijuana as a problem; “we just thought it was a bit of fun”. Connie finishes by saying, “by the time I was 17, I was a bit over it ... whereas my brother kept going”.

Similar to Connie, Vera says, “we [sisters] were off doing drugs ... doing everything we shouldn’t be doing at that age”.

Lorraine refers to herself more as a ‘follower’ of her sister. She recalls:

being naughty as kids, like telling our mother we’re sleeping at a friend’s house and then going into the city and going to parties.

She elaborates saying, one of her stepbrothers knew a dealer so they would “all go after school to the dealer’s house”. Her sister was smoking marijuana daily. Lorraine concludes that drug use between siblings is “a bit contagious”.

In all the time I have worked in drug and alcohol, I have never specifically asked someone about using drugs with their siblings. I had not thought about siblings using drugs together – and when I say this, I am thinking of heroin – and having a good time, although I have no trouble thinking of siblings sharing an alcoholic drink together. Once again recognising my prejudice and being open to new information means that my horizon’s view can expand and, on reflection, my limited view now seems naïve.

**Discussion on knowledge of sibling’s drug use**

The knowledge of someone’s drug use comes to others in multiple ways. In the case of my study, it was sometimes because the siblings used drugs together, other times because someone told them or the sibling disclosed their drug use openly. Some people in my study had selective knowledge about their sibling’s drug use. The idea of only having selective knowledge about the sibling’s drug use could be related to judgements about drugs and the sibling keeping their drug use separate from the sibling relationship.
According to Frrokaj and Tsamparli (2016), numerous studies have demonstrated that substance use by one sibling is often associated with substance use by another, although the relationship between older and younger siblings is not fully understood. Older siblings often function as role models for younger siblings and make substances available/accessible to younger siblings, thus, normalising drug use (Frrokaj and Tsamparli, 2016). Kim et al. (2007) say sibling relationships can function as a risk or protective factor where siblings can learn prosocial or antisocial behaviours. Interestingly, Frye et al. (2008) state that most studies have been focused on the “transmission of drug use between siblings” (p. 21). The idea of transmission reflects Lorraine’s comment that drug use can be “a bit contagious” between siblings.

‘The knowing’ about the extent of the drug use probably changes over time and is dependent on whether the drug use continues over years and what other consequences become apparent. Claydon et al. (2016) state that drug use “contributes to thousands of deaths, substantial illness, disease and injury, social and family disruption, workplace concerns, violence, crime and community safety issues” (p. 2). People in my study were at times exposed to direct evidence of their sibling’s drug use including intoxication (nodding off), injecting (shooting up), overdose or the effects of ceasing drug use. Other issues such as non-fatal overdose, suicidality, mental health issues and related health conditions can also provide knowledge, not just of the sibling’s drug use, but the extent of the drug use.

I noticed that for many of the people in my study, their sibling died during the 1990s. The broader social context shows that during this period in Australia, heroin was readily available. The Australian heroin market was targeted by “Southeast Asian heroin trafficking groups from the early 1990s, supplying cheaper, purer heroin than had previously been supplied to Australia” (Degenhardt et al., 2004, p. 21). As a result of these conditions, many people overdosed and subsequently died. To address the heroin situation in the 1990s, supply reduction strategies, as a component of the National Drug Strategy, were implemented which fall under the auspices of legal interventions. Therefore, in the 1990s, the police had no qualms about showing up at an overdose emergency (as described by
Janet) with the aim of getting information about sources of drug supply and to charge the person with self-administration and possession. To the police, such action made perfect sense. However, the consequences were dire, with people being reluctant to ring ‘000’ when someone was overdosing for fear of persecution or discovery which led to many more preventable deaths occurring (Commonwealth Department of Health and Aged Care, 2001).

The National Overdose Strategy was introduced in 2001 as a health intervention focused on harm reduction, which was also a component of the National Drug Strategy, as there had been a steady increase in the number of fatal opioid overdoses, from 250 deaths in 1991 to almost 1,000 in 1999 (Commonwealth Department of Health and Aged Care, 2001). The strategy noted the benefits of protocol changes between police and ambulance officers at overdose scenes (Commonwealth Department of Health and Aged Care, 2001). Overdose rates reduced significantly in the next decade (Degenhardt et al., 2004). That said, overdose is a frequent occurrence, especially for people who use opioids, with 60% of opioid users reporting non-fatal overdoses every year (Department of Health and Ageing, 2001). Non-fatal opioid overdoses are concerning because they are a predictor of future fatal overdose and can lead to other issues such as head injuries and/or paralysis (Madah-Amiri et al., 2017). Hence, non-fatal overdoses have also been targeted for prevention strategies in the Australian context, encouraging pharmacotherapy replacement therapy, safer injecting practices and access to naloxone (Commonwealth of Australia Department of Health, 2017).

Another fatal outcome of drug use can be suicide. Many people in my study linked their sibling’s suicidality with drug use. According to the World Health Organisation, “mental disorders (particularly depression and substance abuse) are associated with more than 90% of all cases of suicide” (WHO, 2019). In Australia, the 2007 National Survey of Mental Health and Wellbeing found that only 3% of people with substance use disorders experienced suicidal thoughts in the previous 12 months (Prior et al., 2017). However, when people have a substance use disorder and two mental health disorders, for example, one mood and one anxiety disorder, then 41% of people experienced suicidal ideation in the past 12 months (Prior et al., 2017). Therefore, the risk of suicide is more likely when a person has co-occurring mental health (for example, depression) and substance use issues.
In terms of comorbid conditions, Prior et al. (2017) provide four explanations for the co-occurrence of drug and alcohol, and mental health disorders: a) the self-medication hypothesis where the substance use induces mental health disorders, b) the drug and alcohol use causes the mental health condition such as depression, c) the indirect causal hypothesis where one disorder affects a third variable and finally, d) predisposing factors such as bio-psycho-social factors which increase the risk of developing a disorder.

Regardless, Marel et al. (2016) estimate that 35% of people who can be classified with a substance using disorder will also have an affective disorder (for example, anxiety) and these people will usually have more complex severe issues and often have poorer treatment outcomes. This was seen with Lorraine and Donna’s siblings, although Donna’s brother had other associated health issues as well.

Drug and alcohol use is also associated with a range of other health issues, such as infections leading to cardiomyopathy following injecting with an unclean syringe, blood borne viruses and chronic liver disease, endocrine diseases, ascites, pregnancy complications, tooth cavities and the risk of injury (Lahti et al., 2011). When reviewing facts about all drug types, it is obvious that the health issues associated with drug use are varied, based on the type of drug used and how it acts on the body, the immediate effects of the drug and level of intoxication (for example, increased risk of accident or injury) and the longer-term effects due to regular ongoing use over years (for example, liver disease) (Alcohol and Drug Foundation, 2018).

The drug-using world – familiar

When the people in my study discussed what they knew about their sibling’s drug use, the notion of a ‘drug-using world’ was mentioned. In this section I present the familiar commonalities making up this topic of conversation, which include the secretiveness of drug use, drug-related criminality and sex work.
The secretiveness of drug use

Drug use is often accompanied by a secretiveness which could be for a multitude of reasons, including the person taking the drug protecting others from knowing and/or the drug use is an illegal activity.

When Amy reflected on her brother’s drug use, she said, “it was hard to know what we got told and what the truth was”. She goes on:

When someone is drug addicted for a long time, a lot of their life is secret ... so I only found out after he died ... that he started using at 14 ... he knew I didn’t want him using drugs, so he would hide it from me.

Stan says, “I left home when I was 18 ... my brother would have been around 14 ... he was living with my mother at the time. And he was a sneaky little bugger, so she didn’t know a lot of what was going on”. Stan says that he had “no idea” that his brother was doctor shopping. Aside from wanting “to punch out the doctors” he says:

I was pissed off; you know prescription drugs are still one of the highest killers out there ... they are going to find a way to steal prescription pads or break into [a] chemist ... you know junkies are devious [and they are going to find ways] to get drugs no matter what ... [people using drugs are] very clever ... very sneaky and you know ... if junkies ... put their talent into work, like the way they do to score drugs, they’d be CEOs, multimillionaires.

It is illuminating to focus on drug use from the brother’s or sister’s view. Many of the people I have worked with feel deeply ashamed about their drug use and have to muster a great deal of courage to discuss what they have done to procure drugs, especially when they have not acted in accordance with their own values. I am not surprised that their siblings could interpret their behaviour as sneaky, devious or secretive.

Drug-related criminality

For some people in my study, their sibling engaged in illegal behaviour and/or was charged and/or jailed for drug-related crimes, for example, possession or trafficking, at which time they became more aware of their sibling’s drug use. Stan says when his brother died, “he’d
been doctor shopping a lot, he was getting Xanax and all the pills you can imagine, he was living with a friend at the time, they were both into pills and smack”. Stan says when he cleaned his brother’s room:

We found hundreds and hundreds of prescription medications all around the place. He had them hidden ... everywhere ... He had also stolen prescription pads from doctors ... I don’t think it was really heroin that killed him, it was prescription meds.

When Jacqui was about 26–27 years old, she was working in the drug squad. She says:

One of my colleagues ... said, ‘Jacqui we’ve got some information about this person whose importing cocaine and he’s got a girlfriend’ ... and I looked at the job and I looked at the paperwork and went ‘that’s my sister’. Jacqui says her sister ‘just spilt her guts over everything she knew ... and then she started informing ... that was really interesting because she ran with some quite high people ... I found it really yucky ... [because] then I knew what she was involved with ... too much information.

Jacqui clarified that if anyone else had gone to see her, “they would have arrested her. And this was a long time ago. It would never happen today”.

Lorraine says her sister had been out of the country and was arrested as she tried to re-enter, for trafficking drugs. Lorraine says, “she had hash, we were told ... like six kilos ... we actually think she was a fall person for something else that was coming in”. Initially her sister’s charges were too serious for her to get bail. After three months, “she was released into the family home”. Lorraine goes on that a QC represented her sister in court. The family are not sure who paid for the QC but think “the traffickers paid for it”.

Similarly, Isobel says, “he did get into trouble with the police, that was very traumatic”. She says:

He did get sentenced and he had to do weekend jail ... he always claimed it [marijuana] wasn’t his, it was someone else’s in the house, which my parents believed. I believed it ... [Later, when he was staying with her], I found a bag of
marijuana in the house, you know, not what you use, what you would sell ... so obviously that [selling] was happening.

Tony says, “my brother sold some heroin to an undercover policeman ... and he got sentenced to five years, he served one”. Tony laughs as he says, “he didn’t come to our wedding ... he sent a telegram saying, ‘Sorry can’t be there, unavoidably detained’. We knew he was in jail (laughing)”.

Tony goes on to describe visiting his brother in jail:

That’s one of the most horrific experiences I have had, because you have to sign in and say relationship to prisoner, and you write brother ... [His brother was] the best and healthiest ... in jail ... he came out of there looking fitter than me ... and within weeks, he was back in the drug scene ... that was tragic because I thought, ‘This was your opportunity’.

It was not surprising to me that many of the siblings may have been in trouble with the law regarding their drug use, particularly when the drugs used are illegal or the way they used the drug was illegal, for example, having a blood alcohol level over the legal limit. Most people engaging in drug use with whom I have worked, have engaged in some sort of illegal activity. Further, one of the largest referral sources in drug and alcohol is corrective services, indicative of the link between drug use and crime. In fact, reduced recidivism is often a good treatment outcome measured in the field.

Sex work

Sex work is also common in the drug and alcohol field. When working in the drug and alcohol field, I have often met people where sex work ‘fits’ with their drug use in terms of quickly acquiring money on an as-needed basis. Vera says of herself and sisters, “we were all into prostitution”. Vera elaborates:

My sister was such a heavy drug addict ... they [sister and husband] had $1000 [a day] habits. Because I was working in that industry, I could afford to look after myself. But I was paying for her and rent as well.
When drug use is mixed with sex work, there can be an increased vulnerability and the potential for exploitation and disadvantage, largely because of social stigma and stereotyping. Women can be ‘sent out’ to work to raise funds for drug use by both themselves and their partner. For example, Vera says her sister:

married a junkie ... he used to beat her up. She was a prostitute. She worked. He used to send her to work so they could get drugs.

The notion of vulnerability is highlighted by Jacqui whose sister was murdered while working. Jacqui now advocates for the decriminalisation of drugs:

It would have been so different. My sister wouldn’t have been there that night. She wouldn’t have that stigma attached ... she wouldn’t have died ... she’d be alive.

I am not surprised by women and men funding drug use through sex work. Again, through my work, I have frequently been made aware of the vulnerability of people who are using drugs, how open to exploitation they are and consequently, how they are preyed upon by others.

The drug using world – new

in this section I present the new commonalities within this topic, focused on the drug-using world. There were two commonalities in this topic: the first is describing the drug-using world as a foreign, dark and scary world; the second is the idea that the sibling led a double life.

A foreign, dark and scary world

Many in my study talked about the ‘dark’ world of drug use and being scared of their sibling at various times. For example, Amy says, “there was this ... other dark scary part of him”. She goes on to say, “my brother was living in this ... different world to us, none of us had any idea about this world, he was living in a really dark world”. Similarly, Alice says:

My experience had been if you did drop in to see him, there were all sorts of characters that would drop in and be hanging around ... it’s a dark, dark world, it’s horrible.
Both Judy and Donna describe their brothers as scary. Judy says, “he never had been Mr Conventional”. As his drug use progressed over the years, she says he was “definitely looking unwell and sort of a bit scary”. She adds, “well, almost like a derelict”. Donna echoes this sentiment. She reads from her blog kept at the time saying:

He lives in a secure facility ... I don’t visit him practically ever. I can’t cope. He’s too creepy and scary for me. The little brother I knew died for me about 10 years ago.

The idea of there being ‘a drug-using world’ and it being scary and dark was not something that had previously occurred to me. However, on reflection it makes sense. It is foreign for those who are not in that world and, developing the metaphor further, perhaps there is culture shock when exposed to that world.

**Double life**

For many too, there is a notion that their sibling lived in two worlds, almost keeping their drug-use world separate from the family world. Amy describes her brother as:

Jekyll and Hyde ... there was this incredible worry and darkness and, oh God, and then ... this really beautiful charismatic, wonderfully understanding part of him and then there was this really, the other dark scary part of him, that could take ... be secretive. He was hard to be with, unpredictable, crazy, he’d take your money, he would lie.

Judy says whenever she saw her brother, he wasn’t drinking. She says, “I never saw him ... out of control”. She recalls whenever he was with the family, he would behave “in the acceptable way”, there was no “over drinking ... he was in control of himself”. Judy explains she never went to his flat; “he wouldn’t let us into his place, because it wasn’t tidy enough”. Similarly, Connie describes her brother as a very private person and was living in a flat on his own. She says:

He didn’t like people popping in or any of that sort of stuff ... he’d drop over at mum’s, but ... he didn’t want his privacy invaded.
Isobel describes her brother as leading “a bit of a double life ... I can see that now”. She says, “there was obviously this other side of him and that’s what made it so hard because we never ever saw him as an addict”. She says:

The day he died, someone told me, ‘I heard [about your brother’s death] from so and so who’s in jail’, so there must have been far more of a network than I was ever aware of.

Isobel reflects she was looking for explanations for her brother’s behaviour that didn’t make sense; she says she wondered if he was “gay and can’t come to terms with that”.

Krystal recalls, “when he was living at college ... and he got into trouble a few times”. She goes on, “he didn’t want me involved in that. I think he was quite embarrassed and didn’t want me to think any less of him”. She recalls, at the time:

He didn’t want anyone else to know. He was very proud and didn’t want people to see his weaknesses. So almost like, this is me that I’m showing you, and this is me that I’m showing this [other] person.

I found the idea that the sibling had a double life fascinating and illuminating. There is such explanatory power in this concept because the person, in essence, has two identities: one reserved for the family and the other for the drug-using world. By keeping these identities separate, the sibling almost shields the family from their drug use – they can remain a functioning member of the family with all the expectations that involves. The benefit of keeping these identities separate is there are expectations of the person in the family context that have not been compromised, lost or destroyed by drug use – ‘the essence’ of the person is still alive in the family. I suspect too, that having two identities allows the person to remain connected with their family, which is important in the long term if the person is to make changes. A discussion on the topic ‘the drug-using world’ is presented next.

**Discussion on the drug-using world**

In this topic, the drug-using world is considered different to a non-drug-using world and is characterised by criminal activity, sex work, secretiveness, foreignness and a sense of the
sibling living a double life. On the issue of criminal activity, the Australian Institute of Health and Welfare (2021) reports that the social impacts of drug use include risky and criminal behaviour, as well as violence, victimisation and trauma. There is a strong relationship between drug use and criminal activity but there is debate about causality (French et al., 2000). In my study, people suggested their sibling’s drug use led to criminal activity, for example, Stan says his brother had stolen prescription pads from doctors. French et al. (2000) “showed that severity of drug use was significantly related to the probability of committing a property or predatory crime” (p. 105). Others concur; in a publication about supporting families, Frye et al. (2008) note there is an increased potential for involvement with the legal and criminal system when someone is using illicit drugs. Hence, Australia’s National Drug Strategy (NDS) (2017) aims to divert people using drugs away from the legal system and into treatment (Commonwealth of Australia, 2017).

Another common illegal activity connected with drug use is sex work. Studies on sex work in the US and Australia show that the majority of sex workers are women (Roxburgh et al., 2005). Many street-based sex workers are from disadvantaged racial groups, have low levels of education, are homeless, have mental health issues and have experienced childhood and adult sexual assault and other violence (Roxburgh et al., 2005). Street sex workers are also more likely than the rest of the population to report heavy or dependent and intravenous drug use and typically, these women have poorer drug treatment outcomes (Jeal et al., 2018). Further, dependence on illicit drugs is linked to risk-taking behaviours, while selling sex (such as unprotected sex or sharing needles) and keeping women entrenched in sex work (Jeal et al., 2018). Jacqui and Vera both talked about sex work and its links to drug use.

The secretiveness of drug use could be in part be because of the illegal activities associated with drug use or simply because the drug itself is an illegal substance. In my study, Janet drew attention to the latter issue, stating, “because it was an illegal activity [drug use], you had to keep it quiet”. People who use drugs are “described as isolating himself or herself” by relatives (Orford et al., 2010, p. 45). Frrokaj and Tsamparli (2016) found this need for secrecy around the drug use changed sibling relationships, noting that siblings who used drugs became “remote and unwilling to share”, so much so that for their non-drug-using
brothers and sisters, it was like the sibling had “become someone else ... like a stranger” (p. 135). Frrokaj and Tsamparli (2016) surmise that the non-drug-using brother or sister “seem to mourn” the relationship that they had with their sibling in the past, before the drug use. This is also consistent with Boss’s (1999) work on ambiguous loss where the person is physically present but psychologically absent. “It is as if the use of substances has become the ‘organizer’ of how they experience their relationship” (Frrokaj & Tsamparli, 2016, p. 135). Certainly, Donna in my study mirrors this experience, saying “the little brother I knew died for me about 10 years ago [when he began using drugs]”. This idea is reinforced by Schafer’s (2011) study with residents in a rehabilitation program who reported that they had intentionally created distance with family members because they felt too ashamed about past behaviours such as lying, drug dealing, stealing or abusing others.

Schafer (2011) hears about the idea of living a double life. She says people in her study said, when spending time with their family, they often “felt like they were ‘wearing masks’ in order to maintain their secret addiction” or they maintained their family relationship by keeping their “drug addiction a secret” (p. 140). Gibson et al. (2004) coin the phrase ‘entangled identity’ to describe the “conflict between the user identity sustained by user-related practices and routines and the non-drug-user identity” (p. 604). They say that people talked about their drug-user and non-drug-user identities, noting that when they failed to fulfil their roles as a non-drug-user, they noticed social contacts would often withdraw from them. They expand on the idea that maintaining “drug-using routines in priority over non-drug-using routines had direct implications for the identity of the drug user and the person they were becoming, often leading to changes in friends and sometimes close family” (Gibson et al., 2004, p. 610).

In terms of people who use drugs belonging in some way to another alternative world, Anderson (1998) says drug taking is a universal across all cultures. She contends that people are socially marginalised or alienated from mainstream society and, on an individual level, can feel socially isolated and experience a discomfort about their identity and, therefore, are drawn to identify with alternative social groups such as a drug-using subcultural group.
(Anderson, 1998). The idea of belonging to a drug subculture, a different world, with its own rules and ways of being, is how Judy, Amy and Alice thought about their siblings.

The idea of people belonging to a drug-using subculture, is contested by Moore (2004) following his ethnographic study with two groups of drug-using people, the ‘Players’ and the ‘Bohemians’. He argues that the term ‘scene’ is probably a more useful way to conceptualise how these groups operate. In this context, “scenes are cultural, social, temporal and spatial zones in which diverse people interact and contest the meanings of their actions” (Moore, 2004, p. 201). His description of the ‘Players’ scene is relevant to my study. The Players engaged in poly-drug use and undertook ‘deceptive’ and ‘manipulative’ activities to buy, sell and use illicit drugs in an unregulated market (Moore, 2004). There were two specific practices: taxing the drug to be sold-on by removing a third of the volume for personal use, or cutting the drug by removing a portion for personal use and then adding something else to make up the volume for on-selling. The idea of a ‘scene’ fits well with the notion of ‘another world’, a term which people in my study (Judy, Amy and Donna) used to describe their sibling’s drug use and the alternate space they occupied. It is also useful when thinking about the inevitable clashes of the two worlds.

**Clashes with the drug-using world – familiar**

Many people in my study mentioned times when their sibling’s drug use interfered, intersected or clashed with how they knew them. Sometimes this was heightened because the sibling had been, almost deliberately, keeping the drug-using part of their life separate from the sibling relationship. In this section, I present the two commonalities within this topic that were familiar around clashes with the drug-using world including using again and hard to be with.

**Using again**

Alice says about her brother, “he tried over the years; he tried several different things” but he would “just go back to using again”. She says, “I just got to the stage where ... I actually thought he was going to die”. Similarly, Gina says that her brother “had been using for many years, on and off ... he had actually got clean enough at one stage that he’d met a rather wonderful woman and had a child”. Gina says:
at the time of his death, we actually thought that he ... had been clean for a little while and, to our knowledge, he wasn’t using.

Similarly, Helen says her brother “struggled with addiction for a long time”. Jacqui also provides an example, saying her sister:

Leaves the [drug] scene ... and she gets a place ... so my husband and I go and buy her a whole lot of furniture and she’s very house proud ... and then she leaves there and gets back on the gear and goes to live with my mother.

Jacqui says she found it difficult to cope with the situation.

When drug use has been going on for a while, the person will often, repeatably, reach a point where they want to stop and often stop many times, only to relapse. It can be very disappointing for both the person and their family when relapse happens.

Hard to be with
Amy says, “to be honest, when he started using drugs, he was harder to be with”. Amy’s statement is reflective of others in my study. Carl describes seeing his brother less as his drinking increased, partly because Carl was living interstate and because Carl’s wife “was horrified by him and she said, ‘I’m not having him here again’ and partly because it just got more and more difficult”. Carl describes his brother as a:

Loud drunk, he was a drunkard ... he was dishevelled, and he didn’t wash ... it was horrible.

Stan says about his brother’s drug use, “it was pretty hard to deal with”. He says one of the reasons he found his brother’s drug use difficult was because “mum and dad didn’t really know how to deal with it”, so Stan was left to deal with his brother. Stan says when his brother died:

I hadn’t seen much of my brother ... for about a year ... I was sick of him being a junkie.
Alice found it too hard to be with her brother because it was too painful to watch what was happening when she couldn’t do anything about it. She recalls she said to her brother:

Something along the lines of, it’s really painful to watch you doing this to yourself and I can’t be a part of it anymore; however, if you are serious about wanting to go to rehab ... give me a ring ... he rang me on two occasions.

Donna also describes a discomfort in being with her sibling but for a different reason to Alice. She says by the time her brother was 17 years old, “he had delusions ... became aggressive and violent”. She goes on:

We were trying to keep our kids safe. And we were worried about his attitude to our daughter. We weren’t prepared to take the risk that he was suddenly going to ... turn on her, which he could do.

Again, as the drug use had been going on for a while – perhaps a decade or more – progressively more damage seems to be done to relationships. Some people in my study found it harder to be around their sibling, perhaps because they could see the effects of the drugs on their sibling. Other clashes with the sibling’s drug-using world were new to me.

**Clashes with the drug-using world – new**

In this section, I present commonalities within this topic that were new and expanded the horizon. These common aspects include tangible evidence or drug use, characters hanging around and protecting sibling’s children from drug use.

**Tangible evidence of drug use**

Some became aware of their sibling’s drug use because there was tangible evidence, as Judy says, “I remember coming home and they [family] were laughing because he was growing marijuana”. Others picked up on some of the more obvious physical effects of drug use. For example, Gina recalls on one occasion:

Taking him out for lunch and he’d nod off ... I remember getting up and leaving him in a café because he was just so out of it.
When Karen was around 14–15 years old, she remembers “walking in on him shooting up in the bathroom”. Jacqui describes a scene, saying, “I’ve got a picture of her, she’s got track marks up her arms and I haven’t seen her for ages”. Kathryn described how her brother would have withdrawal seizures:

He had a couple of instances of seizures, and they were when he was withdrawing from benzos. They were much later on.

Krystal recalls her brother’s shock when she met him as he was buying and preparing to use heroin. She says, “[I] remember walking up to my brother and him turning around and looking at me and this black look of absolute hatred and horror that I would be there. He didn’t want me there”. She goes on:

I just remember … him going, ‘I want you to go. I don’t want you to meet the person I’m waiting for. Go away’ … and I’m going, ‘No, I want to meet her … I’m not going anywhere, I’m staying here’. And then to find out it was … this prostitute who had been going and getting drugs for him … It just makes me feel sick to think that he would go to somewhere like that … and then going home and just waiting … to hear.

She describes herself at home “just worrying and stressing”.

Evidence of the drug use comes in numerous forms, from actually seeing the drug itself, witnessing the effects of the drug intoxication, seeing evidence of use or withdrawal from the drug taking. These types of evidence allow others around the person to know about their drug use. Being confronted with tangible evidence of the drug use or even being caught in the act of procuring and/or using drugs engendered a range of reactions, from feeling exposed or intruded upon for the person using the drugs, to fear, worry and anger for siblings. As Krystal says, her brother was shocked to see her, just as she was sick to her stomach with worry about what he was doing.

Characters hanging around

Karen says she knew when her brother was using heroin because “these people would show up and you just can’t even get him for a moment”. She describes the group as “dismissive of us” and when they arrived, they got the attention,
You were left not being the priority anymore … it was that sense of being a bit disappointed with him.

Janet recalls her brother:

Had this girlfriend and [sighs] when I met her, I just thought … she’s just so, she was off her face all the time and she’s just not human anymore … she’s just a shell … all she could think about was when she’s getting her next hit and you could see, because he had a job, she was just using him to get money.

When siblings engage in drug use, their circle of friends and partner can also change from those who do not use drugs to those that do. These associates or partners sharpen the focus on the drug-using part of the sibling and with that, an element of reprioritising, unpredictability and unfamiliarity that could be disappointing and uncomfortable for the people in my study.

Protecting sibling’s children from drug use

Some of the people in my study also discussed their sibling’s children in terms of exposure to drug use and protection from the drug use. Karen says that her niece:

Lived mainly with her mother but my brother had a lot of contact … I had always maintained contact with my sister-in-law and niece. But it was only towards the end … when he was dabbling [with heroin] … they [sister-in-law] just stopped him having overnight contact [with her niece] and he was resentful of that.

Karen also recalls a messy time when her brother and sister-in-law had split up and were arguing “so there was this thing happening between them and in the meantime, my niece is crook”. So, Karen said, “I’ll just take her [to the doctors]”. In a different way, Jacqui describes a situation where her younger brother intervened because their niece “was in danger”. She and her brother tried to help their niece:

It’s Christmas time and my brother rings and he says, ‘We’ve got to get our niece out of there’. And I said, ‘Well, grab her and bring her down to me’. So, he snatches the baby and drives … to give me my niece and I’ve got her for two days, and … my sister
rings and says ... ‘I want my baby back ... I’ve called the police on you’ ... in the end, my husband and I went, ‘This is just too much’, so we took her back.

Vera has had two sisters die for a drug-related reason. She says her older sister’s drug use: Impacted on her life, especially when she had the kids because she never had any money. They partied a lot ... and her eldest son ... used to get threatened by the [step] father, he was violent. [Her younger sister] was always chasing drugs ... she just wanted her drugs. She lost custody of her daughter and son.

The people in my study describe their siblings’ parenting capacity as compromised. This is not uncommon when people actively engage in drug use. I know most parents love their children dearly and want to care for their children and do the best they can. However, from a child development and human rights perspective, the home environment may lack in terms of predictability and security that children need to feel safe in the world and develop to their own potential. This is a very sensitive topic from all angles. I have witnessed the removal of many children through child protection services, with varied outcomes. At other times, the threat of having children removed can be a strong motivator for the parent to change their drug taking.

Discussion on clashes with the drug-using world
The discovery of the person’s drug use becomes more likely as time passes and the drug use continues. Trimmingham (2009) describes the time when the drug use is a secret, things are fine and the family ignorant as the ‘happy user stage’. He contends that this stage ends when evidence of the drug use is found, the police arrive or someone has an overdose (Trimmingham, 2009). I describe the point where the drug use and the sibling relationship meet as a ‘clash’. In my study, these clashes were jarring events, filled with a myriad of emotions like anger, frustration and disappointment, especially when the sibling relationship was dismissed in favour of the drug use. For the people in my study, these clashes happened when there was tangible evidence of drug use, such as the sibling relapsed and started using drugs again, when the duration of the drug use made it hard to
be around the sibling, their parenting was compromised and/or their drug-using friends intruded.

In the previous topic, the drug-using world was discussed. The identities of both drug-using and non-drug-using interact with drug-using and non-drug-using worlds. When the drug-using identity is stronger, friends are more likely to be drug-using friends (Gibson et al., 2004). In my study, Karen talks about a particular group of people who would show up only when her brother was ‘dabbling’ with heroin. During these times, Karen found it difficult to be with her brother because she felt excluded and deprioritised.

It seems obvious, in some respects, that for the person using drugs, internal conflicts could arise between the drug-using and non-drug-using identities; especially when drug-using routines take priority over non-drug-using routines because then other changes may occur, such as changes in friendship groups (Gibson et al., 2004). Expanding the notions of identity further, they postulate that a part of identity is about ‘being there for the other’ and, as such, constitutes roles and obligations. This is in contrast to the drug-using identity which is more about immediate gratification – the momentary self (Gibson et al., 2004). Internal conflicts between the two identities emerge when one identity becomes closed off from the other, such as a father not using drugs on a day when he is due to see his children; in this example the drug-using momentary self is closed off. This order could also be reversed hence, there could also be times when the drug-using identity prevails and the father fails to perform daily practices and routines of the non-drug-using identity (Gibson et al., 2004).

Many parents who use drugs could have the duelling drug-using and non-drug-using identities to deal with. On the one hand, they want to parent well and, on the other hand, the drug-using identity closes off the ‘being there for the other’ identity. Many parents also fear negative judgements of their capacity to parent effectively because of the drug use (Barnard & Bain, 2015). To some extent their fears are borne out – they may want to parent well but the effects of the drug use can result in their parenting ability being compromised by the momentary self. As Barnard and Bain (2015) state, “a child in need can become a child at risk even in the space of a few hours where parents are preoccupied with drug or
alcohol use” (p. 178). In my study, Jacqui considered her niece was at risk because used needles were not disposed of safely. When parents are using drugs, the home environment is often chaotic and the care provided for children can be unpredictable and inconsistent (Frye et al., 2008). Therefore, children can exhibit emotional and behavioural problems, including poor emotional regulation, poor school performance and difficulties forming friendships. At the worse extreme, children may be maltreated or exposed to traumatic events (Frye et al., 2008). Schäfer’s (2011) research, she heard about parental fears of passing on addictive behaviours to their children. Others in her study talked about the ‘shame and guilt’ about their ‘abusive parenting’ and/or losing custody of their children while using drugs. In my study, Vera talked about both her sisters losing custody of their children because of their drug use. Certainly, the threat of losing custody or access to loved children can be a powerful incentive for entering into some form drug treatment. Gina talked about her brother saying, “he wanted it to be seen that he was making an effort, especially because of his son. He wanted people to know that he was trying to be a good dad”.

Gina also says, “at the time of his death ... to our knowledge, he wasn’t using” because her brother stopped using drugs many times. Gina expressed anger as well as upset around her brother’s drug-related death. She says words to the effect that he should have known better. Typically, drug use is described in the drug and alcohol field as a chronic relapsing condition, making sustained abstinence after one intervention a rare occurrence (Leshner, 1997). Trimmingham (2009) states that relapse is normal, with many people trying numerous times to make sustainable changes. Drug use occurs in a social context; therefore, there are numerous environmental triggers that cause cravings to use drugs and the subsequent relapses (Leshner, 1997). Gibson et al. (2004) note people in recovery have the difficult task of having to abstain from drug use and their social network who form their drug-using world. It is for this reason that increasing engagement with non-drug using social networks has been identified as important for relapse prevention and achieving sustainable outcomes following rehabilitation (Mawson et al., 2015).
The people in my study also seem to be dealing with experiences that are more aligned with a sense of hope when their sibling enters treatment or makes changes to their drug use, and the disparaging disappointment and sense of hopelessness experienced after relapse. Pauline Boss’s (1999) theory on ambiguous loss is fitting here. Ambiguous loss is a type of loss occurring for two reasons – the person can be psychologically present but physically absent (such as a soldier missing in action) or the person can be physically present but psychologically absent (such as a person who has dementia) (Boss, 1999). Boss (1999) would define having a family member who uses drugs as similar to someone who is preoccupied with work, in that the person is physically present but psychologically absent. Ambiguous loss is characterised by alternative states of hope and hopelessness over a long period of time where the ambiguity becomes increasingly difficult to tolerate (Boss, 1999). As Trimmingham (2009) says, there is a desire to fix things by forcing people into treatment, almost trying to create a sense of control in an out-of-control, uncertain ambiguous situation. Where drug use is concerned, hope arises when the person enters treatment or makes changes to their drug use and, with the oft-inevitable relapse, hopes are dashed and hopelessness resurfaces. Boss (1999) argues the longer the situation continues, the more stress and conflict becomes apparent in the family.

Templeton and Velleman (2018) also identify that having someone who engages in problematic drug use is highly stressful for families, although, the stress is attributed to the negative effects experienced by the family as a direct consequence of the drug use rather than ambiguous loss per se. Along with the stress, there is also a sadness because the person they knew is no longer psychologically present (Boss, 1999). Oreo & Ozgul (2007) similarly notice this type of loss in families, saying many families experience a sense of loss of the person they knew or the loss of a particular type of relationship.

The ambiguity is hard to live with, as people are pulled in opposing directions. In the ambivalence, there is not one ‘right’ answer, just an endless limbo (Boss, 1999). One of the things people try to do is find an explanation for their sibling’s drug use.
Explaining the drug use – familiar

Childhood

Alice says, “my impression of my brother as a young person was that he was quite a gentle and sensitive ... a whole range of things that didn’t fit” with the family environment. She says those traits were not respected and, “therefore, the way to deal with some of those painful things [emotions] can be to use alcohol and drugs”. In a similar way Carl says:

I think it’s about him being a really sensitive person and he keenly felt the injustices of the world ... he always made music ... and entertained people ... he was always trying ... to make the world better ... I think part of the reason why he drank and drugged himself was because thought the world was a cruel place and needed to ... to get better, and he was frustrated that it wasn’t getting better.

In this context, Carl describes his brother’s drug use as, “an attempt at self-medication” because “he was very idealistic”. But in saying this, Carl doesn’t want to make a “martyr of him” either. Gina says when the family moved to the coast, “my brother and I were both allowed to really be pretty wild for most of our later teenage years, and I don’t know if our parents were aware of what we were doing all the time”. Further, she says my brother:

 Didn’t get on with dad ... he dropped out of school ... dad would just call him lazy, so my brother moved out of home ... that’s when he really got stuck into the drugs a bit more ... I do believe ... there comes a point where you’ve got to go ... ‘I’m an adult and I’ll take responsibility for my own actions’, so, I’m cross with him that he never really did that.

Vera talks about abuse and the family context as playing a large role in both sisters’ drug use. She says, “my sister had had incest so ... my conclusion is that they [sister and partner] were on drugs because of their ... pasts”. She recalls her sister:

Started taking drugs about 13 years old ... we started drinking ... because we were from a poorer suburb and everyone’s parents were alcoholics ... drinking was one of the things you did. And marijuana. And because we were all down and out, not going to school ... we all wanted to take drugs.
For many, explanations of their sibling’s drug use originate in the family of origin, as relationships between sibling and parent were strained or conflictual or there was a lack of parental supervision coupled with parental drug use. For others, the sibling was sensitive, their childhood was painful (featuring violence and/or sexual abuse) and the drug use was a means of alleviating or numbing emotions. It is also important here to say that families, particularly parents, get blamed for their children’s drug use and there were quite a few in my study who were adamant that their parents and family upbringing had nothing to do with their sibling’s drug use.

Friends and environment
Many of the people in my study refer to other people in their siblings’ lives who were also engaged in drug use and had possibly influenced their sibling. Connie talks more about the broader social context and the accessibility and availability of drugs. She says there were “a lot of drugs” around. She elaborates, “we had time to waste and time to smoke dope”. Others in my study focus more on the influence of others. Gina believes for her brother “the band scene ... was probably one of the reasons that he’d get back into it”.

Jacqui also says her sister “hooked up with a boyfriend ... he was into heroin. That’s how she got into it”. Karen explains how she understood her brother’s drug use, she says:

My understanding of the heroin use ... was you bought what you could, and you shared it and when it ran out, you ... got over it, it didn’t seem to go on for prolonged periods ... [when her brother and sister-in-law got married, they were off drugs] but an old friend showed up, brought heroin to celebrate [the wedding] and they got back on the drug-using wagon for that period of time and it destroyed their marriage.

When the explanation of the sibling’s drug use highlights external elements such as the broader social networks and context, then the focus is more on issues of access and availability of drugs (supply and demand) rather than something within the sibling. Many of the people in my study refer to their sibling’s peers as possibly influencing their sibling and of the ‘normalness’ of drug use in society. Others thought it was more of an individual choice.
Choice

Amy was initially oblivious to the extent of her brother’s drug use; she knew he used drugs on the weekend and blamed his friends. However, as the extent of his drug use became apparent, she and her other brothers:

Talked to him ... and a conversation is very vivid to me ... I remember the four of us kids sitting ... [saying] ‘you can tell us’, and he was like ... ‘nothing ever happened’ ... ‘I just like drugs’ ... he loved drugs and didn’t want to give them up.

Donna says her brother “was taking heroin and basically anything he could get his hands on” and “he was just troubled and difficult and resistant the whole time”. Similarly, Sally describes her brother’s drug use as “my brother loved his drugs” and “he took everything”. Vera says her eldest sister “loved drugs ... she said, ‘I’m not giving up drugs for anyone’, she always used to say that ... [Vera’s sister would] take anything ... she could get”. She goes on that her sister was hospitalised a couple of times because “she’d overdosed”. In relation to her other sister, Vera says her younger sister’s drug use as different to her older sister. She says:

We were expecting my younger sister to die of drugs ... because she lived for drugs ... [She] was always chasing drugs ... she just wanted to get high. Going out to get sex, just to get drugs.

Gina talks about her brother’s drug use:

I get very cross because I think that he was being very self-indulgent too ... you’ve been a junkie long enough to know ... he should have known better ... you could be clever about your using ... he probably ... had a few drinks and thought ... this won’t hurt. And then I have this sort of image of him going, oh, bloody hell, now they’re all going to know that I slipped off the ... wagon.

Tony reflects back to early adolescence when he and his brother were smoking cannabis and using LSD together; he says, “I don’t know what the epiphany was ... but I just realised I would rather be healthy and fit rather than drugged out and lost”. Tony explains after this decision:
It’s because of the small choices that you make ... if you have a cigarette today it’s no big deal, but if you have a cigarette a day for the next twenty years ... it has a cumulative effect ... [we were] the same kids, in the same household, with the same parents, with the same environment but we made different choices and those different choices have ended up, way down the track, so divergent.

I have often heard people talk about loving their drugs. Certainly, as a young nurse at the detoxification unit accompanying patients to Alcoholics Anonymous and Narcotic Anonymous meetings, I heard many speakers identify as those who for the first time felt normal when they used drugs. If this is the experience, it becomes easy to understand the lack of incentive to change.

**Explaining the drug use – new**

In this section I present one new commonality within this topic focused on the sibling not being a drug addict. This new aspect was quite challenging to understand, but certainly expanded the horizon of drug use.

**Not a drug addict**

Many in my study emphasised their sibling was “not a drug addict”. I rarely describe people who use drugs as ‘drug addicts’ but found this very interesting because it seemed evident to me that many of the siblings had been engaged in drug use for extensive periods of time, had a range of associated issues probably related to their drug use, for example, poor or no housing, associated health conditions and no money and died for a drug-related reason. I was interested in both what the term ‘drug addict’ meant to the people in my study and also the importance of their sibling not being a drug addict. Based on the interview transcripts, it is evident that a person who fits into the stereotype of a ‘drug addict’ is someone who injects drugs and/or uses. For example, Sally and Krystal make direct reference to what an addict is. Sally reflects on her brother’s drug use saying, “yeah, I would never call my brother a drug addict, though that’s probably what he was, particularly once he started injecting”. Krystal says about her brother and his friends, “I don’t think they were ever addicts”. Krystal says, “he used heroin, but I still believe he wasn’t a junkie. He was a recreational user; he didn’t use every day”.
Helen refers to the drug addict stereotype, saying her brother was “a kind of fashionable fellow” and “he was immaculately groomed ... so when he died, a lot of people didn’t know that he had a heroin addiction and were very shocked ... people think heroin addicts look a particular way”. She says later about her brother’s death caused by an overdose of drugs, “I believe it was accidental”.

If a person is using cannabis, the people in my study did not describe them as a drug addict. I noted too there is a fear associated with heroin use as it is considered more dangerous. Connie says about her brother, “he wasn’t like a heroin addict, to be honest. I mean, he tried it a couple of times ... he tried LSD and all those things. He was adventurous with all that stuff”. Connie says she was not really worried about her brother’s drug use because:

I believed that he was quite ... sensible ... I wasn’t worried ... I obviously don’t know exactly how long he’d been trying heroin, but I really don’t think it was that long ... It might have been a couple of months before he died ... I said to him, that’s pretty scary stuff and he said, ‘Look, I’m only experimenting and I’m not going to have it anymore. I just wanted to see what it was like’ ... and he convinced me ... there was just so much around; there were so many people trying things that I suppose I didn’t think it was going to be life threatening, you know?

These observations about siblings not being a drug addict lead into the discussion on the topic of explaining the drug use for this section.

**Discussion on explaining the drug use**

There were four main ways that people in my study explained their sibling’s drug use: childhood experiences, friends and environment influences, choice in that the sibling loved taking drugs and the sibling was not addicted only experimenting or only used occasionally.

There are a number of studies that have been done identifying various risk factors which could lead to drug use by young people. A useful way to organise the various theories about how a person comes to use drugs is to apply the Bronfenbrenner’s person in context model (Bronfenbrenner, 2005). At a microsystem level, personal characteristics, family and friends
are relevant. At a macrosystem level, various environmental issues such as socio-economic status, unemployment and developmental health issues are relevant.

For most of the people in my study, their siblings’ drug use commenced during adolescence. Alice, Carl and Donna all make mention of this. According to Erikson’s stages of development, adolescence is a time of identity formation, through a process of exploring identity choices, which can be a particularly challenging time (Wiley & Berman, 2013). The stage of development is a relevant feature in the microsystem. Further, Mawson et al. (2015) contend that “emerging adulthood is consistently associated with high risk for onset of psychological disorders, problematic substance use and onset of substance use disorders” (p. 2). This is perhaps because of the challenges and distress associated with identity formation, coupled with the reduced influence of parents or family.

Aside from developmental issues, other personal factors at a microsystem level can affect young people and drug use such as high levels of family conflict, family history of drug use, low family income and low supervision of children, all of which place young people at risk of drug use (Frrokaj & Tsamparli, 2016). In my study, Gina made reference to the lack of parental supervision as a causal factor in her brother’s drug use. Other early childhood issues can relate to sexual abuse. Numerous studies have found a relationship between childhood sexual abuse and drug use (Widom et al., 2006). Further, Roxburgh et al. (2005) report in their study that childhood abuse is associated with poorer outcomes regarding substance dependence. In my study, Vera talked about herself and two sisters, all of whom were drug users during adolescence and adult life and all of whom were also sexually abused as children. Widom et al. (2006) found evidence to support the idea that victims of childhood abuse and neglect are less likely to mature out of substance use.

Johnson et al. (1987) argue that drug use by friends/peers is the best predictor of an adolescent’s drug use. They found, “they apparently use drugs simply because their friends do” (p. 336). They also expound that the critical factor in adolescent drug use is situational pressure. Social Identity theory could help explain this finding as it proposes we adopt values and behaviours of groups we belong to (Mawson et al., 2015). Interestingly, Andrews
et al. (2002), in their study looking at peer influences from adolescence through to young adulthood, found that peers play a significant role in substance use during adolescence and into early adulthood. However, they did not find a relationship between ‘hard’ drug use and peer drug use, suggesting that hard drug use may not be influenced by friends.

Another microsystem contributor is that people make choices about their behaviour, including to continue their drug use. Many people in my study considered their siblings’ drug use a choice. If I change my gaze to a neuroscience perspective, psychoactive substances activate the brain’s reward system, thus, reinforcing the behaviour. The activation of the reward system can be so strong that other day-to-day activities are neglected (American Psychiatric Association, 2013). The other aspect of ‘loving drugs’ is not wanting to change. The stages of change theory are well known and applied in the drug and alcohol sector. According to this model, people who are not interested in changing their drug use are considered to be in a precontemplation stage of change, that is, they are unaware or under aware of problems associated with the drug use and, therefore, see no reason to change (Prochaska et al., 1992).

Others in my study said quite categorically that their sibling was not a drug addict, not a ‘junkie’. Instead, they described their sibling’s drug use as recreational or experimental and their death as accidental. These definitions were very important and seemed to go to the identity of their sibling. In Rodner’s (2005) research a socially integrated drug user, who has a structured daily life perhaps through work, only use drugs during leisure time and do not have a criminal record. She finds that the difference between being a drug user and a drug abuser concerned things like being in control or out of control of your drug use. The other differentiating factor was the type of drug used, with heroin seen as a drug that is impossible to control (Rodner, 2005). Similarly, Walter and Ford (2018) in their study say there is a ‘stigma hierarchy’ attached to the type of drug used and the method of drug use, with heroin and intravenous drug use carrying the worse stereotypes. They also found that parents could be particularly protective of their child’s reputation (Walter & Ford, 2018). In a sense, people in my study could be protecting their sibling’s identity, memory and relationship.
Shifting beyond microsystem to macrosystems, other studies identify risk factors for young people taking up drugs as boredom due to a lack of public facilities (Spooner et al., 2001). Spooner et al. (2001) preface their report saying, “if there is one single message, we would like the reader to take away from this report, it is that drug use is as much the result of macro-environmental factors as of individual decisions” (p. vii). Integral to the macro environment are socio-economic status, unemployment and developmental health, defined as “the physical and mental health, well-being, coping and competence of the population” (Spooner et al., 2001, p. 6). In my study, Connie attributes her brother’s drug use to macrosystem issues such as the availability and accessibility of drugs in the environment.

Response to sibling – new
In this section, how the people responded to their sibling was new to me. There were four commonalities forming this topic of conversation. The first commonality discussed is the sense of hopelessness, inability to cope, withdrawal and guilt. The second commonality is focussed on connecting with, acceptance and inclusion. The last commonality focuses on worry. All of these commonalities expanded my horizon of understanding on drug use.

Sense of hopelessness, inability to cope, withdrawal and guilt
Some people in my study expressed a sense of hopelessness around intervening or helping their sibling with their drug use. There was an added burden as well – that they had introduced their sibling to drugs in the first instance. Carl says he feels:

A mix of things really ... there’s a lot of guilt ... I introduced him to pot in the first place ... I didn’t help him in the end ... I withdrew ... I felt kind of helpless too, whenever we had conversations about it, it all sounded as if it was getting through to him, but it didn’t.

He goes on, “and I went along to Al-Anon meetings and ... I can understand from that, that there wasn’t really anything I could have done, but I still regret that I didn’t do anything”. Carl says, “I actually got advice ... to withdraw ... and I did, and I regret it”. Similarly, Stan’s response to his brother’s drug use was, “I just kept on begging him to stop”. Stan says:
You know, I never introduced him to smack or the hardcore stuff but with me introducing him to pot and booze, I felt a responsibility there to at least try something.

Similarly, Isobel experiences guilt about not doing enough. She says:

In retrospect ... I think why didn’t I give up everything I was doing and take you to a dessert island for six months and see if that would’ve made a difference, or out bush or something. And I didn’t and there is a guilt about that. I could’ve done more.

For these people, their sibling’s drug use and their inability to intervene, the sense of helplessness, coupled with the hopelessness of the situation, drives a wedge into the sibling relationship. It is almost too painful to be with their sibling and not be able to help in some way, so they distanced themselves. In a totally different way, others in my study found ways to remain connected to their sibling.

Connecting with acceptance and inclusion
Many of the people in my study remained in contact and included their sibling in family events. Sally explains her approach to her brother; she says, “I didn’t like him taking drugs, but I accepted that that was his choice”. She elaborates:

The acceptance doesn’t mean approval for me, it was so powerful because it allowed me to have a relationship with my brother that was very positive and supportive but didn’t mean I condoned the things that I didn’t like.

Sally recalls being with her brother, “walking around town when he was strung out on speed” so their mum would not be concerned. She looks back now knowing:

Most other people would not find that funny, but when that’s your norm ... that’s just what it was and that was my brother ... the funniness and the craziness, not crazy literally ... just the wildness.

Tony had a similar approach to Sally. He says, “I went through a very judgemental phase ... I was keen for him to get his act together”. He goes on:
Towards the end, my wife said to me … ‘you don’t want to have any regrets when he goes’ … for the last three to four years, all I did was say, I loved him, gave him a hug … there were a lot of times when … we’d invite him around for dinner, I would give him a towel and a bar of soap when he walked in the door, and I’d say, go and have a shower … and I’d give him some new clothes … and then sit down and have dinner with him.

Other families also continued to include and have contact with their sibling. Karen recalls when her sister-in-law and brother began using heroin again and their relationship “became tumultuous and I remember going down there, and mum and dad buying food for the fridge”.

With the benefit of hindsight, others would change their approach to their sibling. Carl says he would not “withdraw … [I’d] stay connected. OK, you can be tough, not lend them 20 quid every time you see them … but I should have stayed in touch”. Similarly, Judy says, “the biggest thing is, you can’t help them when they’re dead. So, try now, and do something before that”. She goes on:

The regret is the hardest thing to live with, because you still care about the people. And I know with addictions, it’s really hard to help but keeping the communication open and doing what you can do, be in touch … it is so important.

As I reflect again on this commonality, the idea of keeping contact with your sibling and prioritising the relationship really stays with me. I had not thought about how siblings might negotiate their relationships, just as I had not considered the worry they might experience.

Worry
Many of the people in my study talked about being worried about their sibling and their drug use much of the time. Amy says:

I was always worried … all the time … just worried 24/7 and … it took years after his death, before I stopped feeling worried … he came to housesit my house … and he fell off my fucking roof with a full beer bottle and didn’t spill a drop, he was always
doing crazy shit, and it would be like, ‘Oh my God’ ... by that stage the rest of us had stopped laughing.

Similarly, Helen recalls her worry when her parents told her that her brother was using heroin; she says:

I remember it was a complete shock because I didn’t know anything about heroin, except that it was awful and dangerous and a serious drug. And I ... was kind of aware of another culture ... people going to dance parties ... but heroin was ... something that was always off the table ... it was a dirty drug and dangerous, very addictive ... I was really shocked and panicked.

Krystal talks about being worried about her brother, particularly after the family found out he was suicidal and depressed. The first time Krystal became aware of the situation for her brother was the night she went looking for him because he had told his flatmate he was going to end his life and the flatmate had told her parents. She says she could not get her brother to go with her, so when she returned home:

[I was] just worrying and stressing ... just really hoping, and worrying, and thinking what if he doesn’t come home, what’s going to happen? And what if he does die? And oh, my goodness, my brother is doing heroin ... that was the first time I found out.

The Christmas after this evening, Krystal describes her family as being “all on eggshells ... [there was] relief, but there was a lot of tension because the three of us were worried about saying the wrong thing”.

Connie has a very different experience. She says she was not really worried about her brother’s drug use mainly because he had reassured her:

I wasn’t worried, because I didn’t think it was anything too serious ... I think it was just sort of an experiment ... he showed me the spoon and the stuff ... I was like, my God ... he said, ‘Look, I know exactly what I’m doing. I’m not going to get addicted to
it or anything or do anything dumb’ and I suppose I believed him. I just thought ...
he’s pretty together, he knows what he’s doing.

Despite years of working in drug and alcohol, I have not considered how a sibling’s drug use could cause worry, or no worry, as is the case with Connie. In the following section, I will discuss all the commonalities articulated above.

**Discussion on response to sibling**

A gamut of responses are generated when someone in the family is engaged in drug use. Initial responses can include shock, anger, dismay and guilt, with many families attempting to contain the problem within the family (Frye et al., 2008). In one study, when people were asked about their emotional responses to a family member’s drug use, they described “feeling worried and anxious, helpless and despairing, low and depressed, guilty and devalued, angry and resentful, sometimes frightened and very often feeling alone” (Orford et al., 2010, p. 49). The study by Oreo and Ozgul (2007) echoes that by Frye et al. (2008) and Orford et al., (2010), adding panic, stress, dismay, shame, confusion, self-doubt, uncertainty, and helplessness. In their study, da Silva et al. (2007) concur, also identifying feelings of helplessness and fear and quoting one participant as saying, “we failed in our attempts to help him” (p. 304). Trimmingham (2009) further adds to the list by describing a feeling of disappointment and hurt.

Some researchers contend that drug use places strain on all relationships within the family. The person’s drug use can ‘take over’, leading some to refocus on their own interests and put distance in the relationship (Frye et al., 2008). In my study, Carl, Stan and Judy talk about withdrawing from the relationship with their sibling. Frrokaj and Tsamparli (2016) found in their study, which considered the quality of the sibling relationship and substance use, that many people worried about what would happen to their sibling in terms of their drug use, health and life. “In the minds of many people addiction to illegal drugs is a one way road leading inevitably to destitution and ultimately to the death of those who become addicts” (Mclntosh & McKeagney, 2000, p. 1501). Orford et al. (2010) contend that worry is central to the experience of having a family member who engages in drug use. Worry about
their sibling’s drug use was emphasised by many people in my study, exemplified by Amy and Helen.

In my study, some found ways where they were able to connect, include and accept their sibling – where, in a sense, the sibling’s drug use did not get in the way of the sibling relationship. One key statement from Sally was “acceptance doesn’t mean approval for me”. Sally’s approach is consistent with the principles for supporting someone who uses drugs outlined by Trimmingham (2009). These principles emphasise communication, acceptance, support, be informed and get help, understand what you can influence and do what is right for you, that is, follow your heart (Trimmingham, 2009). Acceptance as described by Sally and Trimmingham (2009) is not to be confused with ‘tolerance’ that Orford (1994) describes as a method of coping. For Orford (1994), tolerance is where actions of family members support or aid drug use or protect the person from consequences of their drug use. However, the accompanying attitude – believing in the person and not thinking less of the person because of their drug use – is similar to acceptance that Sally and Trimmingham describe (Orford, 1994). This notion of tolerance is similar to Karen’s experience of “mum and dad buying food for the fridge”.

**Interventions in drug use – familiar**

**No service involvement**

Some of the people in my study did not entertain the idea of seeking assistance from services; for example, Stan says, “nobody in the family had the money for rehab or we didn’t even discuss rehab ... it was just like, shit my brother’s a junkie”. He says as a family, “we buried our heads in the sand”. He says in hindsight he would “go to a professional” and “drag my brother there ... I may have felt a hell of a lot better”.

Others talked about their sibling stopping drug use in the community, for example, Karen was aware that her brother would detox himself. She says, “he used to go off to a friend ... and stay up there ... keep him away from things”. Sally says:

> He would come out to mum’s for the purposes of ... getting cleaned up and dry out a bit and have a feed.
Going ‘cold turkey’ is something that most people who have become dependent on drugs will go through at some point, sometimes planned and sometimes not.

Involvement of services other than drug and alcohol services

Many other services, aside from drug and alcohol services, can be accessed when someone is affected by drugs. It is not unusual for the GP to be the first point of call, and mental health and/or the justice system can typically be involved. The interaction with services other than drug and alcohol can be experienced as positive or negative. Krystal says her parents took her brother:

To see their GP, who then sent him onto a psychologist, and it turned out that he’d been depressed for years and was self-medicating with alcohol, heroin and marijuana. It was all about self-medicating. So, she put him on Zoloft.

Isobel says her brother was diagnosed with “manic depressive illness ... he’s got the tablet from the psychiatrist - who knows everything, and life will be wonderful”. She goes on:

I went to with him to the psychiatrist too ... my brother asked me to ... and the psychiatrist actually said how well he was doing, the medication’s good and everything is fine and there are no other issues ... I remember sitting with the psychiatrist ... for an hour or more, each appointment ... and I thought this guy’s an idiot. He’s got no rapport, he doesn’t know, he doesn’t ask the right questions [laughs] and maybe I should have said to my brother, ‘Come on, let’s find another psychiatrist’ but he seemed comfortable with him.

Some people in my study relay negative experiences of services. Janet says after her brother’s overdose the police “hassled him about it ... and then he took off ... so he could avoid the police ... on his own and that’s when he died”. Whereas others have positive experiences, for example, Donna recalls there was one magistrate in particular, “he was really good. He was very supportive”. People in my study also discussed drug-specific interventions.
**Interventions focused on drug use**

Based on my experience, many people are referred to drug and alcohol services by their family members. Many in my study referred to specific drug and alcohol service involvement such as counselling, detoxification, rehabilitation, methadone treatment, and AA or NA meetings (these meetings are not a service per se, rather self-help groups but they are drug and alcohol specific hence, including them here).

Helen says her brother describes a time when he was accessing services. She says he:

Lived for a while with mum and dad ... and tried to ... get himself back on track. He did a methadone program; he did a 12-step program ... the family were very supportive.

Some people in my study talked about their families being supportive of their sibling accessing services and when this occurred, it was encouraged. Amy has a different experience:

My parents ... [got] professional help and it ended up not being good, it didn’t work ... they got a lot of ... what are you two doing wrong? Obviously you are fucked up parents for your child to be using drugs ... [her parents] already blamed themselves ... so this was not helpful.

Accessing services can also occur on more than one occasion.

**Repeated interventions**

Carl says his brother went to “detox” and “rehabs”. Carl says his brother “spent quite a lot of time there ... and then he’d come out and get back into it again”. In a similar vein, Alice says, “he tried over the years, he tried several different things [but would] just go back to using again ... you see so many unsuccessful interventions”. Alice was also aware that her brother had overdosed on previous occasions and says, “even the thought of dying from a heroin overdose didn’t, didn’t change things for him”. Donna says her parents:

Took him to ... counsellors and psychologists and psychiatrists and ... rehab places ... basically nothing ever really worked ... they [parents] tried really hard to help him and so they never really gave up.
Gina says her brother gave up many times. She says, “he’d try methadone programs ... but he didn’t really like methadone because it made him feel quite sick”. She says whenever he was stopping the heroin use:

He’d let us know ... he wanted it to be seen that he was making an effort, especially because of his son. He wanted people to know that he was trying to be a good dad ... and just trying to get healthier.

I am very aware that people can cycle in and out of drug and alcohol treatments. It can be disappointing for the person, family and service providers to witness repeated relapses and not feel a sense of defeat. Retaining hope and trying to keep people engaged in services is a goal because we know that people who remain connected with services do better in the longer term.

**Interventions in drug use – new**

In this next section I present two commonalities that were new to me, thereby, again expanding my horizon. One was helping attempts by siblings and the other was strategies focused on sibling inclusion.

**Helping attempts**

There is often talk between family members about getting help. For some, this is predominantly a sibling interaction, whereas, for others, parents are also involved. Stan says:

I just kept on begging him to stop ... I knew of his dealers, so I would have words with them ... his girlfriend ... his mates, just trying to get them to make him stop ... but they were all bloody junkies as well, so it was just a lose/lose situation.

Janet says after her brother had overdosed, her parent’s response to her brother changed dramatically; she says:

Mum and dad ... they were very understanding, and they got close ... they started talking ... like they had made a breakthrough ... whereas...I was bit exhausted by the whole drug use thing.
When Alice realised her brother was using heroin, she says she thought, “the thing that might make a difference to him is for the family to educate themselves and learn about responding to situations like that so that he doesn’t get forced away further”. To this end Alice:

Organised an appointment for the family ... it was about saying to them [the parents] this is what my brother is doing, these are the ramifications if he continues to use, and we as a family need to respond to him in a way that doesn’t push him further into that place. That was my hope.

According to Alice, this intervention did not go well. She recalls trying to intervene again later by talking to her parents, “they were enabling my brother’s drug habit ... giving him loans for spurious reasons” but she thought her efforts were pointless.

These people in my study were keen, even desperate, to understand, support and help their sibling but a sense of futility came through from some regarding their inability to make a difference in their sibling’s drug use. Others in my study were more focused on other strategies that were not drug-related.

**Strategies focused on sibling inclusion**

For some, the entire family continued to include the sibling in all family activities. At times this seems to be championed by the parents and, at other times, inclusion is more focused on the sibling relationship. Gina says her family’s approach to her brother was supportive and provides the example of “we’d go and turn up at gigs when his band was playing at some venue”.

At times, it is the parents who make more of an effort than other family members. Donna says:

Dad used to make a big effort to see my brother every weekend and know where he was. Sometimes that would be at the police lockup, sometimes that would be at the psych ward.
Similarly, Carl describes his father’s approach to his brother:

My brother would touch him [father] up all the time for a bit of money ... and steal whatever he could from him ... typical addict behaviour. And dad hung in there and kept giving him the time of day.

In terms of the sibling relationship, Helen says she had regular contact with her brother; he says, “I would meet him quite a few times after work for a drink”. When it comes to the best response for family members, Janet reflects on messages from others about enabling and the person hitting rock bottom before change can occur. She says in the relationship with her brother, “we had always lent each other money and he would pay me back” but she was given advice “not to enable him and giving money was enabling”. She stopped lending him money which she says broke the trust in their relationship. She goes on, “I would have preferred to have just stayed well connected”. Based on her experience, Janet’s counsel to families is, “do what you feel is right”.

Drug use carries certain risks including death. I have worked with many family members. I encourage them to do what is consistent with their own values and what they can live with, because their loved one could die while using drugs. My approach is similar to Janet’s.

**Discussion on interventions in drug use**

There are many ways to respond to a person’s drug use as can be seen by the conversations I had with people in my study. There are a range of services that a person engaged in drug use may come into contact with, including but not limited to, medical, mental health and legal services, as well as drug-specific services. Some siblings managed their drug use by going through withdrawal and/or ceasing drug use without accessing services, as described by Karen and Sally. Other siblings and their families did not discuss the drug use or intervention options available, like Stan and Isobel’s family, whereas other families actively sought ways to help the sibling, as Krystal, Amy and Helen said. Orford (1994) suggests that families can be very helpful in bringing family members with a drug problem into treatment. When specific drug treatment is sought, sometimes this is for the sibling alone or for the parents alone, but rarely in the Australian context are interventions for the family as a whole, that is, including the person who uses the drugs. Orford (1994) contends that not
including the family is a neglected topic in the drug and alcohol field which has possibly occurred because of the assumed role of the family in “the genesis and maintenance of alcohol and drug problems” (p. 424). Liddle (2004) similarly conjectures drug treatment services focus attention on the person using the drugs, often blaming families or simply keeping them at bay. Gadamer (1975/2004) would refer to these assumptions as prejudices in the field of drug and alcohol. Some families do not give the drug use per se much attention at all; rather, they continue to focus on the sibling (not the drug use) which seems to pave the way for the sibling to remain a part of the family and continuing to be included in family activities, as Gina in my study discussed.

The drug and alcohol treatment industry is big business in Australia. Yet as McIntosh and McKeeganey (2000) say, not much is known about “what works, for whom and under what circumstances” (p. 1501). They go on to acknowledge that there are those people who “recover only on the basis of lengthy and extensive contact with drug treatment agencies” (McIntosh & McKeeganey, 2000, p. 1501). By the time people are entering drug and alcohol specific services, their drug use is causing them recognised problems (possibly in their relationships, at work, legally or financially). Often by this stage too, the person has developed a drug dependence or substance use disorder as defined by the DSM 5 (American Psychiatric Association, 2013).

There are those who argue against the neuroscience approach of drug. Pickard (2012) objects to the notion of the drug dependence being a chronic relapsing neurobiological disease, with compulsive drug seeking and using features, claiming this view leaves the drug user powerless to make changes. Pickard (2012) draws on population data showing that drug use peaks in adolescence and early adult life, but often resolves itself without intervention as people ‘mature out’ of drug use by their late twenties to early thirties, as they assume more adult responsibilities.

There is also a sizable literature on the idea of spontaneous recovery, that is, where drug dependence is overcome without treatment (McIntosh & McKeeganey, 2000). Cunningham (1999) suggests that “untreated recoveries may be the predominant pathway to recovery”
Waldorf (1983) in a study of people recovering from heroin addiction says there are five ways that people stop using heroin: a) join a religious group; b) change their situation/environment and, therefore, their behaviour; c) retire from drug use; d) develop an alcohol problem or become mentally unwell; e) drift into the mainstream.

In most theories some sort of existential crisis or triggering event motivates the person to change or stop using drugs (Waldorf, 1983). The change theory that is frequently postulated in the Australian context is Prochaska et al. (1992) five stages of change model. The first stage is precontemplation, followed by contemplation, the preparation stage and the action stage, with the final stage being maintenance. Prochaska et al. (1992) contend that when relapsing, the person often returns to the stage of contemplation again, hence cycling through the stages of change. Amy, Donna and Gina all talked about their siblings’ relapses.

In my study, the people I spoke to commented on their sibling’s relapses, with frustration, anger, guilt, disappointment and sadness. Drug use causes disruption, stress and worry for families and much of the impact remains hidden. Families live with a perpetual sense of uncertainty (Orford et al., 2010). Gethin et al. (2016) proffer that the burden borne by families when a family member uses drugs includes both tangible (family breakdown) and intangible (health problems) costs within the family. Schafer (2011) contends that some families also experience disruption and violence as well. Templeman et al. (2007) treat the burden on this family as an unmet need saying, “service provision for family members does not match service need” as services tend to focus more on the individual with the drug problem rather than the family. Family involvement and support was evident in conversation with many people in my study.

Services that are provided for families such as the Stepping Stones program run by Family Drug Support in Australia have been positively evaluated finding that, “family focused interventions effectively improve coping and well-being” of family members (Gethin et al., 2016, p. 47). Schafer (2011) promulgates that research blames the family for the person’s drug use with statements like “dysfunctional family systems can promote, and maintain, alcoholism”. In her study, she also says unresolved family conflicts and “break-down of open
communication and mutual caring, which then became a further trigger for substance abuse” (Schafer, 2011, pp. 143–144). Templeton et al. (2007) trialled a family intervention and found it was difficult for family members to shift their attention from the person using drugs to themselves, to understand that they too need care and attention. However, ultimately many found benefits in the family intervention, such as an increased understanding of their own needs, increased confidence, improved coping and ability to remove themselves from situations. Paradoxically, by family members focusing on themselves, improvements occurred in the family environment, including relations with the family member using drugs. Conversely, the person using the drugs also developed increased awareness of the impact of their behaviour on the family (Templeton et al., 2007).

The people in my study who continued to have relationships with their sibling were more focused on what they needed to do for themselves to maintain the sibling relationship, such as the experiences Sally and Tony articulate.

**Death and drug use – new**

**Stigma around drug use as a cause of death**

Some are very aware of the stigma associated with drug and alcohol use, whereas, others were not at all concerned. Carl says he hasn’t noticed a stigma and when talks about how his brother died, he says, “I usually say, he drank himself to death, because that’s really what he did”. Whereas, others see that their sibling’s drug use could reflect on them personally, for example, Isobel says at the time her brother died, there was, “no way would I have gone back to work and said my brother just died of heroin overdose or heroin poisoning ... I think perhaps I thought it would have reflected badly on me”. In a similar vein, Judy says about her brother, “it got to the stage where I felt almost embarrassed to have him around, because he didn’t look right. Mrs Conventional here. And I wish I had more of an understanding, as I do now. Now I couldn’t care less how he looked. That’s only a superficial thing”.

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Others perceive that their parents and/or family are judged harshly when someone in the family dies as a result of drug use. Amy defends her parents, saying people think it’s “because of their upbringing and it’s because they weren’t loved enough or blah, blah, blah and it’s like, no, some people just choose drugs”. Connie chooses not to say anything about her brother’s death because, “people don’t understand how drugs can take hold of anybody ... people ... probably go, I wonder what happened in their family to cause that? ... I didn’t want people making a judgement of my family”.

Krystal talks about the funeral; she says that the family “didn’t tell anyone”, initially, about her brother’s drug use because, “if he got through this and got past it, you don’t want people judging him on his past”. Similarly, Helen conjectures that perhaps her parents hadn’t told anyone about her brother’s drug use at the time he died because “they are private ... they would have been a bit embarrassed ... they just wanted to get him through it”. She goes on to say that even though the parents “hadn’t told anyone ... they put in the prayer book a paragraph ... about his methadone treatment and how he’d really tried hard and ... gave it his best shot and lost his battle”.

Sally also reflects on conversations about her brother’s death; she says:

When you say that you lost them to drugs ... there’s a whole set of judgement. You see this look flick across people’s face ... which is like, oh what kind of family is that ... it’s really interesting because that in itself is a ... grieving sort of thing, that you’re going through not just the loss, but also the judgement, the stigma ... as if it’s some sort of reflection on your family or your parents ... and my brother’s drug use had nothing to do with my parents ... but ... there is judging, even when that person is dead.

Similarly, Gina says she doesn’t tell others her brother died of a heroin overdose “because I know that they will judge...people do not know how sort of sad [you are]”. She says that someone said to her, “you know, you’ve got to realise your brother was just a junkie, so you’ll get that”. In response Gina says, “well, you didn’t know him. You don’t know what he was like. He wasn’t just a junkie to us”. This last sentence speaks volumes.
When Helen responds to questions about how her brother died, she says, “I have said things like, oh it was an accident and I just leave it there ... it’s not a secret”. When she explores this further, she says, “I think it’s protecting his memory, protecting myself”. She says, “people are really ignorant about addiction. When that actor, Philip Seymour Hoffman died, that was very similar to how my brother died ... struggling with addiction, but people still were so critical and so mean. And that’s only ignorance”.

Janet also talks about the stigma and possible reasons that she may have kept her brother’s drug use a secret she says, “I guess when somebody is alive ... if they had a drug issue ... it would affect their job prospects and all sorts of things, housing” because she says there is, “stigma around illegal drug use ... and because it was an illegal activity you had to keep it quiet ... you just don’t talk about it”. She goes on tearfully to reflect that maintaining the secret meant that others “didn’t know and I felt really bad about that ... yeah I did ... [because] after he died, I just thought, oh God, if they had have known maybe they could have helped”.

Sally reflects on drug use:

I think that there’s a silence thing that goes on when the person is alive ... you can’t talk about it ... you can’t talk to your social network. And then when that person dies ... you not only can’t talk about how traumatic that was, but ... you still can’t talk about the drug use. And then you can’t celebrate that person’s life either because people will look onto that and say, well what are you celebrating? Which is very sad.

Jacqui clearly articulated her thoughts on stigma and drug use; she says:

It shouldn’t be stigmatised, it’s a health issue, it shouldn’t be a law enforcement issue, it shouldn’t be seen as some weakness or deficiency on the part of the person who is the drug user, I just think we deal with it in a really poor way and the whole history of drugs and who controls the drug trade really annoys me and the user is just the end of a whole lot of political machinations. We stigmatise the user and the families and that’s just wrong.
Like Jacqui, Kathryn is also very clear about her views on stigma around drug use; she says:

The stigma has shut it [drug use] off from being part of their public narrative. So, I’m really aware of the stigma ... the more we silence it, the more we sort of stigmatise it ourselves.

**Discussion on death and drug use**

As Walter and Ford (2018) say, “there are clear theoretical reasons why we would expect substance-related deaths, and those who grieve them, to be stigmatised” (p. 67). People are seen as wanting to use drugs instead of participating in society (Guy, 2004). Walter and Ford (2018) contend that the character of the person using the drugs comes into question; the person can be stereotyped as not conforming to social mores, dangerous and/or mentally ill. The stereotype is fuelled further by the perception that drug use and drug-related death is self-inflicted. Cruts (2000) claims social construction plays a large role in society shaping how we think about drugs, arguing that the term ‘drug-related death’ is a social construction (a lens through which to see our world) which blames a drug for killing someone, presupposing that the person would still be alive if that drug was not present in the person’s system. Stigma and stereotyping are similar, both are social constructions, both are about being labelled or categorised and both function to keep people down and can lead to shame being internalised (Walter & Ford, 2018).

Drug use and drug-related death are stigmatised in our society. Family members may perceive stigma as a reflection on themselves or their family and, therefore, can be less likely to talk about their family member (Walter & Ford, 2018). Guy (2004) adds weight to the argument, noting that the family is seen as failing to prevent or stop the drug use. These were certainly the views expressed by Isobel and Sally in my study. When others do know about the drug use, Sayer-Jones (2006) describes not tolerating the judgements and the lack of understanding by others and, therefore, withdrawing and not talking about the drug use to these people. Frye et al. (2008) reinforce this notion, saying family members often conceal the problem from friends. For Krystal, the sibling’s drug use was kept private within the family. Krystal clearly explains that if her sibling had got through the drug use, the family did not want him to be judged by his past.
Walter and Ford (2018) draw attention to people in her study wanting to protect the reputation of the person who died and that of their family. In these circumstances, people may not disclose or be ‘economical with the truth’ about the cause of death, which is similar to Helen in my study who will sometimes say her brother died from an accident. The lack of disclosure served to avoid hurtful judgments by others and protects the memory of the person.

In my study, Kathryn and Jacqui are very clear about their views on stigma and are more inclined to speak out and challenge the stigma attached to drug use. Walter and Ford (2018) discussed this idea as ‘disclosure’ where people speak out for several reasons including to oppose stereotypes, evoke empathy and/or humanise the person who died. Tony Trimmingham (2009) writes, “I got up at three in the morning and wrote a letter to the *Sydney Morning Herald* – my impassioned pleas, as a father, that my son be remembered as more than just another statistic” (p. 19). Gina’s words echo the sentiment when she says, “he wasn’t just a junkie to us”.

**Summary of drug use horizon**

I have been pleasantly surprised by how enlightening this process of interpretation, based on Gadamer’s hermeneutic philosophy and the conditions of understanding, has been. Despite more than 35 years in this field of practice, I have delighted in my own horizon expanding. Simultaneously, I have been humbled as I recognise there is still so much more to understand in the drug and alcohol field, especially where families are concerned. In this summary, I focus on the items that expanded my horizon and, therefore, my understanding of the experience of sibling drug use.

Drug use is insidious; dependence develops over time and affects not just the person using the drugs, but also their family. In this study, my focus is not on the person using the drugs per se, rather it is on their sibling’s perspective regarding how they understood their sibling’s drug use and what it meant to them.
There is a longevity in the sibling relationship; hence, it is often the longest attachment relationship formed. These ideas of longevity and attachment suggest that siblings know each other often quite well. They know things about each other that perhaps others in the family do not, through shared confidences. That said, there were some in my study who knew nothing of their sibling’s drug use. In direct contrast, others in my study had used drugs with their sibling and had a good time doing so. These shared experiences usually originated during adolescence or early adult life where drug use was considered ‘naughty’ and/or ‘normal’ because drug use was so common. Some had introduced their sibling to drugs, whereas others had been introduced to drugs by their sibling. Some thought their sibling was sensible around drug use and, therefore, were unperturbed by their sibling’s ongoing use. Lorraine described drug use among siblings as ‘a bit contagious’.

There were times when many in my study did not necessarily know about their sibling’s drug use but noticed things which were suggestive of drug use, such as their sibling seemed to change and their behaviour was no longer consistent with social mores. Many people in my study commented that their siblings would disappear for days at a time and/or became unreliable, for example, making a lunch date and not showing up. Others talked about finding evidence of drug use (for example a tarnished teaspoon and other drug-using paraphernalia) but, because the drug use had not been disclosed or confirmed, they doubted what the evidence suggested.

After their sibling’s death, the drug use, and the extent of the use often became known or was confirmed. Many in my study talked about the idea that their sibling had a double identity and these identities were kept separate. There was an identity reserved for the family and another drug-using identity. Coupled with this idea of a double identity is the notion that their sibling lived in two worlds, keeping their drug-use world intentionally separate from the family world perhaps due to embarrassment, not wanting to be judged or thought less of, perhaps even to protect family relationships and the family as a whole. In the family environment, often there was no evidence of drug use, or no out-of-control drug use, and the sibling would behave in an acceptable way, in no way compromising the lives of family members.
In contrast, the drug-using identity was characterised by chaos, lying, stealing, sneakiness and secretiveness. The drug-using world was seen as foreign, dark, unpredictable, creepy and scary, involving other drug-using peers and partners, a world of different people, different rules and different priorities. When the two worlds collided, as happened for most in my study, these clashes could be full of the sibling’s anger at being caught using drugs or the sibling’s blatant disregard for the brother or sister because the drug use took precedence. For the people I spoke with, these clashes yielded reactions of shock, panic, confusion, realisation, exhaustion, disappointment, annoyance and a constant sense of worry.

When the drug use is known, there is often talk between siblings (and sometimes other family members) focused on a) trying to understand the drug use and b) where to get help to intervene in the drug use. These strategies shine a spotlight on the drug use. Many in my study expressed a sense of hopelessness – “I didn’t know what to do” – towards their sibling’s drug use, creating a situation where it is almost too painful to be with the sibling and ongoing interactions were difficult. In turn, some then withdrew or ‘switched off’ and went on to experience guilt and regret for not helping, especially when their sibling died. The guilt was amplified when the person had introduced their sibling to drug and alcohol use. Others expressed guilt and regret for not doing more for their sibling.

Other strategies were more focused on continuing to the sibling and/or family relationships. For example, supporting the sibling’s other pursuits (such as playing in a band) or including the sibling in family gatherings/events. These approaches were about remaining connected with the sibling and emphasised the sibling relationship, making the relationship in a sense more important than the drug use. People in my study found ways to be with their sibling because, as Sally says, “she could access the essence of her brother independently of the drug use”. These people did not condone the drug use; they just did not pay much attention to it and, therefore, found ways to have their sibling in their life.
The sibling’s child(ren) were also a focus of intervention. Some in my study were involved in taking the niece to the doctor and others took custody of their niece for safety reasons. Others talked about their nieces and nephews being removed from the care of their sibling because the drug use interfered with the sibling’s capacity to parent.

The stigma of drug use in society also featured for many of the people in the study. Some expressed concern that their sibling’s drug-related death would reflect poorly on them as a person and/or their family. Some decided not to tell other people how their sibling died, instead emphasising the accidental or suicidal nature of the death rather than the drug-related component. These decisions seem warranted given others talked about the harsh judgements they witnessed. The stigma and judgements experienced about drug use generated protective responses for themselves and their family and the memory of their sibling. Being on the receiving end of harsh judgments about someone you love, in the midst of grieving their death, is indeed grim; it means there is no capacity to talk about the experience of their sibling’s drug use, their sibling’s death and associated grief and no ability to celebrate their sibling’s life. The stigma is primarily associated with illicit drugs; if these drugs were legalised, some thought their sibling would still be alive and there would be no cloak of secrecy embroiling the sibling and their family. Legalising drugs and drug use would mean there was no stigma and, with that, access to support for the sibling or family members and the ability talk openly.
Chapter 8: Family horizon – findings, analysis and initial discussion

Introduction

This chapter is focused solely on the family. After interviewing people for my study, transcripts of the conversations were produced. I then went through a process of interpreting each transcript from a family horizon and identified topics of discussion that went across the conversations. These topics include the family structure, family response to drug use and family response after death. The analysis process involved reading and re-reading parts of the transcript fitting with the topic of conversation, and identifying commonalities within the topics, that made sense as a ‘part’ of the broader ‘whole’ conversation. There were between one to nine commonalities noted for each topic. Through this process, I developed a deep understanding all the conversations. As this is a hermeneutic phenomenological study, interpretation plays a significant and overt role in the analysis. As the researcher, I then worked through a process of questioning if these commonalities were familiar or new (foreign) to me. Familiarity occurs when something is almost expected to be heard on the subject and, when we project from what is known, we find common ground with the other person so that further newer and different understandings become possible. These familiar commonalities are representative of the historicity, traditions, situatedness and prejudgments informing our shared family horizon. When a commonality was new, it contained information that extended the horizon of understanding on the subject matter. A new understanding comes about through fusion of horizons. What then happens is that the new is only new once – it then becomes integral to the horizon, creating opportunities for further interpretations to be made. Another aspect of the analysis was to then identify if the new understanding had any overlap with the other two horizons; for example, bereavement and the drug and alcohol horizon, as interpreted from the family horizon (see Appendix 8).

In the following section, each familiar and new commonality is attached to the conversation by drawing on specific quotes from the participants, providing some contextual information and at times my personal reflections. I then present a discussion on each topic of conversation and draw the chapter to a conclusion by presenting an overarching summary of new insights that have deepened the horizon of understanding on the family.
Family structure – familiar

In this section, the focus is on family structure. I present two commonalities that were familiar – parental alliance and the eldest child being parentified. How parents parent can impact on children and certainly, some people in my study drew attention to the effects of the parents on their siblings within the context of the family culture.

Parental alliance

I have absorbed an idea about what is exalted as good parenting. In essence, it involves two parents being ‘on the same page’, ‘singing from the same hymn sheet’, uniting as a parenting team in their efforts to be consistent and predictable in their responses to the children. When I work with parents, I often hear the opposite from them, noting that differences in parenting approaches can become pronounced when relationships are under pressure, for example, from drug use, or mental health issues. For some of the people in my study, their parents were separated and parented quite differently.

Donna says her parents had different approaches to her brother. She says:

Dad’s … more likely to say, I think he’s making good progress … things are going well, and mum will say things are going badly.

Sally describes the differences in her parents’ approach. Her mother had a hands-on approach, whereas her father had a hands-off approach. She says her brothers were “truanting school and getting involved in things they shouldn’t have”. They lived at her father’s:

Farm but my dad would go and live in this other town … there wasn’t a lot of supervision … the boys would ring mum up and then she’d go up there and look after them … another mum top-up … that was just how it was.

Sometimes her brothers would hitchhike to “our town, so they would … turn up … and stay with us for a few weeks. My mum would look after them … feed them up … and … they would go back … because they weren’t allowed to do the things [with mum] … they wanted to do”. Sally goes on “my mum … always bailed the boys out”. She describes her mother as being “knee-deep in the trench in sorting out their issues on a yearly basis”.

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When there is no parenting team, it is difficult to maintain a consistent family structure. The lack of consistency can be a source of conflict, confusion and stress for children; children can also ‘play’ parents off, one against the other, to get their needs met. There are other ways family structure can impact on children in the family.

**Eldest child is ‘parentified’**

When parents are not parenting, often a child (usually the eldest) will step into a parental role and, and in doing so, can become ‘parentified’, that is, the child is imbued with responsibilities that are beyond their age or position in the family. Difficulties arise when a child is parentified and the direction the child wants to take is different from the parents and/or if the parents start to parent again. Alice describes this situation well. She says she wanted the family to know “how to deal with my brother” and, to this end, organised an appointment with a specialist for the whole family to attend. She says the appointment was “an absolute disaster”. Alice vividly recalls:

> I have this picture of dad in his double-breasted suit right up the front, the guy at a desk, and mum cowering up the back … the whole conversation took place between my dad … [and the] psychologist.

She remembers that the main message from her father was our “family is not like that … that’s not happening”. She says, “I had some hopes … but having the whole thing shut down in denial was just not what I imagined would happen”.

In this situation, Alice is in a parenting role until her father takes over that role. It is confusing and disappointing to have responsibility given and then to have it taken away. As Alice says, “I was so pissed off … I probably shut it down inside”.

Alice also says when her sister was born “a sort of murky mothering … happens because, my mum ends up drinking, I feel like the relationship I have with my sister is not clear”. Similar to Alice is Jacqui’s experience as the eldest in her family. Jacqui describes her relationship with her sister as close although clarifies “in a maternal sense”. She says:
My sister was the baby and mum and dad were working and I brought her up … I used to have to go and get her from childcare … I think I was about 8 at that time.

Jacqui says when she was in her thirties, she moved overseas and she would still “get numerous phone calls a week” from her mother who wanted assistance with her sister. Similarly, Vera describes her eldest sister’s role in the family; she says, “my sister brought us up. Mum ... had two jobs ... we were left alone”. Vera says her sister:

Used to look after me when I was crook. I was a very sick kid ... I was a very nervous kid. I couldn’t handle the domestic violence ... my sister put up with a lot for our sakes. She took a lot of the incest, so we wouldn’t suffer.

Parentification can have long-term effects on relationships, especially between the eldest and the youngest siblings, and when a child has parental responsibilities and meets parental demands but has limited power to affect change.

Family structure – new
In this section I present commonalities within this topic that were new and expanded the horizon. These common aspects are the experiences of being the eldest sibling, being the younger sibling, closeness and distance in relationships, family boundaries and talking inside and outside the family.

Being the eldest sibling
Being the eldest child in the family is a different role to being a sibling with younger siblings in a family. Each role is different and results in different childhood experiences. Judy as the eldest child in her family says:

I had a very sort of influential [role] ... [I] paved the way ... I went to see him [in rehab], my parents found it all a bit intimidating, where I didn’t ... I wanted to encourage him ... this is the path forward ... stick at it.

In a similar vein, Donna, who is also the eldest in her family, describes her “natural instinct is to try and rescue”. She reflects that she was “feeling really bad” because:
Part of me was sort of feeling like I needed to do something as the big sister, to fix things and feeling that that really wasn’t going to work, but also feeling guilty about that.

Alice recalls being the eldest in her family and having a very specific role which was conveyed by her parents. She remembers being told, “you are the oldest, you are responsible, you have to give the good example”. She says, “I grew up feeling like I needed to look after my younger brother”. She says, “I definitely had a role of looking after everybody”. She elaborates:

I have had a role in my family where, I am reliable, and I look out for people ... I was responding to mum with her drinking, and my brother with his drug use and all the other crazy stuff.

Many of the people in my study who were the responsible eldest sibling also talk about feeling guilty. Jacqui as the eldest says:

I’d left to go to uni ... I blame myself for a lot of this because I wasn’t there to look after my little sister ... [when] she went off the rails.

Similarly, Judy talks about feeling responsible for her brother; she says, “I did definitely [feel responsible]. Being the eldest ... it was terrible ... I really didn’t know what to do”. She says, “The guilt that I carry around is huge”. Judy says if she had her time over, she would communicate more, “I wish I’d been more in touch with him. We loved each other”. She goes on, “I had to let myself be forgiven that I didn’t spend enough time with him”.

Similarly, Stan says:

You’ve got your own stuff going on, yeah, he’s into drugs, he’s doing crazy stuff, I went through that too, he’ll be right, he’ll get over it, until they die that’s when you think you should have done this, you should have done that.

Stan, as the eldest, lives with regret; he says:
There’s always that feeling I could have done more, I could have done a lot, a lot more, but I just didn’t.

Stan’s message to others is to “do as much as you can”.

In this section I have reflected on how position in the family shapes relationships and roles in the family. The eldest child often paves the way and feels responsible for encouraging, protecting, teaching and helping younger siblings and can feel regret or guilt when unable to do so.

**Being the younger sibling**

I am the eldest in my family; occupying this role did not prepare me to understand how younger siblings thought of their older brothers or sisters. Many younger siblings in my study held their older sibling(s) in high esteem, regardless of their sibling’s drug use. Kathryn reflects on her relationship with her older brother; she says, “at the time, my brother was my best friend. I used to like hang out with him every night”.

Sally says, regardless of the issues her brother had:

> He still was very much my big brother and I really did look up to him and he taught me a lot about the world ... respect and empathy for other people...I think I might have mentioned he was a bit of a, you know, a wild man from Borneo ... especially before he had a bit of a clean up.

Lorraine’s family describes her sister as, “a wild child ... [because] she didn’t really follow rules”. Lorraine says, “I thought my sister was cool. She got drunk at school and told them to get fucked. She told the boss at Hungry Jacks to get fucked”. Similarly, Gina says, “I thought my brother was really cool ... he was an artist ... he had a great job ... he had a band ... he was a pretty cool dude”.

In quite a different way, although still similar to Sally’s notion of looking up to her brother, Helen describes her brother as “a bit of a hero”. Helen says when she returned from overseas, she decided to live in the same city as her brother because:
I wanted to ... be closer to my brother ... like I said, he was a bit of a hero ... I did have him up on a pedestal ... I was in awe of him ... I thought he was the coolest thing ever.

Karen also describes her brother as a hero; she says:

I have to say that my brother was my hero ... I held him on a pedestal for many years, I have this memory sitting at the dinner table and I was about three saying, ‘I’m going to marry you’ because I just adored him ... he was a good brother to me ... [We] enjoyed a close relationship up until the time of his death, we spoke every couple of days.

Krissie says her brother was on a “a massive pedestal. He was right up there. He was my hero”. Krissie recalls that when she was around her big brother:

I always felt I could do anything if he was around ... I always had a lot more confidence ... if he was there ... I felt very safe.

For the younger children in the family, the older siblings had roles of being heroes; to be admired and placed on a pedestal; teachers, special people who made them feel loved, safe and protected. As with the position in the family, notions of closeness and distance will also shape family relationships.

Closeness and distance of relationships

When working with people I will often ask questions about closeness and distance in relationships. However, when I tuned into comments made by people in my study, the depth of understanding was extended greatly; therefore, I have included them as new commonalities. Many people in my study described their relationship with their sibling as close, with some stating they had the closest relationship in the family. Janet says, “we were very close, me and my older brother”. Similarly, Carl says, “I was closer to my youngest brother than anyone else really”. Karen also says about her brother, “he and I were very close ... despite all the chaos”. Connie says:

In my childhood, I probably would have been closer to my brother, because we spent the most time together.
Connie’s comment is about proximity and draws attention to life circumstances. Later in life, Connie lived interstate with her own family and there was less contact with her brother; both factors impacted on the sense of closeness. Krystal says in her late teens, early twenties, she didn’t have time for her brother:

I was living my life; he was living his. If we combined, that was great, and if we didn’t see each other then it wasn’t masses of problems.

Others qualified the closeness, noting that relationships are not static, therefore, closeness and distance in a relationship can be influenced by life stage and/or circumstances, for example, Alice describes her relationship with her younger brother as close during their childhood but more distant in adult life. Tony similarly reflects on childhood; he says, “we’d play together” but as late teenagers “we had drifted, we had definitely gone in separate directions by then’. He says, “our paths became absolutely divergent”.

I get the sense that for Tony it is almost incomprehensible that the two brothers so close in age, with the same upbringing, from the same home, could be so very different. He draws attention to this notion by describing a scene as he worked in the garden at the family home; he says, “it was poignant finding … a toy soldier we used to play with and a [used] syringe beside it”.

As close as some relationships and families are, others can be distant, sometimes out of necessity. Lilibet describes her family situation as violent and, therefore:

We were all so much in survival mode that there wasn’t actually time to be emotionally close to each other and there was probably a lot of distrust between us because you had to protect yourself.

When looking at closeness in relationships, this done by comparing and contrasting the distance in relationship in the family. Amy also draws attention to differences and distance in a different way, describing herself and her brother as close because “our personalities are
very close but he was ... just so wild that I found it a bit hard to be close to him”. For Amy, her brother’s wildness put distance into their relationship.

In a slightly different way, Vera talks about closeness to her sisters, one older and one younger, both of whom died from drug-related reasons. She says, “we slept in the same room when we were kids”. When she was in her twenties, Vera realised that her life was on a particular course; she says, “I can’t be here. If I’m here, I’ll end up like my eldest sister” so she moved to Australia. “I just went my own way because I had to, that changed my life, for the better”.

In contrast, Vera talks about her relationship with her younger sister which was not close; she explains:

I didn’t like her following me around, coming to hang out with my friends all the time ... so we had pecks at each other ... we were competitors ... we weren’t close at all.

For those in my study, distance in the sibling relationship seemed protective because the other is too wild, the situation is volatile or unsafe or to create a new life. In contrast, closeness in the relationship could be impacted by life choices, life stage and circumstances. Other factors influencing the members of the family are the interactions outside the family environment.

**Family boundaries**

A family’s boundaries are about whether the family is more open or closed to the outside world. When they are closed, there is a firm boundary around what happens inside the family which prevents others from outside the family knowing what is going on inside. For example, Alice describes her family system as closed, saying the family had a way to “present in public and people would have absolutely no idea about what was happening [inside the family]”.

However, at times things with Alice’s mother (who had a drinking problem) and her brother spilled out into other areas of her life. She spoke about her brother dropping in at inopportune times at the group house where she lived, she says, “I would feel embarrassed
... and I would just dismiss it ... as if it didn’t happen”. She says she was not free to “be” because she just never knew when “things are going to explode”.

Sometimes a family may respond to a specific situation and become more closed. Krystal described her family as closing ranks around her brother when they discovered his drug use and suicidality the week before Christmas. Krystal says the family were “just being a strong family ... we’re here to support you, we’re here to help you ... we sort of cut everyone else out”. Her brother, in the meantime, was making a Christmas feast. She reflects that her brother was probably trying to convey, “this is something I can do, and I know I can do it well, I’m going to show you that I’m not hopeless, I’m not useless, I can do something”.

Closed families can look protective, in terms of protecting a family member or family reputation from the outside, so that what goes on inside the family remains private; although, as Alice noted, this is not always helpful because it means that those on the outside cannot see in and offer assistance.

**Talking inside and outside the family**

The people in my study spoke of who they can talk to in the family and outside the family and, as I listened, I wondered if closeness in relationships is linked to open communication within the family. Karen says her brother:

> Was a good son ... he was a very soft person so always phoned home and wanted contact, he always wanted to have a relationship ... to be close ... but I guess sometimes too, he was probably too open about stuff they [her parents] didn’t want to know and he would be talking to them about it.

Kathryn’s experience with her brother is similar; she talks about closeness and communication in her family, saying:

> My brother was very open with his drug use with mum and I ... it’s just the way our family operated ... even if you were doing something that somebody didn’t like, you still told them.
Alice had done a lot of reading about drug use in families. She identifies clearly that there were ‘things’ that could not be spoken about outside of the family and ‘things’ that stayed inside the family. Alice recalled as a child she would be “blurt out the truth about various things” and just being shut down. She says, “I was told that was rude, you can’t talk about that ... and ... it’s none of your business, things like that”. For Alice if you can’t talk outside the family, then, “it doesn’t allow the kids to ... it doesn’t give you permission to ... there is no-one looking from the outside in and wondering what’s going on, are you ok?”.

When I asked Alice if her father could talk outside of the family about what was happening inside the family, she said, “he operated in a circle that wouldn’t allow you to talk about those things. It was too shameful”.

Alice laments that, “there were a lot of topics ... we weren’t able to discuss [inside the family]”. She says, “I would like to have been brought up in a family where it was okay to have those discussions”. Isobel’s experience is similar; she said emphatically and repeatedly during our discussion that her brother’s drug use “was never talked about” and “my parents ... never ever talked” and “even after my brother died ... I remember one day ... dad said we got the results from the coroner about how your brother died”. Isobel already knew, because she had contacted the coroner’s office and had the report sent to her as well. She goes on, “there was no discussion just a tacit, ‘oh, so you know’”.

As I listened to Isobel speak of her experience, I had a sense of someone living in a vacuum trying to fill in the gaps. During our conversation, Isobel contemplated if not talking about the situation was somehow protective; she says:

Once it’s acknowledged, he’s got no hope because how is he ever going to get out of it? While ... he’s still going to get a job ... things still are going to happen ... this is going to get better.

The idea that not talking could be protective in some way was new to me. We do live in a world that thinks talking things through is helpful. However, as the conversation with Isobel demonstrates, there could be benefits in not talking as well.
Stan spoke about his brother’s drug use and conversations in the family; he says, “well, I suppose we didn’t really talk about it”. He contends that not talking makes it “easy as well because we buried our heads in the sand a bit”.

When Stan was trying to help his brother stop using drugs, there was ‘no-one’ to help him or to talk to. The experience of not being able to talk within the family – as Alice, Isobel and Stan describe – strikes me as both lonely and burdensome. When Stan reflects on his brother’s death, he says, “we never really talked about it at the time or even since really”. Similarly, Jacqui says, “mum’s got her head buried in the sand saying it’s all going to be fine”.

Stan and Jacqui have similar experiences to Alice and Isobel – the drug use and sibling’s death was not shared through language in the family and, because it is not spoken about, there can be no shared meaning about the sibling’s death created by the family. If there is no shared meaning within the family and family members are looking to develop an understanding, then different stories may emerge which can subsequently also cause conflict and/or distance in relationships. Family life is a system of intricate interrelated relationships.

**Discussion on family structure**

Family systems theory is useful in terms of understanding the commonalities identified in this topic of conversation. Systemic theory is broad and, when applied to families, the theory is usually referred to as family therapy. One of the key concepts of systems theory is that the whole system is organised through a series of interdependent relationships and, therefore, parts of the system cannot be understood in isolation from other parts or the system as a whole (Goldenberg & Goldenberg, 1985). Family therapy focuses on patterns of communication and interaction, behavioural sequences and relationships in the family (Goldenberg & Goldenberg, 1985). From this perspective, individual experiences are understood and explained in relational terms, that is, within the context of interpersonal relationships (Vertere & Dallos, 2003). What became apparent when writing this discussion is that to understand issues such as parental alliance, parentification, birth order, position
and roles in the family, boundaries and rules, then family therapy provides a solid foundation from which to work.

Structural family therapy is a particular type of family therapy developed by Minuchin (1974) who saw families organised around complementary and reciprocal roles, routines, expectations, rules and function through subsystems and transactional patterns between its members (Lindblad-Goldberg & Northey, 2013). He focused on the boundaries (imaginary lines) between internal subsystems and external social environmental systems (Vetere, 2001). Minuchin contended that if a boundary is too permeable, then “the system loses its integrity and identity” and, if too rigid, “the system is cut off and isolated” (Goldenberg & Goldenberg, 1985, p. 29). Family subsystems are coexisting smaller groupings of family members who meet and interact and can be organised according to gender, hobbies, parents, or siblings or function (Colapinto, 2019). Members can belong to more than one subsystem and will learn different skills and have different roles and power in the different subsystems; for example, the oldest child will likely have power in the sibling subsystem (Vetere, 2001). Subsystems need clear and firm boundaries to function effectively (Colapinto, 2019). Family structures help organise the subsystems, roles, rules and function of its members.

The parental subsystem is a hierarchically informed generational subsystem with executive powers in the family (Tadros & Finney, 2018). The parents form the subsystem which is responsible for making decisions and rearing children and, as such, Minuchin (1974) argues the subsystem must have authority. The parental subsystem is in charge of the care and safety of children and fulfils major socialisation requirements within the family by providing the security needed to reassure children. The “parents are in charge of their children, not as tyrants, but as providers of the nurturance, guidance, and protection that allow a child to grow safely” (Colapinto, 2019, p. 111). Together, parents form an aligned team responsible for making decisions while having the ability to negotiate conflicting interests (Vetere, 2001). This occurrence is the basis for seeing a parental alliance as desirable.
When the parents are not aligned, and at times in conflict, there are likely to be inconsistent reactions from parents and the child will move between parents seeking to have their needs met (Goldenberg & Goldenberg, 1985). Couched in Bowlby’s attachment theory, interparental conflict is burdensome for children (Cummings & Miller-Graff, 2015). When children are exposed to ongoing parental conflict, the child both worries and feels less secure (Davies et al., 2014). McIntosh (2003), who writes extensively on children post parental separation, suggests it is well recognised now that it is the lack of resolution due to enduring parental conflict which distresses children, rather than parental conflict per se that engenders worry and insecurity. Again, the focus is on a strong parental alliance to provide children with the optimal secure environment needed to foster their emotional development. This theory is relevant to the experiences described by Sally and Donna in my research. What is apparent is that for their siblings, the different parenting approaches and lack of alignment made possible a greater range of responses between the sibling and the parental subsystem and possibly meant there was more pushing of boundaries by their sibling.

Parentification also concerns boundaries, between the parental subsystem to the sibling subsystem. Minuchin (1974) is firm that the differential allocation of power should be clear between the parental and sibling subsystems, and when boundaries are unclear, children may enter the parental subsystem. Children might enter the parental subsystem because the parent is otherwise occupied (for example, when the parent drinks to excess) and, in effect, the child becomes parentified (Mackensen & Cottone, 1992). The child transforms into a parent-like figure, with all the parental demands and is not given the chance to be a child. The parentified child is seen as overburdened due to coping with more than their ability makes them capable (Minuchin, 1974). Hence, much research on the topic has considered the deleterious effects of parentification, even though there is also the potential for growth and other positive outcomes such as self-reliance, independence and maturity (Hooper et al., 2011).

While Jacqui and Alice in my study did not speak directly of missing out on their own childhood per se because they were parentified, they certainly did comment on the
relationship they had with their younger siblings, both lamenting the fact that their role was more of a mother than that of a sister. As Alice says, “a sort of murky mothering ... happens”. What is interesting for these two women is that both made efforts within the family to intervene with their sibling’s drug use, and both were thwarted by a parent. I suspect having parental responsibilities and then being stripped of power when the parent steps back into the parenting role, and to be relegated back to the sibling subsystem, must be a bewildering and frustrating experience. The child in this circumstance is left with the adult worry that comes from the burden of parental responsibility, for their sibling who engages in drug use, but they have no power to intervene.

Another issue that is relevant to the sibling subsystem is birth order. Despite numerous psychology informed studies, none have proven that birth order is a determinant of personality (Stroup & Hunter, 1965). In their study, Marini and Kurtz (2011) found that personality differences related to birth order are apparent only within the home environment. As stated earlier, a family therapy perspective looks at people in relation to others. Family therapy can also focus on the person’s functional position in the family; this is not a static concept – it acknowledges that families continually change and, therefore, functional positions of family members can also change (Goldenberg & Goldenberg, 1985). Taking the idea of ‘function’ further, Cook (2007) talks about the oldest child having a tendency to over-function while the youngest in the family tends to under-function.

In the late 1970s, Wegscheider built on some of the ideas espoused in the family therapy literature, although the work was specifically on families with one parent who had a drinking problem (Devine & Braithwaite, 1993). Interestingly, Logue et al. (1992) tested the applicability of Wegscheider’s roles on university students and found that all participants thought that Wegscheider’s roles described them well, regardless of parental alcohol dependency, indicating application beyond alcohol-dependent homes. In my research, many of the younger siblings referred to their older sibling as having a ‘hero’ status; someone they looked up to, was perched on a pedestal, a source of safety and guidance. This definition fits well with Wegscheider’s model and the hero role. Similarly, the older siblings in my research discussed feeling responsible for their younger sibling and explained how they tried to
intervene in their drug use. To cope with their inability to stop the drug use, they put distance into their relationship and subsequently experienced both guilt and regret.

Closeness and distance in relationships are also described by Minuchin (1974), although he uses words such as enmeshed and disengaged. These terms refer to the preferred degree of emotional and functional levels of proximity and distance in relating to one another (Lindblad-Goldberg & Northey, 2013). Enmeshment is where family cohesion is prioritised, family members are over-involved in each other’s lives such that system boundaries are breached; there can be a lack of privacy and a sense of intrusion (Goldenberg & Goldenberg, 1985). The other family type is disengaged where there is excessive distance among members, lack of mutual support, communication is difficult and protective functions of the family are limited (Colapinto, 2019). When family boundaries are clear, enmeshment and disengagement are not issues because the family system is balanced, allowing for both the differentiation (that is, autonomous individuality) of members and the sense of belonging (emotional connectedness) to the group (Goldenberg & Goldenberg, 1985).

Krystal discusses the change in her family when they all realised her brother was suicidal. They closed and strengthened boundaries around the family, prioritising cohesion. However, other features of being enmeshed were not evident, in that her brother’s individuality was respected and encouraged (he prepared the family Christmas dinner), but the family mobilised to foster emotional connectedness and belonging. Thus, there is a clarity in how the family responded in a time of crisis. In contrast to this is Alice’s experience of her family boundaries. She experienced boundary breaches in her own space away from the family, a lack of privacy and sense of intrusion. In this context, Alice’s differentiation from the family was not respected.

Families also have external family boundaries and rules to protect information inside the family and regulate the dissemination of information to those outside the family (Petronio, 2010). When the family has rules about not talking outside the family, then the family ostensibly has a secret. The family is often the first place that people learn about privacy (Serewicz, 2013). Barnwell (2018) argues that secret-keeping (the practice) is vital to the
constitution of the family. Secrecy is a strategy aimed at controlling the flow of information and is universal to all social organisations (Brown-Smith, 1998). There are three types of family secrets discussed in the literature. There are secrets that are shared differentially between family members, for example, siblings may know things about each other that parents will not know (Brown-Smith, 1998), the concealing of information by individuals from their family (Orgad, 2015) and those secrets kept by the entire family from outsiders (Vangelisti et al., 2001). For example, when Australia’s assimilation policies were enacted, an entire family could conceal their aboriginal heritage, which was a highly protective strategy (Barnwell, 2018). On the one hand, a whole-of-family secret puts a boundary around the family which can internally strengthen internal bonds, the sense of cohesion and emotional commitment, as well as create a family identity, be strategic and contribute to the family’s survival by protecting the family from outsiders (Rubinsky, 2018). However, a whole-of-family secret can also create a wall between the family and the outside world, meaning those outside the family cannot see in and provide help when needed (Brown-Smith, 1998). Alice makes this point by saying, “there is no-one looking from the outside in” and, for Alice, that meant she was not able to access assistance for her mother or brother. Petronio (2010) refers to Alice’s situation as a ‘dilemma’ because there is an inability personally to help the family member, and there is no ability to get assistance from those outside the family. Vangelisti et al. (2001) expand on the reasons for concealing family secrets. They recognise competing motivators are at play in these dilemmas, for example, avoiding the negative evaluations of others even though disclosing a secret could lead to emotional support and, while family support could be useful, the act of revealing family information could be the source of disapproval in the family. A family secret will be disclosed if there is an important reason to do so and the reason will influence whether they are supported or obstructed by family members and can also affect if they are accepted or ridiculed (Vangelisti et al., 2001).

In summary, families are not straight-forward. Presented in this discussion is theory that has explanatory power to aid understanding around some of the experiences discussed by people in my study. The process of reviewing theory in the context of the transcripts has led
to numerous insights and a greatly expanded horizon. How the family responds to the sibling’s drug use is considered in the next section.

**Family response to drug use – familiar**

This next section’s focus on the family response to the sibling’s drug use. There are two commonalities which formed a part of the horizon. These commonalities were a sense of missing out and siblings keeping secrets.

**A sense of missing out**

Jacqui discusses the idea of missing out when both her own son and daughter were born. She describes the situation when her mother visited:

> So, I have my son ... he’s got a whole lot of problems at birth ... my mother comes, and she’s got my niece with her [my sister’s daughter] so it’s all about my niece ... and I’m like, ‘But I need you’.

Similarly, Tony reflects on his own adolescence and playing hockey. He says, ‘I had been playing for 10 years and my parents had never seen me on the hockey field’ until he expressly said, ‘I’d like you to come’.

When I read Tony’s transcript, there was an overwhelming sense of him missing out from my perspective but, for Tony, the situation was more an accepted fact of life. His brother’s artistic endeavours seemed to be prioritised and actively supported by the parents. As I listened to Tony, I wondered if being independent, strong and capable looked as though he did not need the same support or validation from his parents as his younger brother. The next section concerns secrets between siblings.

**Siblings keep secrets**

Alice describes conversations with both her brother and sister to which her parents were not privy, sometimes for protective reasons. Alice says she knew her brother was smoking dope as a teenager because he told her. When I asked her if she told her parents, she said, “no, that’s not shareable information”.

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Alice was fearful about how her father might respond to her brother. In this context, Alice is protecting her brother by keeping his secret from their parents. Alice and her sister could talk openly about their brother and his heroin use. Connie also reflects on sibling secrets in her family. She says, “all of us around the same age, we’d all smoke dope”. She goes on, “we were really good at hiding” the cannabis smoking.

Janet also says, in her role as the younger sister, even though her parents ‘were worrying anyway ... you try to hide things from them, so they wouldn’t stress’. Janet says she knew about her brother’s drug use well before her parents did; she says, “but I didn’t say anything”. Janet goes on that her brother “did tell me a lot”. She says:

I did hold on to all these things and it didn’t even cross my mind that I should tell my parents ... it was also about keeping confidence with my brother, not betraying him by telling them, that’s what it was mostly about. It was about protecting my parents from being worried and protecting my brother by not betraying his trust and, yeah, allowing him to lead some kind of secret life.

Amy says, “I don’t remember getting concerned about my brother’s drug use until mum and dad were overseas”. She says that all the siblings were talking about her brother’s drug use, but she would not have told her parents. “I knew ... I didn’t want to worry her [mother] ... even if she asked me outright, I would have lied”.

Lorraine says, “there was two kind of pivotal things that happened to my sister ... two incidents of sexual abuse when she was a child, that I know of”. Lorraine says her mother was aware of one; however, about the other, she says:

When she [sister] was in high school, she said she was sleeping at a friend’s house and ... they met up with these guys and she was raped ... to my knowledge, mum didn’t know ... until the coroner’s inquest.

As Alice, Lorraine and Connie describe secrets between siblings function to protect the sibling from getting into trouble and are also protective of the trust in the relationship. Janet
and Amy show also that these secrets also protect the parents from worrying, especially when they may be experiencing their own difficulties.

**Family response to drug use – new**

In this section the commonalities presented were new and expanded the horizon. These common aspects include family tension and stress surrounding the sibling’s drug use and associated behaviours, the parental approach, the sibling continues to be included, children help parents, the struggle of not being able to help, finding a way to be with the sibling or withdraw and protecting the sibling’s children during drug use.

**Family tension and stress surrounding the sibling’s drug use and associated behaviour**

The ideas of family tension and distress were noted by many of the people I spoke with in my study. Stress in the family can emerge before knowing about drug use, when the drug use is discovered and after the drug use is known. For some of the people I conversed with, conflict characterised relationships when the drug use was unknown. Janet attributes her depressed state in part to “all the stress at home too, because it was stressful”. She describes the stress as conflict between:

- Mostly mum and my brother, because mum was worried about him … there was always a clash going on, I mean they [parents] clearly loved him very much, but he was always lashing out … verbally.

Isobel likens the tension in her family home to living in a volcano. She says:

- For the years … it was this constant volcano type of thing … sometimes I’d go home, things were fine, other times it would be terrible … I could see the enormous stress on mum and dad.

When the drug use is known, the family stress can take on a different form. Similar to Isobel, Lorraine talks about how difficult the situation was with her sister; she says:

- Even before she left [went missing] … we could tell she was unwell, but we didn’t know who to call or what do you do. I mean, I think families are always like that, when they’ve got someone who is substance using and got mental health issues, they don’t know what to do.
In a similar vein, Krystal describes a scene where the family had just discovered that her brother was suicidal and had been using drugs. The family surrounded her brother in a protective way over the Christmas period while simultaneously being hypervigilant and watchful. Krystal says, “we were all on eggshells”.

When the drug use was known, the stress expressed by people in my study was more focused on the unpredictability of the sibling’s behaviour. Amy says when someone in the family:

Is doing really wild crazy stuff and taking drugs, lying and leading an extremely chaotic life, it does interrupt things. And sad and horrible as it is ... I’m not stressed or worried all the time now ... he put us through a lot of stress all the time because of his own selfish drug habit ... he kept ... choosing drugs ... over being a good dad, being a good son, being a good brother.

Gina also spoke of the time after her brother broke up with his partner and was using drugs; she says:

You were never quite sure what his behaviour would be ... there was a succession of quite dysfunctional junkie girlfriends that would materialise at family events ... that sort of thing was pretty hard.

Again, focused on the unpredictability, Donna says about her brother, who was mentally unwell and using drugs, “he was clearly unpredictable ... he would suddenly hit people”. To emphasise the point, Donna describes her brother:

Wearing a t-shirt that says, ‘I do what the voices in my head tell me to’ and that’s literally true. So, he was definitely a huge stress. You had to steel yourself every time ... the whole time, it’s having to steel yourself for being around him.

Drug use by a family member is stressful because there is conflict, unpredictability and a constant sense of worry present, making it difficult to relax. How a family responds was often influenced by the parents.
Parental approach

What was new to me was how the people in my study talked about their sibling’s drug use and how their parents responded, and how the parental response affected other family members. Many of the parents took a ‘burying their heads in the sand’ approach, that is, they ignored the sibling’s drug use. Stan says, “mum and dad didn’t really know how to deal with it”. Stan says his parents’ approach was very much to bury their heads in the sand and to some extent, he followed suit. Stan says, with hindsight:

I think if I went back, I don’t care what mum and dad are doing, I am going to go to this rehab place, I’m going to find out ... I’m going to drag him there ... get him sorted out.

Karen explains her parent’s response to her brother’s drug use was similar to Stan’s parents; she says:

You ignore it and hopefully it goes away ... I can remember garbage bags of cannabis being in the garage where my brother would sell from. And mum and dad turning a blind eye to it, rather than confronting it ... there were a lot of things they [parents] ignored about him, in order to have him around.

Similarly, Jacqui describes her family as “a really dysfunctional family” and attributes the dysfunction to her mother. She says her mother was “secrets and lies”. She describes her mother’s strategy, “let’s put our head in the sand and it will all go away if I don’t think about it”. Similarly, but slightly different, Alice felt angry about the “lack of response to her brother”. She describes visiting her parents, and her brother:

Would be nodding off on the couch ... I would just get so frustrated, they were delighted to see him ... but here he is, he’s used and he’s nodding off, oh dear.

Alice says if this was the situation and her parents did nothing, she would leave “because I couldn’t watch it”. Alice was powerless to influence the situation and the distress was such that she had to remove herself. She goes on:

I attempted to have conversations with them over the years about what was happening but ... it’s hard to explain because it’s so damn crazy to be in a family that doesn’t discuss important things.
When someone is not well or behaving differently, it is difficult initially for the family to know what to do. Many of the people in my study looked for or followed the lead provided by their parents. For example, Lorraine reflects that she thinks she was looking for direction from her mother; she says, “because she was the one ... who was seeing the doctors”. She goes on:

My mum might not have been the best person ... [because her mother is] kind of stoic and she thinks she has to manage everything ... it was beyond her ... I think if the kids [siblings] ... had a better idea of what was going on with our sister, that we would have supported her more, not stayed away from her and if we kind of had direction of what we could do, that might have helped.

Parental direction can be subtle. Carl describes his father as a quiet man who led by example. Carl says, “dad was the supportive one ... dad was the one holding the family together”.

Other parents might provide direction in a more overt manner. Donna says her father:

Would be more encouraging me ... goading me or jolling me along a bit to go and see my brother, which often I would be quite reluctant to do.

The parents’ approach can be not to respond and ignore the situation which might make it possible to maintain and protect to some extent relationships, or to respond by supporting relationships by continuing to include the sibling and encouraging others in the family to do so as well.

**Sibling continues to be included**

Many families I have worked with over the years in drug and alcohol get to a point where their only option seems to be to exclude their sibling or child from family relationships. This is often promoted in the drug and alcohol field as setting boundaries and/or ‘tough love’. I expected to see elements of exclusion in my research; however, when interpreting the transcripts, I noticed the opposite for many people in my study, as their families continued to include the sibling using the drugs.
Donna says when her brother was about 17 years old, he had been unwell mentally, hearing voices and having delusions; she says:

He thought my daughter was the devil, so we sort of really restricted our access to him at that point, which was difficult because the rest of the family, I don’t think, really understood ... we were saying things like: ‘if he is at a family gathering, we won’t be there’ ... my husband and I together were taking a firm position ... but they would still arrange things and invite him but not tell us ... they knew our stance, but they would try and circumvent it.

While Donna was trying to limit contact with her brother, the family were continuing to include him.

Gina’s family also continued to include her brother:

We always tried to invite him along to things. He was a very likable fellow, so we always wanted him to be part of our lives.

Judy’s brother was also included in family events. She recalls her brother was well presented for her father’s birthday dinner; she says, “he really behaved himself. He wasn’t over-drinking ... he was in control of himself”. She says with the family he would behave in “the acceptable way”. Judy says emphatically, “I never saw him out of control”.

When I reflected on these family experiences, I felt a deep respect and warmth. These families conveyed such love, acceptance and support for their sibling, often in quite difficult circumstances. I was fascinated by Judy’s observation that her brother curtailed his behaviour when with the family. Other activities involved helping the parents help their sibling; such activities also encouraged a sense of family inclusion.

**Children help parents**

Some people in my study were not parentified but definitely occupied a ‘parental helper’ type of role. It is interesting to note that all these people were the youngest sibling. Kathryn as the younger child says, “mum was helping my brother ... but ... mum would get burnt out,
living with… someone with bipolar is exhausting… so often I’d be the one helping her help him”. Kathryn says in terms of her brother’s drug use, overdoses and bipolar, “that was just my normal… mum was a single mum… trying to work… it was exhausting at times, but I suppose it was just my normal”.

Similarly, Sally describes herself, saying, “I was always the good girl I guess, like the helper to my mum… help with the housework… that was very much a norm for me”. Sally talks about finding her brother with her mother, “we’d track him down, wherever he was, and sometimes he would be passed out in some hallway or something”. As Sally reflects on family life, she says, “there was so many issues all the time with my brothers that it was just something you would kind of absorb”. She clarifies, “for me it wasn’t abnormal… there was so much going on all the time. You just dealt with it”. She says when her brother died, even though she too was in a state of shock, “there was no time to fall apart” as her role was to “try and be supportive to her mother”.

Similarly, Connie talks about her mother as “not a very good coper with things”, so Connie and her siblings organised the funeral because, “she wouldn’t have wanted to be involved in it. She was happy for it to be done”. In a similar vein, Gina says, when she was organising her brother’s funeral, “I just felt I had to hold mum up, really. She was just a mess”. She says both her parents “were so fragile, just so emotionally upset. I felt on a few occasions that I had to be a bit stronger for them, I suppose, and keep it together”.

Isobel talks about her role as the ‘buffer’. She describes her parent’s relationship:

My parents had been together since they were 16… absolutely devoted to each other and I wouldn’t have been surprised after that [brother dying] if they split up. I could see, the difficulty they were having… they could see the pain in each other, and it was driving them apart that they needed to be with me… I had to be okay… they had… to be a part of my life… I look back as a parent… for people who were fabulous people, they really got a bum deal.
Isobel says of her role in the family, “I guess my role ... was just to take mum and dad out of that, like I’d go home we’d do things ... go out to dinner ... the theatre”.

Janet laughs as she describes her role in the family conflict as:

I was trying to make peace, but everyone would say keep out of it Janet ... even my brother would say stay out of it Janet ... I thought I had a valuable contribution to make ... but no, clearly not.

The people in my study could see their parent’s efforts and suffering and tried to help their parents, both before and after their sibling’s death.

The struggle of not being able to help

When Helen returned from overseas, she lived in the same city as her brother. She says, “I remember I ... had in my head that maybe I could help him ... support him somehow”. She says, “I didn’t know what that meant”.

Lorraine was also keen to help but was unsure. She says when her sister was released from jail all the siblings were at home but, “we really didn’t know what to do and I think we kind of stayed away from her a little bit”. Lorraine goes on, “if us kids had been given some support then we might have been more influential ... and known what to do”.

Judy says she would have liked to have, “got the family together and tried to do something to help him ... and I mean my parents; they were totally out of their depth”.

Isobel experiences guilt about not doing more. She says:

Why didn’t I ... intervene more ... but I guess you trust because he was going to this psychiatrist and he was on this Lithium, you assume someone who knows a lot more than you, has got it under control ... and sometimes things would be fine, but a lot of the time they weren’t.
Isobel said a few times during the conversation if she had been older, she would have done something. She says, “I think if it had been reversed [she was the eldest], I would have taken control”.

Many people in my study wanted to help their sibling but were unsure what to do or how to do it. For some there is a sense of futility and helplessness at the inability to intervene, and a subsequent pervasive guilt. Hindsight reflections highlight what may have worked, for example, being informed, talking in the family and being supported. Others in my study found ways to be with their sibling.

**Finding a way to be with sibling or withdraw**

Tony reflects, “there was a fair bit of trying to look after little brother” in the earlier days of his sibling’s drug use. Over time, Tony describes the process of finding another way to be with his brother. He says:

> At some point I had to say, my brother ... is an adult, he is making his own decisions. I can’t control him ... and if he makes poor decisions ... as much as I don’t condone it, I can’t condemn him for it. And all you can do is offer the support.

He goes on, “you can’t be responsible for them ... you don’t take it on board as your problem, because it’s not your problem, it’s their problem and you’re there to support them with their problem”. He says, “the last thing I said to my brother is ‘I love you’”. On that occasion Tony recalls tearfully, “he was so far down the rabbit trail, he was gone, it was just a matter of weeks [before his brother died]”. This was the last time Tony saw his brother.

Sally too found a way to be with her brother. She says:

> Oh, look, my brother loved his drugs and I guess for me, I had ... come to the realisation that acceptance doesn’t mean approval. Like, I didn’t like him taking drugs, but I accepted that that was his choice ... his drug use was very much in your face, but he didn’t do it in a way that compromised my life.

Alice’s way of responding is very different from Sally and Tony. She says, “I got to the point where I actually had to say to him, I couldn’t watch what was happening anymore”.

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For Alice there it is a tormenting ineffectualness, an inability to influence or change her brother’s drug use, and this was so painful for her that it is almost as though she has no choice but to withdraw from the relationship with her brother. Similarly, when Carl talks about withdrawing from his brother, he compares his approach to his father’s approach of staying connected; he says, “it’s easy to withdraw comparatively. You know what my dad did, stay in touch, [that] was harder”. Carl also talks about regretting withdrawing from his brother he says, “and I am sorry I did it”. Carl goes on, “I found it really difficult, and to my regret now ... I withdrew ... I felt ... helpless too”.

Donna says she was “probably the least supportive sibling of my brother”. Donna says repeatedly that she found it difficult to be around her younger brother. She reads from her blog:

An hour with him was quite exhausting … I just found it really hard being around him … brain damage, enlarged heart … in a secure facility … I can’t cope … I’m not a great sister to him, I’m sorry to say. He’s one of my official guilt trips.

When I reflect on this section, I am struck by the desperate desire to do something helpful for a much-loved sibling. Some expressed a forlornness and torment of being unable to do anything, bringing with it a heavy emotional burden. However, others found a way to focus on the relationship with the sibling, not the drug use, or shifted that focus to their sibling’s children.

Protect sibling’s children during drug use
Karen describes how her parents visited and supported her brother and his family, taking Karen (as the youngest child) with them. Karen says, “you did that propping up, you did it for the niece”.

Jacqui describes a situation where she and her younger brother tried to intervene with her sister’s daughter. She says her niece “was in danger … they were using, and they were just chucking [used] fits around the place”. Jacqui and her brother forcefully intervened by taking their niece out of the environment. It was not a strategy that worked in the longer
term but is indicative of the desperateness to do something, paired with the inability to do anything else to help the sibling.

The sibling’s children are important; intervening when needed for nieces or nephews and maintaining contact and relationships when the sibling is using drugs and/or dies is meaningful; another way that the family responds in this context.

**Discussion on family response to drug use**

In this discussion I am looking at the family response to drug use. Theory abounds to assist in developing a deeper understanding of the topics and commonalities. The catalyst for drawing on theory here is the explanatory power and relevance to the interpretation of the interviews. The discussion again looks at the family structures, subsystems and components of family culture, such as communication and roles, before moving on to focus more on the tension and stress within the family when a family member is using drugs.

When reflecting on the idea that the parental approach may, to a greater extent, determine family responses to the sibling and subsequent relationships in the family, I turn again to structural family therapy and the parental subsystem. Subsystems “carry out distinctive functions in an effort to maintain themselves and sustain the system as a whole” (Goldenberg & Goldenberg, 1985, p. 37). For Minuchin (1974), the parental subsystem is responsible for carrying out the executive functions for the family incorporating socialising and implementing age-appropriate constraints and rules for the family. Many of the people in my study talked about their parents’ approach to their sibling. Most people in my study followed the parental lead. Some parents modelled maintaining relationships and ongoing inclusion of the sibling at family events. Other parents ignored the sibling’s drug use, which also meant there was little room for discussion.

In the previous section I discussed the notion of the parentified children relating to the experience for Jacqui and Alice. Both were the eldest and both were given roles of being responsible for others in the family, especially younger siblings. For these two women, their parents’ approach to their sibling was to ignore the situation and both were unable to influence approach. Alice says, “I tried to have conversations with them over the years” to
no avail until she “couldn’t watch it” (inaction and continued drug use) any longer so she stayed away. This situation for Jacqui and Alice is a confluence of parentification and being given responsibility for younger siblings, but then having that responsibility removed and not being able to help their sibling as they are ejected from the parental subsystem and left to follow the parents’ lead with which they did not agree. This experience is perplexing, frustrating and difficult to endure and understand.

Ignoring a family situation can be coupled with the inability to talk about the situation in the family. The ability to talk inside and outside the family constitutes the ‘talking rules’. To gain an understanding of these rules, I turned to other subject areas such as mental health. Van Parys et al. (2015) in their study, of young adults with a parent who is treated for depression, found that talking about ‘the depression of the parent’ was a taboo subject, coupled with a reluctance to talk about their own feelings. They contend that for children to talk and explore their feelings, they needed permission from their parents to do so (Van Parys et al., 2015). Similarly, Van Loon et al. (2017) found that adolescents with a parent who has a mental illness might not talk about their own worries “because they feel their parent already has enough problems” (p. 151). Again, Van Parys et al. (2015) make the point that children are perceptive and do not want to burden the already overwhelmed parents by talking about their own emotions. They conclude these children “were not able to really experience what they experienced” (p. 533) and lacked awareness of their feelings. However, they went on to identify that the ‘not experiencing’ is protective – in terms of coping – for the entire family system. This idea of not putting words around feelings and experiences at the time is how Isobel describes her family. When there are no words and no sharing of the experience in the family, then the family and its members go on as usual – the situation is normal.

Talking in the family is usually promoted socially as a good thing to do, especially when something is happening (for example, someone is using drugs) or has happened (for example, someone has died). Nadeau (2001b) writes about the idea of meaning making in families when someone has died. She defines meaning making in this context as the meanings constructed through family interactions (Nadeau, 2001b). Similarly, Harrington
(2017) draws in part, on Nadeau’s theory by describing the process of meaning making as the creation of stories, individually and/or within the family context, to understand and give meaning to death. Nadeau’s (2001b) research draws attention to the enhancers and inhibitors of meaning making within the family. She contends frequency of contact, willingness in the family to share meanings and tolerate difference all enhance meaning making. Whereas, family secrets, distance in relationships and family rules that function to prohibit sharing inhibit the process of meaning making. Her theory ties in well with Van Parys et al. (2015) findings that, without talking, reflection and sharing of experiences, it is difficult to understand and gain meaning from what has transpired. This is entirely consistent with Gadamer’s ontology that language shapes our experiences in terms of what we attend to, gives structure to our thoughts, and the act of sharing thoughts and experiences helps to create understanding and meaning.

Before looking further at talking rules in families, it is useful to circle back to Minuchin (1974) and look at the sibling subsystem, as doing so will help in understanding family secrets. Just as there is a parental subsystem, there is also a sibling subsystem among many other subsystems. It is through membership of various subsystems within the family that the child learns relational patterns and develops a sense of identity (Minuchin, 1974). In the sibling subsystem, children learn about the nature of relationships, for example, cooperation, conflict resolution, competition, ways to avoid or surrender, gain, or lose an ally (Vetere, 2001). The boundary around the sibling subsystem should be sufficient to allow the children to develop within the subsystem.

Minuchin (1974) notes that within the sibling subsystem, there can be other divisions between the younger and older children. Two authors, Black (1979) and Wegscheider (1976, in Devine & Braithwaite, 1993), looked at the roles children take on to cope in homes where one parent consumes excessive amounts of alcohol. Black identified four roles: the responsible child, the adjuster, the acting out child and the placator (Devine & Braithwaite, 1993). Black’s roles correspond with Wegscheider’s roles of the hero, lost child, scapegoat and mascot (Vernig, 2011). Devine & Braithwaite (1993) investigated the validity of these coping role typologies noting that, “family disruption is a far more potent predictor of their
use than parental drinking” (p. 75). These roles, as described by Black and Wegscheider, are familiar in families, regardless of parental alcohol consumption. In part these roles are also identified implicitly within family therapy literature with reference to the responsibility function usually taken on by an older child (Goldenberg & Goldenberg, 1985). Nadeau (2001b) explains that family therapists often identify other roles, such as scapegoat, mascot and peacemaker in families. While Black and Wegscheider (in Devine & Braithwaite, 1993) were focused on roles and birth order, in family therapy the functional position of a child is of more interest than birth order position because family therapy acknowledges that family structures continually change as do the functional positions (roles) of the family members (Nadeau, 2001b).

The reason I have drawn attention to these roles is because of the explanatory power and relevance to the roles taken on by some of the people in my study. Some people in my study helped their parents help their sibling, providing direct help to their sibling(s) in their parent’s absence, or helped their sibling’s children. In Vernig’s (2011) description of the hero, he says this child “is capable of taking on greater responsibility for the wellbeing of the family early on” (p. 536). Both Sally and Kathryn describe themselves as helpers learning what is needed for their siblings from their mothers. Sally says when her mother was working in the city, she would help her older brothers. Both Connie and Gina stepped in to help organise their brothers’ funerals. The other role some people in my study occupied in the family was the role of the placator or mascot. They were responsible for distracting the family from problems, trying to make the peace and relieve tension at times of conflict (Vernig, 2011). Janet says she was “trying to make peace”. Isobel describes her role in the family as the ‘buffer’ and the child who takes the parents out of the turmoil generated through brother’s situation.

These role typologies have utility in terms of explanatory power, aiding in the understanding of the roles and functions taken on in the family environment. However, when these typologies are applied rigidly, that is, only according to birth order, as a determinant of personality type, or as a predictor for future problematic adult relationships, then their utility diminishes (Vernig, 2011). Knecht et al. (2015) contend that family life experiences
often include changing roles out of necessity, for example, a child will step into the primary carer’s role if the carer is attending a sick child in hospital. Another example comes from Nadeau (2001b) who observes that family members will take on the roles of a family member who has died. Hence, from a family therapy view, these roles are not fixed, prescriptive or static and, as family structures change, so can the roles that family members occupy change within the family context.

A familiar commonality in my analysis that is relevant to the sibling subsystem is the notion of missing out. Tony did not talk about missing out but gave an example that seemed to indicate he missed out. And Jacqui talks about a difficult time in her life surrounding the birth of her own child, and how she needed her mother, saying, “I need you”; however, her mother was otherwise occupied and perceived as unsupportive. In my search for literature on this idea of ‘missing out’ in the drug and alcohol field, I struggled; however, two studies are helpful. Templeton and Velleman (2018) report in their research that family members can have “feelings of resentment and anger at how the drinking or drug problem has restricted family members’ lives” (p. 19). Similarly, Webber’s (2003) study explored the issues faced by parents and siblings of illicit drug use in the Vietnamese community. She outlines numerous responses people in her study have to their sibling who use drugs, for example, but not limited to, jealousy, resentment and deprivation of parental attention. She quotes a participant in her study who says the parents:

Devote all their time to the person on the drugs. So, they don’t devote as much time as they should to the others in the family … the parents are most likely to look after the person who is going through all the shit and forget all the others because they think, well there is nothing wrong with them, so they can look after themselves. And then the other kids feel neglected (Webber, 2003, p. 235).

There is a relevancy in this statement, noting that for both Tony and Jacqui, the sense of missing out only manifested during times that were significant in their lives, but the remainder of the time they looked as though they did not need parental attention.
The phrase ‘differential parental attention’ is used to describe giving more attention to one child than the other (Israelsson-Skogsber et al., 2019). Often in families with a chronically unwell child, the amount of attention given to the ‘healthy’ child is less than that given to the sick child. The siblings in the Israelsson-Skogsber et al. (2019) study felt a responsibility towards their sibling, were worried and loyal, understood their parents’ situation and were concerned about their parents’ concerns. In another study focused on chronically unwell children, Carnevale et al. (2006) report one mother said, “whenever he’s sick, my daughter has to learn to come second. Because of sickness, hospital things, my daughter has had to often miss things ... I try to make her understand that it’s not because we love her less or that she has less space. It’s just that she is in a different space and that she needs to learn to live with that” (p. 57). Of course, there are vast differences between having a chronically unwell child who is connected to a ventilator and a child who uses drugs, but the focus is on the similarities that exist in these situations. Carnevale et al. (2006) note that family functioning can be constrained, quality of family life can decline, the family can experience social isolation, financial hardship, physical and mental demands, a perceived devaluing of the child’s life and live with the reality that their child could die at any moment. These experiences are similar for families with a member who uses drugs. Knecht et al. (2015) describe having a family member with a chronic disease as a ‘family affair’; this description is also apt for families with a member who uses drugs. It seems a realistic inevitability that healthy children will miss out in terms of parental support and attention that can be directed their way (Israelsson-Skogsber et al., 2019).

In another similar study, Arnold et al. (2012) found brothers and sisters emphasised they wanted support “just like their parents”; they wanted to be included in the care arrangements and have information and education especially as many provided ongoing support to their sibling (pp. 377–379). Some people in my study made similar comments, lamenting the fact they did not know more; for example, Isobel says, “you assume someone who knows a lot more than you”, and Sally says, “there’s not a lot of support for siblings”. Stan says, with hindsight, “seek some professional advice” and Lorraine says with information and support, “we [brothers and sisters] could have helped, supported her, we needed direction though”. Lorraine elaborates, “I think the system tends to overlook ... the
family ... it would be more useful perhaps to see who else is around in that family to influence; not just the parents”. These comments draw attention to the depth of experience in families when a member is using drugs.

Sometimes, holding a sibling’s secret is compounding or adding to these experiences. Most of the people in my study knew about their sibling’s drug use before their parents did. The idea of keeping family secrets has often been portrayed by family researchers and clinicians as negative (Vangelisti et al., 2001). However, the reality is that the practice of secret-keeping has both positives and negatives. Family therapist Brown-Smith (1998) states that secrets in families are crucial. Barnwell (2018) describes two primary reasons for managing secrets within families – one is for discretion and active not-knowing, for example, not speaking of Aboriginal heritage when Aboriginal children were being removed from their families (Barnwell, 2018) and the other is respectability and uprightness of character, for example, Alice says it was “too shameful” for her father to talk about the family situation. Family secrets might appear simple – we either keep a family secret or we do not – but detailed consideration reveals how multifaceted secrets in a family are and the potential consequences that can arise from both keeping and divulging a family secret.

Petronio (2010) applied communication privacy management theory to the family context which aids understanding around the revealing or concealing of family information. She argues that “at the core of privacy management is the need to be connected to family members while retaining a sense of autonomy apart from those members” (p. 175). Her theory is premised on individual family members and the family as a whole having a private life. Conversations and events within the family environment generate information which is owned by the family; how this information is shared among family members and to the outside world is based on privacy rules and boundaries. It is these boundaries that determine the ownership of information. Therefore, agreed rules must come into play to manage the privacy boundaries; however, when these rules are not negotiated, then inadvertent violations can occur, causing turbulence (Petronio, 2010).
The rules governing who has access to the information inside and outside the family is a key principle to this theory (Petronio, 2010). Sometimes, revealing a family secret can implicate other family members, potentially leaving them in a vulnerable situation, especially when the secret was protective (Barnwell, 2018). Janet’s situation is consistent with this proposition. Janet did not tell her parents about her brother’s drug use because “it was about protecting my parents from being worried and protecting my brother by not betraying his trust”. Rubinsky (2018) concurs, noting that disclosure of information can threaten important family relationships. Also, when a family member discloses a family secret, they may feel anxious and/or disloyal to their family; there can be a struggle between an obligation to tell the truth versus the obligation to respect the privacy of others (Brown-Smith, 1998). Families understand how permeable their system is, who else can know and the amount of independent control members have to reveal information (Petronio, 2010). An example of how privacy rules must be recalibrated, Serewicz (2013) notes that the sudden death of a family member can cause rapid changes to privacy rules and result in privacy turbulence. The family boundaries and rules around talking and privacy are either learnt after a breach, similar to Alice’s example where, as a child, she was told by her parents that she “was rude” when she broke the family rules, or they can be explicitly stated (Petronio, 2010).

In my study, people said sources of tension were conflict in the family, dealing with an unknown/unspeakable thing, not knowing how to help or what to do, being hypervigilant, walking on eggshells, having a prevailing worry and living with the unpredictability of the sibling’s behaviour. Templeton and Velleman (2018) found stresses in the family arose when a member was using drugs, because of events like overdose, suicide attempts and stealing, as well as exposure to the drug use and associated lifestyle issues, such as police at the house, conflict and worry about the person dying and the stigma attached to drug use. These factors are mediated by the duration and severity of the drug use problem, the drugs being used and any associated mental health, criminal activity, and/or unemployment issues (Templeton & Velleman, 2018). Isobel captures the experiences, saying it was like “living in volcano” – she never knew what to expect.
How family members respond to the tension and drug use varies. Kaufman and Pattison (1981) contend that families have three choices: they can continue as is with no change, create emotional distance or put physical distance into the relationship. Orford et al. (2010) reviewed the collective findings of numerous studies over decades and found that living with a family member who is consuming drugs is most stressful when previously close relationships were tainted by conflicts over money, uncertainty and unreliability, worry and a pervasive insecurity within the family as a whole. Family members experience a range of emotions, such as “feeling worried and anxious, helpless and despairing, low and depressed, guilty and devalued, angry and resentful, sometimes frightened and very often feeling alone” (Orford et al., 2010, p. 49). They contend that there are three positions family members take to cope with drug use in the family: put up with it, challenge it, or withdraw from it (Orford et al., 2010). Orford’s et al. (2013) model is similar to the framed ‘choices’ families have, as noted by Kaufman and Pattison (1981). Which coping strategy is used may change and will depend on the circumstances and resources available to family members (Templeton & Velleman, 2018).

Orford’s et al. (2013) research resonates with my study, although I consider in more detail other things that may influence the tension or distress, for example, it must be distressing to be unable to help or not know what to do. To feel helpless on the sideline, watching, was an experience many people in my study had. As Isobel says, she trusted others who knew more than her. Based on my study, other factors will also influence levels of distress, such as parentification or the parental lead. As Judy says, the family could have done more but her parents were “out of their depth”. Alice and Jacqui, both of whom were the eldest and parentified, did not agree with the parental approach to their sibling. Both tried to challenge their sibling’s drug use but, without family support, the situation became untenable and consequently, they withdrew entirely from the situation. Carl and Donna, also the eldest, also withdrew but both regret doing so. For Carl, this was after failed attempts to get through to his brother and feeling helpless. Webber (2003) also heard in her study that the eldest feels responsible for the sibling and tries to help and then experiences a difficulty in coping with the effect of the drug use on the family, and distance themselves. Similarly, Knecht et al. (2015) mention that siblings in their study withdrew. Templeton and Velleman
(2018) quote people in their study as coping with their relative’s drug use by keeping them “at arm’s length” (p. 30). They go on to state in their study family members withdrew from the drug use by “removing themselves from the problem or endeavouring to have some independence from it” (Templeton & Velleman, 2018, p. 36). The experiences of people in my study and the studies noted above show withdrawing from the person using drugs is a strategy often deployed, as Orford et al. (2010) observed.

While Orford et al. (2010) contend withdrawal from the person is due to the stress and strain experienced at the family level, the role of the broader socio-political context also features. Drug and alcohol interventions could be viewed as isolating and punishing the person using drugs. There is a school of thought in the drug and alcohol sector which encourages disengagement or detachment from the person using drugs because they are powerless to influence the person to make changes (Roozen et al., 2010). Much of this thinking emerges from the Alanon literature, an offshoot from Alcoholics Anonymous. Carl says that he “went along to Alanon meetings … there wasn’t really anything I could have done”. However, Alexander (2000) contends we have a need to be psychosocially integrated – to be engaged with a group who understand and accept us. Alexander (2000) describes dislocation as being as form of social isolation that is difficult to bear – the opposite of being psychosocially integrated. Alexander (2000) states when psychosocial integration is not possible and dislocation continues, people “eventually construct lifestyles that substitute for it” (p. 502). Hence, it is better to belong to ‘street junkies’ or a ‘gang’ than to experience the painful aimlessness of social dislocation and in this way contends that dislocation is a precursor to addiction (Alexander, 2000, p. 203).

The upshot here is that a sense of belonging and connectedness to family helps alleviate the sense of dislocation. In my research, other family members will put up with the drug use or ignore the drug use if this is what the parents are doing, that is, they will follow the parents’ lead. I draw attention to Sally and Tony, both of whom found a way to be with their sibling despite the drug use. For Tony, there was a struggle and a judgemental period initially but after realising he could not “look after” his brother by intervening in the drug use, he found another way to “look after” his brother such as buying him clothes and sharing a family
meal. A similar example is found in Webber’s (2003) study; she quotes a participant as saying, “one of my friends got on drugs and the parents did the best that they could, by sending him to Vietnam, and when he came back, he is still on drugs and they sent him back again, but he is still on it. They tried their best, but the kid won’t get off drugs, so they don’t know what to do so they just let him do whatever he wants” (p. 237). Webber’s (2003) example, together with Sally and Tony’s experience in my study, exemplify Orford’s et al. (2010) notion of putting up with the drug use. As noted above, typically putting up with the drug use is not routinely encouraged through policy or treatment strategies in Australia. Yet, it is interesting that research shows around 70% of people with drug and alcohol problems ‘mature out’ of, or spontaneously and naturally stop, drug use without treatment (Schutte et al., 2006). What interests me is that putting up with the drug use means the sibling can remain included in and connected to the family, their identity and lifestyle are not just about using drugs – factors that are purported to contribute to the idea of ‘maturing out’ of drug use (Dawson et al., 2006).

This has been a lengthy discussion full of twists and turns and much interconnectivity. I have looked at how the parental subsystem provides the lead in terms of how the family will approach the sibling and the difficulties that can be experienced by parentified children who disagree with the parental approach. I have looked at ‘talking rules’ in family and how these might shape experiences, thoughts, information sharing and create shared stories (meaning making) within the family context. I then returned to the sibling subsystem to look at the functional roles children occupy in families including the roles of placator or helper. In addition, within the sibling subsystem I have examined the notion of missing out on parental attention and more broadly missing out on information concerning the sibling and their drug use. I have examined the multifaceted nature of secret keeping within families, especially concerning the holding or divulging of secrets. And finally, I looked at coping strategies deployed in response to dealing with the tension and distress generated in the family when a member is using drugs. The coping strategies – challenging and withdrawing from the drug use(r) – were examined from the family and sector perspectives. I completed this discussion by shining a slightly different light on the ‘putting up’ with the drug use coping strategy as a useful means of reducing social dislocation through a sense of family
belonging and connectedness. In the next section, I look at how the family responds when the sibling dies.

**Family response after death – familiar**

When the people in my study began to speak, we spent time reflecting on their experiences of how their family responded when their sibling died. Some of the experiences discussed were familiar to me within the family horizon based on, as Gadamer says, my historicity, traditions, situatedness and prejudgments. In this section, I present commonalities within this topic, including the parents blame themselves, family organising after the death of the sibling, talking and understanding in the family and the sibling’s story is known to nieces and nephews for education purposes.

**Parents blame themselves**

Kathryn describes her mother as doing “so much for us to have the opportunities she hadn’t had” and “the biggest heartbreak” was that her son was not a happy child, “he just didn’t fit in ... and it must be incredibly difficult for a parent to watch that and not be able to do anything”. She goes on:

> For mum, it was very much all her fault ... [she] would ... never take any credit for things that went well. Like, if I achieved something, it wasn’t that she’d been a good parent, it was that I was a good kid. Whereas, if my brother did something bad ... she’d failed as a parent.

Similarly, Isobel says that her mother “actually blamed herself enormously” for what was happening with her brother. She says her mother said, “he had a really difficult birth ... and she said that’s why I have always had to compensate or look after [him]”.

Gina says, “my mother has never forgiven herself” and thinks she was the cause of her brother’s addiction to heroin during a parental split when her brother was 13 or 14 years old. Gina says her parents:

> Got back together again to try ... my brother and I were both allowed to really be pretty wild ... and I don’t know if our parents were aware of what we were doing all the time.
Gina acknowledges the parents were distracted; however, she says, “There comes a point where you’ve got to ... take responsibility”. Gina also says, “I’m cross with him that he never really did that [took responsibility]”.

Connie recalls how her father blamed himself for her brother’s death. She says for her father, “it was so disappointing ... for him, losing a son, blaming himself, what have I done wrong?”. Connie says, “I knew it wasn’t his fault ... I was sad for him ... a horrible thing to happen and you start looking at what you’ve done wrong”.

Parents blaming themselves and being blamed for their child’s drug use and death, especially when it is drug-related, is not uncommon. Although Gina makes an interesting point, children make their own decisions independently of the parents, particularly once the child is an adult.

**Family organising after the death of the sibling**

When a family member dies, it affects everyone in the family – the family is never the same again. Many of the people I spoke with said that their family changed. Helen says her brother’s death and his absence “changes the dynamic of the family ... someone is missing”. Amy says that about her brothers, “we’ve always been quite tight but I think that has all increased since our brother died”. She has also noticed a difference with her parents as well, “they are much more ... like family is number one ... and it’s much more important all getting together ... as much as we can”. Similar to Helen, Amy reflects that “the death of a sibling ... changes the whole dynamic in the whole family”.

Jacqui says after her little sister died, “the whole family just fell apart” and “everything turned to shit, everything turned to shit”. She goes on to say that relationships have been repaired:

That’s part of the past and he’s packed that away and I’ve packed that away, and we just continue on ... they [family] were so angry with me was because I walked away.
As those in my study said, the dynamics of the family change – there is someone missing – and for some families, distance in relationships is needed until what sounds like a ‘resetting’ can happen.

**Talking and understanding in the family**

Lilibet says in her family “we don’t talk about” her brother’s death by suicide. She says her eldest sister would say in response to Lilibet’s questions, “you don’t need to know ... it shuts you out”. Lilibet tried to talk others in the family about her brother’s death, unsuccessfully. She says:

> I don’t really know ... what happened, other than bits and pieces that I have gleaned over the years. There wasn’t a sit-down family talk ... this is what we all know, this is what happened ... it was ... let’s just organise the funeral and let’s have the wake and ... thank you everybody, wish them all goodbye. It’s like that performance is over, stage door shut, off you go.

She says that one of her girlfriends was also good friends with her brother and “said that ... before he died ... he’d said to her that he found it really hard to cope with the rejection from my parents”. She says, “so then when this young woman [he proposed to] rejected him, it was too much for him”. Lilibet’s parents discarded this idea, “my dad will tell you that their [parenting] behaviour had nothing to do with his suicide. He’d borrowed money to buy a car ... and he was worried he wouldn’t be able to pay it off”.

For Lilibet, “the lack of acknowledgement” of her understanding by her parents is upsetting because her parents’ story doesn’t make sense and, as a family because they were not able to talk together to create a story that makes sense of her brother’s death. Lilibet finishes by saying, “I would accept my girlfriend’s record of discussion ... it makes sense about why he died, you know”. She also says, “I will go to my grave believing that he couldn’t cope with the rejection”.

Similarly, but for different reasons, is Krissie’s experience of not being able to talk about her brother’s death. At the age of 13 years Krissie wanted to talk about and understand her
brother’s death but her parents thought it best not to talk about it. The lack of information made it hard for Krissie to understand how her eldest brother, who was:

Our invincible protector ... how did he die? How does that work? It’s just not possible. You know, he was almost like a God to us ... he can’t die, it doesn’t happen that way.

For Helen’s older sister, talking about their brother is different again. Helen says about her older sister, “she just finds it harder to talk about”. She says her sister:

Came to visit a couple of years ago and I said, ‘how are you feeling about it [their brother’s death] these days?’ and she said, ‘I just feel ripped off ... he should be here with us’ ... and if he comes up, she will just go, ‘the fucking idiot’.

Helen is also aware that “my siblings have different stories about how we remembered it. I think we all differ with the same ending”.

Some people in my study also talked about finding out more about their sibling after they died. Sometimes, the news challenged ideas about how they knew their sibling. For example, Krissie’s family discovered after her brother died that he had a child. She says his daughter “does have his last name, so she shares a last name with me as well ... it was like, oh, maybe he wasn’t so great. He had a child that he’d never introduced to us”.

For others there is almost a quest on behalf of the family to understand more. Krystal’s brother left a diary that the family read:

I wasn’t the first one to read it ... you read it and it’s amazing ... and he wrote some lovely things about his family in there ... we kind of needed to read ... it also talked a bit more about things that we didn’t know about ... I guess, [it] filled out the narrative that we didn’t know about.

Others talk about their sibling often within the family. For example, Gina says, “mum and I talk about my brother. There’s a few people that remember him, some of my friends, so I can talk to them about him”. Similarly, Helen describes herself as:
The one that talks about it most … I put up something on Facebook about Overdose Awareness Day on the first of August … and I said to my younger sister that I did that … she went, ‘okay, just as long as you didn’t tag me or mention my name’.

What comes through in these conversations with people in my study is how important it is to develop an understanding and make some sense of what happened for their sibling. How understanding is achieved is different, depending on the family culture. Some people in my study were able to talk within the family; others achieved understanding by accessing different information sources. Others talk outside the family of origin as a way of giving meaning to their sibling’s death – remembering, honouring or remaining connected with their sibling. They can also talk to their own children about their sibling.

Sibling’s story is known to nieces and nephews for educational purposes
Some people I interviewed talk to their children about their sibling as a means of talking about broader drug-taking issues. Jacqui says her own children know what happened to her sister, she says:

They know she was murdered and they know she was an IV drug user, which I think has actually allowed them to open up the dialogue on what drugs are and … they are very, very, very anti-drugs.

Similarly, Tony says his children both “know his brother died of drugs and my daughter … was a little evangelist”. Tony goes on:

One real benefit has been my brother’s example to my kids. I can use it positively to influence them to not end up in the same place … there is a fantastic book called The Slight Edge … it talks about how every day you make small decisions which will either have a cumulative positive effect or a cumulative negative effect. As young teenagers, my small decision was to go and hit a hockey ball against the fence as opposed to going and shooting up smack. And those decisions led us two [brothers] to different points that were so far divergent it’s ridiculous.
For Jacqui and Tony, talking about their sibling with their children allows them to convey messages about the negative consequences of drug use. These are educative talks that also give meaning to their sibling’s death.

**Family response after death – new**

In this section I present the new commonalities within this topic which were at times quite surprising to hear about and I found yet again my horizon expanded as my field of vision was extended and my understanding grew. The new commonalities were the changing roles in the family, maintaining relationships with the sibling’s children, similarities in own children can cause worry or reassurance and the ongoing sibling relationship.

**Changing roles in the family**

When someone dies in the family, the roles they occupied essentially become vacant. This is not a new concept to me. However, how their sibling’s role was described by people in my study was new. Some of the people in my study talked about how their own role in the family changed when their sibling died. Amy says her role changed after brother died; she says, “he was always the wildest one, and now I’m the wildest one … that sucks … it’s better having someone really a little bit wilder than you, I reckon”.

Similarly, Krissie reflects on role changes in her family after her eldest brother died. She says her second oldest brother:

> Sort of took on that role of being the big brother … he was supporting my dad … he still does now. He really took that in his stride and became that older, protective brother, whereas he used to be the sort of fun, naughty one.

Some people in my study also talked about their sibling as a rock or a linchpin for the family. Vera says after her eldest sister’s funeral, “the whole family changed. We never were the same. We never got on the same … she was kind of a rock, even in her situation”. When I asked for more detail around what a ‘rock’ is, Vera said a rock deals “with all that crap … all the responsibility”.

Similarly, Sally says after her brother died:
I realised ... the significance of my brother within the family, and what he contributed ... when you've got someone who has a mental health or a drug and alcohol issue...there’s so much about the looking after of them, and not so much what they contributed to the family ... which I realised in hindsight. So, it really affected me when my brother died because I hadn’t realised that he was actually the linchpin of the family ... in terms of the closeness of everybody because he was such a warm, open person.

Again, the change in dynamic and the fact that someone is missing means the sibling’s role in the family is no longer filled, so others need to take on that role, albeit in a different way. It is also refreshing in a way to notice that siblings who engage in drug use occupy significant roles, such as being a ‘rock’ or the ‘linchpin’, in the family because this is not how they are often portrayed.

**Maintain relationships with the sibling’s children**

When the sibling dies, one way of maintaining connection with them is through their children. Many in my study emphasised the significance of these relationships. Gina describes the relationship with her nephew and sister-in-law as, “a very important connection. I think it’s a very important connection for all of us”. Similarly, Amy says, “we, as a family, are massively close to her brother’s daughter and mother”. She says, “that’s one of the things that we got, [is our] niece”.

Alice also talks about going out of her way to stay in contact with her brother’s daughter. She says her niece:

> was interested in knowing what my brother was like from the time he was born to around his teenage years ... I could fill her in with the stories about him.

Jacqui talks about wanting to raise her niece; “my husband and I asked for her because my niece had some significant developmental delays” but Jacqui’s mother would not give her up.
It was important to Jacqui that she tried to intervene. Karen also talks about her relationship with her niece, saying:

I have really good relationship with my niece, she used to stay with me every second school holidays for a couple of weeks. And that used to happen when my brother was still alive and ... we’ve always been really close.

The relationship with the sibling’s children is important before and after death. I wonder if this is because the niece or nephew represents the sibling, they are a part of the sibling and that ongoing connection is important. I also wonder if it is something to do with being able to do something practical for the sibling’s child when perhaps there was nothing you could do for the sibling.

**Similarities in own children can cause worry or reassurance**

Family resemblances between family members intergenerationally are not uncommon. In this commonality, what was unexpected was how these resemblances might link to their sibling’s drug use and death. Krystal says her son and her brother look similar, noting,

Their sense of humour is very similar ... and I had to be careful because my emotions about him [brother] sometimes get mixed up with the emotions I feel about my older son, and they sort of merge a bit ... I have to go, ‘this is my son, he’s a different person, let it go’ ... so I guess I’ve just got this fear ... I don’t want to lose him [my son] like mum lost my brother.

Gina voices her concern about her son, saying, “he just doesn’t seem to have much direction at the moment”. She says, “you know, and it’s funny, I said to my mum the other day, there’s times when my son’s jokes remind me so much of my brother ... you never met him, but somehow you’ve actually got this sense of humour like him”. She reflects on her son’s pot use and says:

I just do worry ... I don’t think he’d ever go any further with it, but ... I want him to find his direction in life.
Gina went on to reflect that while there are aspects of her son that are similar to her brother, he is a different person. Janet also comments that her eldest son is like her brother “because he’s very sensitive and I can see a lot of similarities there”. She goes on:

So that does worry me. But I think it will be okay ... I’ve put in a big effort to make sure he tells me everything...I feel like I know everything about him. I probably don’t, but I feel like I know a lot about what he thinks.

Janet says that as a parent, “I do worry about my own kids ... because it’s a reality that people can die young, and I do worry a lot about my kids”.

Isobel says that sometimes her son looks like her brother, she says:

Occasionally, I see a look and that scares me. And, yes, I mean it’s quite natural that there is a family resemblance, whether it is just that shock, or if you look a bit like him, then you might be a bit like him.

Isobel clarified the concerns about her son, saying, “It’s more the genetic thing that frightens me – Is there a genetic predisposition in our family?” She says, “you do wonder about if he did have bipolar, that’s hereditary type thing ... should I be looking for signs of that? Is he going to be more inclined to take drugs?”. She goes on:

I look for signs in my son constantly ... is he going to take drugs, has he got any mental illness?

Then there were some people in my study who almost drew comfort from similarities between their children and sibling. Judy says her son is similar in looks to her brother so much so that “other people have commented” on the resemblance.

Karen is similar to Judy, saying, “my eldest son is very like my brother, just in nature and the way he is in life”.

As I reflect, I understand that life is never quite the same when your sibling dies. Death becomes an absolute reality; it is no longer something that happens to others.
in my study drew attention to the notion that life is tentative and, flowing from that understanding, that others you love, such as your children, could also die. It makes sense that the resemblance to the sibling could leave some in my study with a disconcerting or niggling worry about their child. Whereas, for others, noticing that their children have similarities with their sibling can serve as an ongoing connection to that relationship.

The ongoing sibling relationship

Many of the people I interviewed spoke of the significance of their sibling and the sibling relationship in their life. Karen reflects on sibling relationships; she says:

I am very close to my kids ... but they will never be as open and honest with me as they are with themselves ... I think that’s what it is with siblings, you might not like things about one another but there is something intrinsic in your relationship that there’s a closeness that nobody understands you better than your siblings. So, to cherish it while you have [it] ... I imagined my brother being around in my life now ... you just never know what is around the corner.

Connie says that she has talked to her children about her brother:

Over the years. You remember something we did together ... the fun stuff ... he was a real ... imaginative kind of brother ... and now ... my daughters have never met him, but I’ll tell them things we did together ... 20 years later, it’s a good memory of my childhood with him.

Similarly, Helen clarifies her children do not know the details of her brother’s death, yet she has said to them, “he took something he thought would make him feel better, but it didn’t, and he got very sick and died from it”. She also says, “they know of my brother” because:

I tell them silly stories of when he used to tease me when I was little ... fart a lot and tell bad jokes ... and my nine-year-old son thinks that’s hilarious ... my son will do something and ... [I] say, ‘Is uncle whispering to you? because he used to do things like that?’ And he would go, ‘yeah, he’s telling me to be naughty’.
Childhood stories focus on memories when the sibling was living, and the relationship enjoyed. It means the sibling continues to be known and a part of the family. The sibling relationship is maintained and cherished.

**Discussion on family response to death**

In this section, numerous interrelated responses to death in the family are discussed. Parents blaming themselves for the sibling’s death was considered in depth, along with shame and guilt. The discussion then shifted to focus on how a sibling’s death disrupts family order – what is known – especially roles and birth order, and how a sense of normalcy/organisation eventually returns with the recognition that someone is always missing. The capacity for talk about the sibling’s death within the family was explored thoroughly. Initially, the discussion considers talking or not talking inside the family – the benefits and the strain – and what affects talking in the family, including the sociocultural doctrine of closure. From there, the discussion cycles back to look at changes in identity and roles and how identity reconstruction occurs through finding meaning in the story of the sibling’s death and life together. Other ways of maintaining the connection with the sibling are also detailed in the context of the next generation. The mediating factors and importance of relationships with nieces and nephews are explored, as are the secondary losses experienced when these relationships are not possible. Finally, the concern expressed by people in my study about their own children being similar to their sibling is analysed. In this context, the link between bereavement and trauma, and bereavement being medicalised, are investigated, arriving at the point where the visceral experience of their sibling’s death is readily accessible and protective, that is, a normal parental response.

Becoming a parent means assuming responsibility for the wellbeing of a child. When something goes wrong with that child, it is the parent’s responsibility to intervene, whether this is soothing/reassuring the child or obtaining other assistance. In *Not My Family, Never My Child*, a book about drug use in the family, Trimmingham (2009) notes that many people initially want to help their child and know how to fix the drug use. If parents are unable to protect or fix the situation for the child, it is not uncommon for parents to blame themselves. Buckle and Fleming (2011) identified parental guilt and self-blame arises for numerous reasons, including the “feeling of having failed to protect their children” (p. 57).
In my study, Kathryn empathises with her mother, saying, “it must be incredibly difficult for a parent to ... not be able to do anything”. As discussed in the previous chapter, many parents already feel the stigma of their child’s drug use; they feel judged, blamed and responsible, and yet they usually are at a loss about what to do or how to intervene. This backdrop can already be in place before a child dies for a drug-related reason, and will be compounded by their death, especially knowing their death was preventable (Trimingham, 2009). As Walter and Ford (2018) say, “it is normal to make judgements of others and for those judgements to be based on assumptions and stereotypes. At no time in the life course are we more prone to make judgements than at the end of life” (p. 85).

In the thanatology field, more intense, prolonged or severe grief reactions are associated with self-blame, shame and guilt, making these worthy topics for investigation (Duncan & Cacciatore, 2015). How each state is defined varies depending on the research, with the majority of research focused on the parent-child relationship. Garstang et al. (2016) identify four different categories of blame relating to parents: self-blame, blaming others, feeling blamed, and blaming no-one; they found mothers predominantly blamed themselves for their child’s death. Duncan and Cacciatore (2015) conjecture that guilt and shame are precursors to self-blame and go on to define “guilt is a negative evaluation of behaviour, and shame is a negative evaluation of the global self” (p. 314). They contend that bereaved mothers experience more guilt and shame, whereas guilt and shame are more problematic for fathers. In my study, Connie recounts her father’s guilt response after her brother died and how difficult that was for her to witness. In Duncan and Cacciatore’s (2015) study, almost half of the participants experienced self-blame when the child died but this reduced to around a quarter over time. Slightly different again is the Stroebe et al. (2014) study where they define self-blame and regret as components of guilt. In discerning self-blame and regret, they define bereavement-regret as a perception that things could have been done differently in the relationship and self-blame more about self-responsibility for the death. Further, they state, “there is no significant decline in average levels of self-blame or regret over the two-year period” (Stroebe et al., 2014, p. 5). Based on these studies, when their child dies many parents respond with self-blame, guilt and regret, just as Connie’s and Gina’s parents did in my study, putting these parents at risk of a prolonged grief reaction.
However, an insightful point was made by Garstang et al. (2016) who investigated SIDS deaths which could have been mitigated by different parental behaviour. They suggested that perhaps self-blame stops the death being a random unexplained event and brings with it a sense of order, making the situation easier to live with in some way (Garstang et al., 2016). From this perspective, self-blame may have helped Gina’s and Isobel’s mothers to make sense of what had happened to their children.

Sibling death brings a struggle to find meaning in death and life, in the midst of emotional turmoil and disrupted family structure and systems (Funk et al., 2018). What happens individually and, in the family, becomes a melting pot of emotion and uncertainty, threatening the family’s sense of security. Bereaved brothers and sisters can be affected by the rawness of their parents’ grief and their years at school can be cut short (Fletcher et al., 2013). However, after the disruption of established family routines and habits that previously provided comfort, security and connection, there can also be growth and change in relationships with others, a better sense of self and a more purposeful life philosophy (Mayer et al., 2013). Mayer et al. (2013) contend that no-one can prepare themselves for, nor comprehend, the magnitude or intensity experienced when a family member dies. In a sense, the ‘knowingness’ that was the family, is no longer; the family environment is thrown into disarray. As Funk et al. (2018) state, the “death of a sibling disrupts roles and relationships between parents and children” (p. 1). They noticed people in their study invariably began their narrative with a predeath context, in that they described their own identity development in relation to the sibling and how the sibling functioned in the family (Funk et al., 2018). This is the situation for Sally and Vera in my study. Both identify their older siblings as the family ‘linchpin’ or ‘rock’ and described how their siblings’ role functioned in the family. The predeath context is the back story, if you like; it highlights the disruption and distress experienced when their sibling dies (Funk et al., 2018).

The birth order of children, as discussed previously, shapes family relationships and roles, yet changes the instant their sibling dies (Funk et al., 2018). This is reinforced by Mayer et al. (2013) study where “all participants commented that their lives were forever changed in the
instant when their family member died” (p. 170). The significance of change – in the instant – is not lost on Joan Didion whose powerful words after her husband’s death capture the experience: “Life changes fast. Life changes in the instant. The ordinary instant. You sit down to dinner and life as you know it ends” (Didion, 2006, p. 3). Mayer et al. (2013) explored sudden death in families, finding unexpected death brings radical changes in roles and tasks of living family members. Brothers and sisters can move from the position of second child to the eldest child or the only child; such changes can generate feelings of sadness, frustration and confusion (Funk et al., 2018). In my study, Krissie described her second brother moving into the big brother role when her eldest brother died, saying, “he really took that in his stride and became the older, protective brother”.

Bussolari and Horsley (2017) present a case study to explore issues of sibling bereavement. They note that when Barbara’s brother was murdered, she was the only remaining child in the family and was now expected to endure the brunt of her parents’ grief and take care of her parents into the future by herself (Bussolari & Horsley, 2017). This was like Krystal and Stan in my study, both of whom became the only child after their brothers died. Elizabeth DeVita-Raeburn (2017) expresses a similar sentiment as the only sibling of the ‘boy in the bubble’. She says he had been ‘centre stage’ in the family for so long that when he died and the spotlight turned to her, she felt pressure and obligation to live extra well (DeVita-Raeburn, 2017). DeVita-Raeburn (2017) also says when her older brother died, she lost her leader. New roles, new routines, new recreational activities and missing the role of the sibling who died (as Sally in my study described), are all examples depicting the disruption and distress experienced in a family when their sibling dies (Mayer et al., 2013).

The people in Funk et al. (2018) study said that it “took several years for any type of normalcy to return to family gatherings” (p. 9). Similarly, in their study, Mayer et al. (2013) identify themes related to family bereavement, such as “life goes on … but never back to normal” (p. 170). As Helen in my study explained, her brother’s death changed the dynamics of her family because someone was ‘missing’ and it could never be the same again. With sibling death, there is a shift in the family dynamics – systems and roles are all changed; the world as it was, is no longer, and must be relearned (Bussolari & Horsley, 2017). Ellis (2002)
captures the sentiment well; she says, “I’m going back to the town of my childhood, but not back to childhood innocence. That dissolved when my brother died. Returning home was never the same after that. My mother will not be able to soothe my pain; she can’t handle her own” (p. 389).

Grief pain can affect the ability for the family to be together and talk. Marshall (2017) says some families cannot talk because it hurts too much and do not want to make others in the family cry. As can be seen in the research of others, and in mine, talking is not always something that happens in bereaved families, as described by Krissie and Lilibet. Both Helen and Amy describe the talking difficulties in their families for similar reasons. Sometimes, the sibling’s name may not be mentioned by parents or others in the family, as in Lilibet’s family (Bussolari & Horsley, 2017). Often too, family members may hide their grief to protect others in the family (Funk et al., 2018). Sims Franklin (2017) relates words written by her 16-year-old self about her family’s approach to bereavement after her brother died, saying they tried to protect one another from the depths of their individual pain. She goes on to say that she “didn’t want to burden” her parents with her grief (Sims Franklin, 2017, p. 39). Bussolari and Horsley (2017) conjecture that the inability to talk within the family places strain on relationships, which captures Lilibet’s experience with her family. For Lilibet, her brother’s death by suicide was a taboo subject in the family. Lilibet was sanctioned by her parents and siblings for bringing up her brother’s death. The inability to talk in the family resulted in divergent stories of understanding developing about her brother’s death which for Lilibet created more distance in family relationships.

Further, while the benefits of talking are often espoused by the helping professions, this approach is not necessarily matched by more dominant messages existing in the broader sociocultural context. Families are vulnerable to sociocultural influences, including social narratives which exert pressure and actively discourage people from talking about their bereavement experiences (Mayer et al., 2013). Berns (2011) contends that the public talk around ‘closure’ has framed grief as something that needs to end. She says closure is marketed as desirable and good, sold as the end goal that we must all seek and move on from as soon as possible (Berns, 2011). Beike and Wirth-Beaumont (2005) begin their report
stating that Americans often talk about needing ‘closure’ after problematic events and contend that psychological closure, where the end state is to remember an event without emotional arousal, is a desirable adaptive state. However, Berns (2011) argues that closure is not a term used by the bereaved or traumatised. Paxton (2014) says of his own bereavement, “I will never move on from the loss, but I can learn to live with it” (p. 166). Kirkpatrick (2017) uses the phrase “a state of loving grief” to describe grief that does not end. He says loving grief keeps his brother alive; “the dead depend on the living. Our love for each other keeps us both alive” (Kirkpatrick, 2017, p. 125). Ellis (1993) observes when editing her own written work about her brother’s death years earlier that “in spite of my agony, my interaction with this text enriches my life by making available to me emotional intensity. Through feeling the pain of loss, I also feel the attachment to my brother and to my family” (Ellis, 1993, p. 727). The term closure “thrives in popular culture, politics and marketing” and is very much a part of the vernacular, shaping how emotions are experienced and expressed in different social contexts, in that people manage their emotions by looking and feeling the way they think they are meant to look and feel (Berns, 2011). In a similar way, Klass (2007) agrees (albeit from a slightly different angle) and argues that grief is an interpersonal process where traditional communities supplied mourning rituals to be accomplished; thus, prescribing the inner experience for the bereaved. Neimeyer et al. (2014) also draw attention to the more social aspects of bereavement such as negotiating changes and transitions both within family and community, and performing grief as socially prescribed; although, they note while some conform, others resist such influences. What is apparent here is that at a sociocultural level, there are at least two different messages about bereavement. One is about the benefits and desirability of closure – finishing with – and the other is about – continuing with – by talking about and staying connected to, the person who died. These messages are conflicting and perplexing for bereaved family members in terms of how to be (individually and within the family) and what to expect when interacting with others in different sociocultural contexts.

Closure seems to be more about the public social self, whereas continuing the bonds is about the private personal self. Mayer et al. (2013) state, “sharing stories of loss and grief are often socially unacceptable”; however, they found that people were grateful for the
opportunity to talk in their study. Niemeyer et al. (2014) go a step further, actively encouraging bereaved people to talk about their experiences because it helps with meaning reconstruction. They contend that we ‘story’ events by structuring our experiences with beginnings, middles and ends (Niemeyer et al., 2014). Mayer et al. (2013) also commented on this phenomenon in their research stating, “participants consistently structured the death story in a temporal fashion, including a clear beginning, middle and ending” (p. 170). People in my research did the same. Hektke and Winslade (2017) agree to an extent, they contend that “generating meaning about someone’s life begins in the past” when the person was alive, but they do not limit the story to only being chronologically ordered (p. 197). Their work with the bereaved in based on a fluid notion of time where the relationship with the person who has died flows from the past into the present and moves on to the future (Hedkte & Winslade, 2017). They contend that the past continues to influence the present, as does the future, because there is a flow between these three domains of time. This means a person’s life may “accumulate new ways in which it might matter that were not available at the time the person was alive” (Hedkte & Winslade, 2017, p. 157). It is by beginning with the past, when the person was alive, that aspects of the person who died can become a part of the bereaved person’s present and future identity (Hedkte & Winslade, 2017). As Moules et al. (2004) note, “death does not mean the end of a relationship” (p. 104).

Niemeyer et al. (2014) state that having a sense of identity is a narrative achievement. Talking about bereavement helps to process the story of loss and understand what the loss means in our life. On the first point, Balk et al. (2017) agree, saying that determining the meaning of the loss is an adaptive task of grieving. Valentine (2007) also concurs, eloquently describing how people bring their “loved one’s dying moments” into sharp focus and construct a sense of self in interaction with the other so the moment of death becomes pivotal in “continuing social presence of those who have died in the lives of those they leave behind” (p. 234). Again, Ellis (1993) described the details of the last time she saw her brother saying, “he hugged me like he didn’t want to let go. I don't know when I'll be back. Expect me when you see me, he said” (p. 718). The story of last moments together speaks of connection and relationships, but also emphasises the impact and meaning of death. When
experiencing a profound loss, there is a threat to our sense of “continuity between life we had and the life we face now” and, by accessing the “back story of the relationship”, it is possible to “construct a durable continuing bond” with the person who died (Neimeyer et al., 2014, p. 489). Godfrey (2017) exemplifies this point by saying that even though her brother died 25 years ago, she has not lived without her brother as he “is still a constant presence in my life” (p. 95). Similarly, Ellis (1993) says by writing about her brother, he remains a part of her world. Hence, continuing the bonds theory concerns not only finding ways to stay connected with the person who died, but also the continuity of our identity (Berns, 2011).

Paxton (2014) identifies the various ways people maintain connection with the person who died. He contends that telling stories about the person who died is one way to stay connected; other ways include birthday celebrations, conversations with the person who died, looking at photos, playing music or wearing their clothes. With a slightly different focus, social worker Berzoff (2011) describes her experience of meaning reconstruction following her sister’s death. She went on to specialise in palliative care which gave new meaning to her bereavement, reshaping herself and her identity. Similarly, Planer (2017), when newly bereaved, wrote letters to her sister and later moved on to become a grief counsellor. Berzoff (2011) transformed her unbearable grief into something that contributed to the social context in which her sister’s death occurred and, in doing so, maintained the relationship with her sister. As Berzoff (2011) says, by working in palliative care, she did not have to relinquish ties with her sister. She goes on to capture meaning reconstruction and continuing the bonds well, saying:

We maintain internal and interpersonal relationships with those who have died because this brings comfort, solace, and new changes in ourselves as well as in our view of the other. In healthy mourning, continuing bonds afford us access to our memories while offering the opportunity to create new kinds of relationships with those who live in the name of those who died. In the process, our self-image changes and our image of the other changes. When someone dies, the mourner’s self is never the same self that it was before the loss (Berzoff, 2011, p. 267).
In this context, Berzoff (2011) describes bereavement as multidimensional in nature. Neimeyer et al. (2014) concur, reiterating that at a personal level, the bereaved endeavour to find meaning in the person’s death, reconstruct the self in relation to the person who died and maintain bonds.

Nadeau (2002) describes grief as a family affair, with family members interacting to make sense, and attach meaning to the death of a family member. For this reason and others, talking is promoted and encouraged as a helpful pursuit in fields such as drug and alcohol, family therapy and thanatology. Funk et al. (2018) advise that some families strengthen their relationships by sharing (talking about) their grief. Certainly, maintaining relationships with the sibling’s children and talking about their sibling with their own children is another means of remaining connected and creating meaning. Many of the people in my study discussed this aspect of the sibling relationship. In an interesting article, Langer and Ribarich (2007) discuss ideas of socialisation within the family and the past history of the kin relationships, as determinants of relationship expectations within the family. They contend that some aunts and uncles play a “special role in the life of a sibling’s child. They are among the first adults the children meet other than parents and grandparents ... they are generally free of the responsibilities of raising the child” (Langer & Ribarich, 2007, p. 76). Similarly, although the research focus was totally different, is the study by Tanskanen and Danielsbacka (2017) on the investment by Finnish aunts and uncles in their sibling’s children. They found that maternal aunts invest more than uncles; if the aunt/uncle was childless, they also invest more, and higher levels of emotional closeness with their sibling also increased the frequency of contact with their nieces or nephews. These findings relate to my research as seen by Karen’s experience. She had an emotionally close relationship with her brother and has maintained a close relationship with her niece. In a sense, Karen’s niece experienced a childhood where she was surrounded by a supportive family network which was maintained even though her father died. This point is elaborated by Langer and Ribarich (2007) who identity family networks as a source of support that develops over time as “family structures change through death or less significant changes” (p. 78). Past kin relationships and expectations evidently shape ongoing family relationships. As Jacqui says, she was keen to look after her niece when her sister died but was shut out by her mother.
This pattern of interaction was familiar and had occurred in the past between Jacqui and her mother. Amy describes her family as close, and those connections have been maintained with her sister-in-law and niece after her brother’s death. Alice talks about going out of her way to stay in contact with her niece. Alice was motivated to also “fill her [niece] with the stories about him [her brother]”. In this way, Alice maintains a connection with her brother for herself and her niece, as well as fulfilling family expectations around kin relationships.

Some of the people in my study also discussed worries they have for their own children who have similarities with their sibling who died. The similarities described concerned looks, facial expressions, characteristics or behaviours. My response to these expressed concerns was, “well, this makes perfect sense”. Curiously, literature searches on the topic yielded no results. The only article even remotely linked was by Planer (2017) who wrote that she named her son after her sister, attributes him with similar qualities as her sister and teaches him values her sister had. I was perplexed about the lack of information, so I turned to critically assessing my own thinking for prejudices on the topic. What makes me think this makes perfect sense? I think that similarities in some way trigger a response. The word ‘trigger’ takes me to trauma theory.

For the people in my study, the pain associated with their sibling’s death and the fact that their family was changed irrevocably in an instant, was palpable. These ideas are captured by Janoff-Bullman (1992) who describes the experience of trauma as an assault against ideas (assumptions) that the world is benevolent and meaningful, and the self is worthy. In a similar way, Johnson (2005) defines trauma occurring:

> When a person is confronted with a threat to the physical integrity of self or another ... trauma nearly always involved a sense of loss. It is the moment when we can see the world shift and turn, understanding that neither we nor the world will ever be the same, once we have been so wounded, we are faced with our own vulnerability in an irrevocable and palpable way (p. 14).

Lehrner and Yehuda (2018) find in their studies on intergenerational trauma experienced by Holocaust survivors, that it is not the exposure to the trauma but the level of coping and
distress that is key. Along similar lines, Solomon and Rando (2014) contend that, “when the loss is triggered, anguish, pain, and difficulties in adaptation result. The loss can be so distressing that other memory networks with positive memories of the loved one cannot be accessed, experienced, and felt” (p. 120). In this article, the focus is again on coping with the trauma experienced rather than the trauma per se. Based on this literature, it follows that memories/thoughts/emotions experienced as a result of their sibling’s death can be readily triggered by a similar look or characteristic shared by their sibling and child. When their sibling died, death became a reality, not just for their sibling but for everyone they love as well. As Krystal says, “I don’t want to lose him [my son] like mum lost my brother” and this reality is scary. What is triggered is the deeply distressing experience of their sibling’s death. Death is a reality. The visceral meaning of this reality is readily accessible and highly protective. Gina, Janet and Isobel say they are aware of their reactions and watchful of their children, ready to intervene if needed. As Janet says, “I’ve put in a big effort” with her children.

This discussion has woven through the interrelated responses to death a family may have, ranging from parents blaming themselves, to the upheaval of the family’s order, through to talking or not talking and the external influences such as closure. At times a family member’s identity within the family may be redefined, and an ongoing relationship with the sibling is established through finding meaning in their life, talking about them with the next generation, having relationships with their children. The discussion concludes by normalising the fear that arises, when next generation exhibit similar characteristics of the sibling who died, as a protective response.

Summary of family horizon
This chapter has been exceedingly challenging to write. There are so many interwoven aspects of family life, different theories and experiences both personal, and for those people contributing to my study. Analysing the interview transcripts from the family horizon has been a process of constant questioning, *Is that new to me? Is that a prejudice I have in my horizon? How can I organise the information so it can be analysed?* I should note that the final decisions, while arbitrary (in that I have to stop somewhere), a) do also have a good fit with the overall aims of my research, b) capture well the experiences of the people with
whom I spoke, and c) interpretively, add value to this field of practice. Many a time the commonality was not necessarily ‘new’, but there was a newness in the depth of understanding derived by interpreting the interviews. In this summary I focus on the common aspects that have expanded my horizon and, therefore, my understanding of the experience of sibling relationships within the broader family context with a backdrop of the sibling’s drug use and sibling bereavement.

There are layers upon layers of rules, roles, responsibilities and relationships forming the delicate latticework of family culture. The position a person occupies in the family shapes relationships, roles and experiences within the family and with one another. Many younger brother or sisters in my study held their older siblings, regardless of drug use, in high esteem. These older siblings were on a pedestal, as heroes and protectors, who made younger family members feel loved and safe. When the older sibling did not deliver in their role, then disappointment ensued until they acceded to the pedestal again.

The eldest brother or sister often paves the way for younger siblings. They can feel responsible for encouraging, fixing, protecting, teaching and helping younger siblings and, if in their own eyes they fail in performing this role adequately, then they will likely experience guilt, frustration and regret.

When someone dies in the family, the roles that they occupied essentially become vacant. Some of the people in my study had to take up these vacant roles when their sibling died. Others became aware of previously unacknowledged roles their sibling had occupied, especially the ‘rock’ or ‘linchpin’ role which held the family together. As Sally says about her brother, “there was so much about the looking after him that I hadn’t realised, that he was actually the linchpin of the family”. Highlighting this fact is important because people who use drugs are not often seen in this light.

Closeness or distance in sibling relationships was fascinating to analyse, bringing multiple new layers to my understanding of this concept. Some compared and contrasted relationships within the family, for example, between sibling and parents, or other siblings.
Others qualified and compared closeness and distance based on life stage, that is, in childhood, relationships may have been closer but became more distant in adult life. Distance was also put into relationships through choice and as a means of protection for the people in my study, for example, when their siblings were too wild or unsafe to be around.

Along with closeness and distance are notions of boundaries within and around families. Closed systems protect the family from outside influences and allow what goes on in families to remain private – thus protecting family reputation – but it also means that those outside the family cannot see in. Sometimes a family will close ranks to be a strong family. At the other extreme, when family boundaries are too open, the family is permeable and unsafe.

Closeness and distance in relationships, closed and open family systems, are connected with talking inside and outside of the family. Each of these dichotomies exist on a continuum with movement between the two, and layer together, to form the family culture – how the family do their business. The position on the continuum for each dichotomous pair is determined by the specifics of the circumstances (for example, drug type), family rules and relationships within the family. For example, usually siblings will share a lot more information on topics like drug use between themselves but not with their parents. In Krystal’s family, her brother did not talk about his heroin use inside the family but once the family were aware, they closed ranks around him in a protective manner, but didn’t share this information outside the family. Other families may respond in a similar way, but strain arises in relationships because they are in unchartered territory, existing in a perpetual state of watchful worriedness.

The ‘not talking’ in some families was described as ‘burying their heads in the sand’ by people in my study. Again, there are layers upon layers that make up the family culture. In this situation, with none or a limited capacity to talk in the family, the eldest who has the responsibility of helping the younger sibling may be thwarted, experience a painful futility and need to put distance into relationships. As Carl says, “I felt kind of helpless too, I still regret that I didn’t do anything”. For Isobel, not being able to talk about her sibling’s drug
use within the family was confounding. She likened the unpredictability, strain and conflict within the family as “living in a volcano”. Other families had to deal with unpredictable behaviours – such as when the “dysfunctional girlfriends” materialised at family functions – requiring a certain agility when responding. At times too, disappointment would prevail in the relationship as the older sibling fell off the pedestal again. However, it is also possible that not talking about the drug use meant there was hope for change and relationships could be maintained.

Another part of the family latticework lies in the role the parents have in setting the direction and providing the leadership to other family members. This leadership could be subtle or overt. Some took the lead and set the direction for the family to come together, accept and support the sibling, noting that some siblings therefore curtailed their drug-using behaviour when with the family. Inclusion in family events conveyed love, acceptance and support for their sibling. This approach empowered the brother or sister to take a position in relation to their sibling and the sibling’s drug use. As Tony said, “as much as I don’t condone it, I can’t condemn him for it ... you’re there to support them with their problem”. And Sally says she came “to the realisation that acceptance doesn’t mean approval ... I accepted that was his choice”. Still others – the younger children in my study – became parental helpers as distinct from parentified children. As Kathryn said, her role was to help her mother help her brother.

For others, when the drug use was ignored and not discussed by the parent in preference to maintaining relationships, the sibling would continue to be included in family events. The latter approach left some people in my study puzzled in hindsight by their own inaction, riddled with guilt and regret, arguing that their approach would be different if they had their time over.

When talking is not possible in the family, it may not be possible to create shared meaning around the sibling’s death. Without these shared meanings, further conflict and relational distance becomes possible.
Regardless of talking, relationships with the sibling’s children – the nieces or nephews – were important before and after the sibling’s death. So important that Jacqui wanted to raise her niece. For others, maintaining relationships with the nieces or nephews also featured as a means of maintaining the relationship with their sibling – telling childhood memories to bring the past into the present and keep the sibling alive. As Helen said of her own children, “they know of my brother”.

Then there are the concerns for the next generation. While some of the people in my study were reassured by the similarities their children had with their sibling, for others these similarities were a source of worry and fear because, as Isobel says, “if you remind me of him, you might be like him”. This leaves those concerned, watchful and wary and endeavouring to reassure themselves that “he is a different person”.

Family culture – how the family does its business – is multilayered and full of subtle interactions between roles, responsibilities, rules and boundaries. The intricacies of these factors meld with multiple relational interactions to form a rich and detailed overall experience of family life. Each family member can have a different experience of the same family, interpret and be shaped by family life differently. To achieve understanding means being open to hearing something new, something that challenges old ways of thinking. In the drug and alcohol field, talking and challenging drug use in the family is usually encouraged so as to intervene in the drug use but, when unsuccessful, this can place strain on family relationships. However, ignoring or making room for the drug use can mean there is a focus on other aspects of the relationship with the sibling which can actually bring hope and allow for relationships to be maintained.
Chapter 9: Pulling it all together

Introduction

It is impossible to conceptualise at the beginning of a doctoral research project how far the thesis tendrils will reach into your life. Getting to this outcome – the end of the research project – has been quite a trip. When I began, I had no idea this project would take so long, occupy every spare space in my brain and become such a central feature of my existence. And, because it has been huge, as I commence writing my ‘pulling it altogether’ chapter now, there is an anxious trepidation accompanied by excitement and a sense of wonderment about what life will be like when all is said and done – that’s me, ever questioning and reflecting, endlessly learning.

What informed the research

In the process of writing this thesis, I have had to think about my theoretical framework. I value reflective practice and consider it vital in research, professional practice and life in general. The utility of theory must also be underscored here as something to be valued, guiding what I do and how I do it. I believe it is through reflection that we learn, revise and refine our knowledge and understandings. I might learn about, and reflect on, a particular theory and, in turn, apply that theory to practice or, more broadly, to life; this knowledge will then inform my conversations with others. I will then reflect on, and learn from, those conversations with others, in essence co-constructing further understandings. For me, my beliefs around the utility of language and the inherent goodness and relatedness of all people in the world provide a solid platform to allow for multiple understandings of an experience to exist. Based on these beliefs, how I think knowledge and understanding arise and what I value, I already had a leaning towards qualitative research methodologies well before I began this research project. That said, through doing this research project, I am now better able to articulate the value and place of qualitative research and no longer see it as a defensive competitor to quantitative research.

As with most research projects, mine began with a kernel of an idea. I wanted to increase the knowledge around sibling bereavement. This idea already linked two areas of my practice in family therapy and bereavement. One of the goals of higher research degrees is
to contribute something new to the body of knowledge on a specific topic. With this in mind, I decided to augment the other practice area in which I have extensive experience – drug and alcohol. Simultaneously, I was already researching the available literature, and in doing so, identifying the deficits therein. Here I confess that in part the humble beginnings of this project were based around being indignant about the limitations in the bereavement literature.

It concerned me that most of the literature was primarily quantitative based (often critical and dismissive of qualitative works) and situated within a couple of years of the death event. There was not much literature available on families and bereavement, but even less on sibling bereavement and not much at all about death for a drug-related reason. I could not find a specific study that studied sibling bereavement when the brother or sister died for a drug-related reason. Later, during the course of my research, Valentine (2018) edited a publication outlining the results of a multi-person study on families bereaved by alcohol or drugs and some sibling voices were included in that book. However, at the inception of my project, there was no such publication.

At the end of the literature search, I was clear – the experience of sibling bereavement and drug use within the family context was an unexplored phenomenon. Accordingly, this research has two aims: to develop a rich understanding of the participants’ experiences of sibling bereavement when the brother or sister dies for a drug-related reason, and inform social work practice theories in bereavement, drug and alcohol use and families. The following broad research questions address the aims:

- What are the reflections on initial experiences and meanings of sibling bereavement and any changes to these experiences and meanings over time?
- What are the stories of connection to the sibling who died, family processes around meaning making and experiences of growth, hope and resilience?
- What are the bereavement experiences when the sibling’s death is drug-related, including the experience of living with drug use?
These questions determined the type of methodology to be used. As my questions were about experiences, it was clear my study would be phenomenologically based. The next question was which philosopher should underpin my project. Gadamer’s contention that the researcher brings their subjective self to the research and cannot be separated (bracketed) was appealing. This is consistent with how I think knowledge and understanding develops, and my beliefs. As well, his position on scientific method was that it is – a special case of knowing – complementing other ways of knowing, also drew me in (Hekman, 1983).

The conditions of scientific method often make retrospective studies a dubious pursuit. Gadamer’s philosophy makes room for recalling past experiences, recognising these are not static objects of study; rather, phenomena that continue to be reinterpreted as time passes. For Gadamer, there is not one understanding, one meaning or one truth in the human and social sciences – multiple truths and meanings are possible for different people but also the same person over time. Understandings are broad because the process of knowing, finding truths and meaning is iterative and circular, as per the hermeneutic circle. Hence, seeking out people who had significant distance from their sibling’s death and talking about their memories and experiences was well within the realms of a hermeneutic study. This decision led me down a path that could not have been anticipated. A phenomenological study seeks to describe, as accurately as possible, the experience of those studied. Hermeneutic phenomenology which evolved into Gadamer’s philosophical hermeneutics means, in essence, interpreting experience which requires active involvement of the researcher in the interpretative processes. Gadamer’s philosophy emphasises equally, understanding the phenomenon and simultaneously the phenomenology of understanding.

The depth of understanding garnered by reading and re-reading Gadamer’s (2004) magnum opus, interviews with him, his biography and later publications and critiques of his work, have followed a hermeneutic process. My initial rudimentary understanding of Gadamer’s work grew and deepened every time I read more. I am enamoured with Gadamer’s philosophical hermeneutics, so much so, it now infuses my very being. His philosophy around interpretation and the conditions of understanding draw attention to the ubiquity of language in understanding and meaning, and the role of the hermeneutic circle where the whole then informs our understanding of the part, and the part informs our understanding.
of the whole. Also, the notion that the word prejudice as neutral in meaning, and how
prejudices, historicity, traditions and situatedness all comprise our horizons and constantly
influence our interpretations and understandings. All these elements of Gadamer’s
philosophical hermeneutics are now fundamental to how I now think about being in the
world. His philosophy enriches my thinking, writing, work, and relationships with others.
Deepening my understandings of Gadamer’s particular brand of hermeneutics expanded the
‘understanding’ possibilities that could be derived from my research and, of course, guided
every research decision made.

The benchmark of good qualitative research work is that the methods and various research
decisions are consistent with the philosophy underpinning the research project (Fleming et
al., 2003). Moules et al. (2015) emphasise “research ought to have consistency between
philosophical assumptions, its conduct and the expression of its conclusions (p. 179). What
this meant for me was that Gadamer’s philosophy must be apparent in every process and
decision I made throughout this project. This task was not easy because Gadamer does not
provide a method per se – he wanted researchers to think deeply about their research and
be creative. Therefore, for me, a key at this point was that the conditions of understanding
and the hermeneutic circle would have to be maintained throughout the project.

A phenomenological study is focused on the experience with information usually gained by
interviewing people. When undertaking human research, ethics approval is necessary. One
part of applying for ethics approval is to outline the recruitment strategy and inclusion
criteria. The literature review informed the inclusion criteria for my study as follows: people
would be over the age of 18 years; English speaking; not be affected by a cognitive or
intellectual disability or mentally illness; have experienced death of a sibling five years or
more ago; and describe their sibling’s death as drug-related. While I defined the term drug
as incorporating all psychoactive substances that depress, stimulate or cause hallucinations
– therefore including alcohol – I was not prescriptive in defining ‘drug-related’. In fact, I was
interested in hearing what this term meant to those who contributed to my study; the terms
they used were drug overdose, drug poisoning, accidental overdose, drug-related illness,
drug-assisted suicide and homicide.
What do I now know?

At this point I want to cycle back to the aims and questions of the research, as the project was designed with these in mind. In a sense, this goes to the primacy of dialogue and the structure of question and answer, when understanding subject matter (Gadamer, 1975/2004). According to Gadamer (1975/2004), I came to the research with questions and these questions have a horizon, which is already comprised of my prejudices, situatedness, traditions and historicity. When I ask questions, it “means to bring into the open” (Gadamer, 1975/2004, p. 357). While the question is about something I want to know (that I know, I do not know), I am holding myself open, but the question is also limited by the horizon of the question. Thus, there is both an openness and a limitation to my questions. Therefore, I have to be aware of the horizon of the question (as much as possible) and open to the undetermined possibilities that an answer to the question may bring. Hence, “understanding is always more than merely re-creating someone else’s meaning. Questioning opens up the possibilities of meaning and thus what is meaningful passes into the one’s own thinking on the subject” (Gadamer, 1975/2004, p. 368).

In this section, I analyse the information collected in a slightly different manner. First, I work through the broad research questions and present the key points. A focus on each of the broad research questions provides a slightly different view of interpretation because the standpoint is different. I present these understandings as a means of honouring the participants’ contributions to the study, recognising that some of these broader questions took them to a difficult experience in their lives. I then go back to the three subject matters and look at the overlaps between the subjects as follows: bereavement and drug and alcohol, bereavement in the family context and drug and alcohol in the family context and summarise the key points. I then consider the nexus point where all three subjects overlap and present those key interpretations. Below, I treat each research question separately, beginning with the first question focused on the initial experience of bereavement.
What did the participants say about their reflections on initial experiences and meanings of sibling bereavement and any changes to these experiences and meanings over time?

The people I interviewed reflected on their initial experiences of learning about their sibling’s death. For some, their memories were fuzzy but, for others, these memories were crystal clear; there may have been a sense of disbelief, relief or physical sensations at the time of death. Many had pleasant, detailed memories of the last interaction with their sibling, but disturbing recollections about the awfulness of their sibling’s death which they said also hindered their bereavement experiences. Another part of the initial experience concerned rituals around death, such as viewing their sibling’s body, putting items in the coffin, deciding who could attend the funeral, and later scattering the ashes. Some also talked about troubled family relationships around the time of the funeral. Soon after a person’s death is a busy time, with innumerable duties, all of which people in my study attended to in varying degrees, such as identifying the body, informing others of the sibling’s death (for example, parents), clearing out apartments, representing the family in statements to the police, advocating for parents, organising the funeral and presenting the eulogies.

Some in my study also provided very detailed accounts of their grief experiences, including the pain of their grief being likened to losing a limb, feeling unsafe in the world and their ways of coping. They recalled incredibly insensitive moments with others and also cherished moments of kindness, neither to be forgotten. Sometimes they reflected on their regrets. They shared their views on grief as something to be lived with, accepting the sadness would be remain with them but was not something to be indulged in.

Many also talked about the changes over time in themselves and others. For example, some talked about changing jobs after their sibling died because the workplace had a statute of limitations on how long grief could affect your work. There were many meaningful changes; some noticed an increase in their empathy for others and a lack of tolerance for life’s trivialities, and a change in perspective; therefore, no longer taking things for granted or they developed a more honed sense of responsibly for their relationships with others. In order to create meaning, some later participated in the system (for example, mental health) to bring about change within the system for others.
Despite these profound grief experiences and life changes, all talked about the magnitude of their parent’s grief as being much more than their own. So elevated was their parent’s grief, that people in my study took on various duties to help or protect their parents. Next, I look at the key points around maintaining connection to the sibling and meanings made from their sibling’s death.

What did the participants say about: stories of connection to the sibling who died, family processes around meaning making and experiences of growth, hope and resilience?

The notion around an ongoing connection with their sibling was evident when people talked about thinking about their sibling, often at particular times, even though their sibling may have died more than 30 years ago. Some talked about having a sense of their siblings’ presence or seeing their sibling everywhere, especially soon after their death. Everyone talked about their memories and everyone had mementos, notably clothing. Relationships with the sibling were maintained by telling stories of the sibling to their own children, an uncle or aunt, so the sibling continues to have a presence and is known by the next generation. For some too, similarities between their children and their sibling were either experienced as disconcerting or reassuring.

Family processes around meaning making in the family were talked about, but not as much as I had anticipated. However, I heard about parents blaming themselves, how the family had to reorganise after the sibling’s death and the recognition of the roles the sibling played in the family, for example, being the linchpin. Around the time of death, some people talked about needing to know more and actively deciding what to tell others about their sibling’s death. These fed into a story of understanding the sibling, their life and their death. For many, openly talking within the family was not a part of family culture, and therefore, there may have been no or limited talking about the sibling’s drug use, the sibling’s death or the meaning of the sibling’s death for various members of the family. Family structure is relevant here as well, shaping family life in terms of closeness and distance in relationships, family boundaries and the rules about talking inside and outside the family – as are the sibling’s personal characteristics oft described as rebellious and wild and/or gentle. These
processes, roles in the family, reorganising, knowing more, talking in the family and other
aspects of family culture and structure all shaped the meaning that people I spoke to made
in relation to their sibling’s death.

Many talked about changes in their family after their sibling died because of the notion that
‘someone is always missing’ and the overall family sadness, which was ongoing. For the
siblings I spoke to, the sadness around what could have been with extended family was
upsetting and, if the sibling had had children, it made these children even more important. A
protective approach was often taken towards nieces and nephews during the sibling’s drug
use and after death, and often again these relationships were intentionally maintained.

Implicit in the discussions with people in my study was a sense of resilience and hope,
although this is not something that was discussed explicitly. For example, many
reflected on the meaning they took from their sibling’s death, such as, being grateful in life, career
choices or what sort of parent they were to their children. When I endeavoured to enquire
more explicitly around experiences of growth, hope and resilience, these questions were
not well received and perhaps even seemed offensive in the context of the interview. It felt
as though I was pushing my own agenda and changed the direction of the conversation. In
the planning of the research project, I had hoped to finish interviews on a positive note, but
I abandoned questions of this nature early on, relegating them as unhelpful, preferring
instead to allow the conversation to unfold and come to a natural conclusion as I listened
carefully to the person because, invariably, I would hear something along the lines of hope,
resilience and growth anyway. Next, I consider the third question relating to the sibling’s
drug use.

What did the participants say about their: bereavement experiences when the sibling’s death is drug-
related, including the experience of living with drug use?
I begin with the experience of living with the sibling’s drug use. Many attributed their
sibling’s drug use to childhood experiences, such as, family life and/or the environment and
friends. Some said their sibling made a choice because they ‘loved drugs’, whereas many
said their sibling was not an addict, more a recreational drug user. People in my study
discussed things they noticed about their sibling when they did not necessarily know about
the drug use or the extent of the drug use, such as, leaving school early, having money
issues, variable work and living arrangements. They described their sibling as unreliable and
talked about finding evidence of drug use, for example, a tarnished teaspoon. Some in my
study did not know about their sibling’s drug use until after their sibling’s death. Others
knew about some drug use but not all of the drugs used, while others used drugs together
and even described drug use by siblings as contagious. Many talked about secrets between
siblings and the secretiveness of drug use more generally.

Interestingly, the sibling was described as leading a double life and being a part of a dark
and scary drug world. Often, the longer the drug use, the more likely some or all of the
following would become apparent: tangible evidence of drug use and/or lapsing, mental
health issues, suicidality, overdose, criminality, sex work, children removed from care and
relationships with partners and/or a peer group who also used drugs. Interventions in the
drug use were surprisingly mixed and again probably reflective of the longevity of the drug
use. For some, there were no services involved or more general services like a doctor or
counsellor, whereas many accessed drug-specific interventions repeatedly.

People in my study talked about a range of responses to their sibling’s drug use. Frequently,
there was family tension and stress surrounding the sibling’s drug use and associated
behaviours. All in my study attempted to help the sibling. Some responded with a sense of
helplessness, inability to cope and withdrawal; after death, this response would generate
guilt and regret. Others talked about the endless worry. Still others found a way to connect
with, accept, and continue to have a relationship with their sibling.

When the sibling died for a drug-related reason, their cause of death can, and often did,
define the sibling in a negative way and, through association, the family. Many talked
explicitly, and others more implicitly, about the stigma around drug use. This was
particularly evident in what information was shared even years later about how their sibling
died. In the next part of this section, I slice through the information collected, slightly
differently again, by returning to the three subject matters.
Subject overlaps
What became apparent during the analysis phase of the project was that I had collected information on three subject areas. This meant that some people I interviewed focused on death and bereavement, others discussed their sibling’s drug and alcohol use, while others spoke more of the sibling relationship. Interpretation is always informed by different standpoints as “the subject presents different aspects of itself” (Gadamer, 1975/2004, p. 285). Collecting information on three discrete subject matters made possible three different interpretations of each interview transcript.

The utility of contemplating each interview transcript from a different subject matter and listening from that horizon showed places of overlap between drug and alcohol, families and bereavement, presenting many new insights for me. Next, I present the subject overlaps between bereavement and drug and alcohol, bereavement in the family context, and drug and alcohol in the family context.

Bereavement and drug use
When I look at the overlap of bereavement when death is drug-related, many people described a sense of relief, such as, “he was out of misery” and/or regret experienced when their sibling died. This speaks to how unwell some siblings had become. Many also talked about the worry, distress, tension, the sense of “living in a volcano” (where things are likely to erupt at any moment) and not knowing what to expect next. In an exasperated way too, one person was clear that it was not okay to make choices to use drugs – “look at the effect on your family” and “your life is not your own” – a sibling has relationship responsibilities to other family members including their own children.

Some drug-related deaths were just awful, for example, dying from an overdose and not being found for a couple of days in an Australian summer and then the relatives not being able to view the sibling’s body or being able to view the body and not being able to unsee what was seen – memorable in the worse possible way. People I spoke to did not want “junkie skanks” at the funeral and, therefore, made decisions about who could attend, with the aim of protecting other family members. Deciding whether to tell others about the cause of the death is not usually a consideration for other types of death but it is when the
death is drug-related. Many had a protective response to judgements from others about their family, parents, sibling and themselves and, therefore, explicitly said they would not talk about the cause of death if they talked about their sibling at all.

Stigma is primarily shaped by legal status of the drug used and the method of use also features, hence, injecting heroin is probably the most stigmatised drug. Stigma and secretiveness surround the drug use because it is illegal. Hence, there could be less stigma associated with death from alcohol, although there might be embarrassment associated with being with the person when they look dishevelled. Similarly, parents may feel embarrassed telling others that their child is using drugs. The stigma silences people from talking about what it is like having a sibling who uses drugs when the sibling is alive and these ongoing judgements, associated with how the sibling died, are experienced as another type of silencing. One person in my study said people are “ignorant” about drug use and another claims, “he wasn’t just a junkie to us”. So silenced are they that there can be no celebration of the sibling’s life and that silencing can reinforce the stigma. If drug use was legal and treated as a health issue, the embarrassment, stigma, secretiveness and silencing would dissipate. The situation would be different and, as one person in my study said, it is possible that their sibling may still be alive.

One person in my study quietly challenges the silencing stigma and in her own way brings about change by working in the health system and ensuring “that families are included” in client treatment. Another person – Kathryn – refused to have a pseudonym for the study and deliberately challenging the stigma by disclosing her brother’s drug use, saying not to do so in her mind means the “person’s life is sort of denigrated by the virtue of how they died, it totally overlooks who they were”.

**Death of sibling and family context**

By looking at the sibling’s death in the family context, it is possible to get a sense of how the sibling’s bereavement is subjugated by parental bereavement. One person in my study was told by a family friend to “look after your parents”. The unintended consequence of this message is that it has the effect of silencing and deprioritising the sibling’s bereavement. The bereavement is disenfranchised, that is, it is not socially recognised as much as the
parent’s bereavement. The social expectations add to the experience where “you’ve got to get on with it, life’s got to keep going on”. Here, sibling bereavement is socially recognised but only for a limited time and social expectations dictate “people aren’t allowed to just wallow in grief”. There is another component here shaping the sibling’s experience and these factors seem to come more from within the person, for example, “parents get the attention at such times [death of a child] because they are the ones feeling the greater loss”. This could be read as these people think their emotions are unjustified.

Yet they also clearly expressed the magnitude of their grief experience. The deep sorrow felt, the pain of grief – “my heart was wide open and exposed”. Others talked about allowing the sadness in and not wanting it to go, because it keeps the sibling present – “I am glad I am still sad about him too. It’s interesting, it’s sort of, like, I feel like there is a little piece of him in my heart”. The significance and enduring nature of the sibling relationship is evident by how frequently they think of their sibling and by the mementos people had, for example, the sibling’s photo “beside my bed” 15 years after his brother died, and “I still wear his trackie pants” 17 years after her brother died.

Despite the evident gravity of the experience, the parent’s bereavement is prioritised and, therefore, the people in my study stepped in and did things such as organised the funeral – “mum was a mess” – or automatically did the eulogy – “I am the eldest and my parents couldn’t do it”. They looked after their parents because “obviously, you’re more devastated for your parents, that’s what you’re thinking about most of the time, thinking what are they going through?”; thus, they protected their upset parents by sheltering them from “nasty surprise” when clearing the sibling’s room, advocating for parents by being “the person who spoke for mum”, acting as a buffer between parents because “all you see in the other person is that child, the key to that relationship” or doing the parent’s bidding by clearing out the sibling’s apartment when “we were crying, and I remember thinking this is way too early. But none of us were going to say no”. Such deep empathic responses showed care and love, placing second their own bereavement in order to look after and protect the parents who are no longer “the same, because they lost their child”.

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There is also a need to know more about the sibling and their death, especially when there is little talking in the family context and/or parts of the sibling’s life were secret/separate from the family. This information was obtained by reading coronial reports and attending the coronial hearing, consulting doctors/counsellors and talking to friends and reading the sibling’s diary.

There are realisations and numerous secondary losses after the sibling died, such as recognising the pivotal role the sibling played in the family – “she was kind of a rock” – or – “the linchpin of the family ... in terms of the closeness of everybody because he was such a warm, open person”. There is a sadness in the family but “siblings put on a brave face for the parents” and “we try not to talk about all the sad stuff, because you know, if there is anything worse that being sad yourself, it’s seeing people you love sad”. This is the unsettling nature of sibling bereavement because they become the only child and no longer having a sibling with whom to check childhood memories. The impact on their own children – “it’s just not having that naughty uncle around, that’s the bit I’ve grieved the most” – and the loss of the extended family – “I’m not only grieving that past of having a sibling, but the future of not having a sibling and grieving the fact that my children don’t have an uncle and they’re not going to have cousins, and we don’t have that family, you know, when it’s just ... five of us, whereas it could have been so much more”. These can also be considered secondary losses flowing from the central grief of the sibling dying.

The sibling’s death “was life changing”, it permeates and pops up in unexpected ways. When the sibling had children, these nieces and nephews can become “a very important connection” because they don’t have the sibling but “that’s one of the things that we got, [our] niece” and it is important to maintain a “good relationship with my niece ... we’ve always been really close”. When their own children look like or have similar characteristics as their sibling, this can be reassuring but it can also bring fear. The fact that their sibling died makes death a reality; the meaning of the sibling’s death transfers to their own children with messages such as, “I will say [to my children], don’t take this for granted ... because you don’t know when something will stop, or something will change, and things change in a flash ... so it’s about being ... grateful too”. Some parented very intentionally
because of what happened with the sibling. Therefore, they may parent their own children differently to their sibling by “being the parent he wasn’t able to be” and others parent differently to other parents – “I feel like I know everything about him. I probably don’t, but I feel like I know a lot about what he thinks, and what he’s doing at school, and I think it’s a lot more than what other parents would know their kids are doing”. Many also talk to their children about their sibling’s death to “positively to influence them to not end up in the same place”. Consequently, their own children can take an anti-drug position. These messages, ways of parenting and connection with the sibling’s children give meaning to the sibling’s life.

**Drug use and family**

When I look at overlaps between the drug use and the sibling relationship in the family context, the importance of the sibling relationship is evident. The idea of the sibling living in two worlds is both enlightening and useful. The sibling has their family world and their drug-using world. In family, the sibling often behaved and/or protected their family from the full extent of their drug use – “I never saw him out of control”. Being able to be included and participate in family life functioned in some way to help the sibling maintain the sense of belonging in the family, a different identity, some hope of change or comfort. And while the family were protected from the full knowledge or extent of the drug use, jokes could be had about the sibling being unreliable and the siblings could even use drugs together.

However, the inevitable would happen and there were times when there would be confronting clashes between the drug-using world and family life. People talked about “walking in on him shooting up in the bathroom”, the disappointment with being sidelined in favour of drug-using associates and “dysfunctional junkie girlfriends that would materialise at family events”, and then there was the endless worry. Clashes also came through lack of access to, and a sense of missing out on, the parents, because the parent’s attention is on the sibling. Certainly, clashes between family life and the drug-using world led in some cases to family tension focused on the sibling’s drug use and associated behaviours. The drug-using world is “a dark, dark world”, unfamiliar and distinct from the family, and its unfamiliarity probably perpetuates the fear for the sibling and the endless worry. The sibling was described as “Jekyll and Hyde” leading “a double life”.

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How the drug use was experienced is multilayered and influenced by many factors in the family, including the parental alliance and what role the person I spoke to occupied in the family. For example, the eldest child felt more responsible for their sibling’s drug use, particularly if they had first introduced the sibling to drugs. These older siblings also found it was hard to be with their sibling because there was an inability to affect change, and a sense of hopelessness or guilt ensued. The struggle of not being able to help their sibling meant that sometimes the older one withdrew from the relationship or had to find another way to be with their sibling. Being younger in the family meant the older sibling who used drugs may still have occupied more of a hero role, although, periodic disappointment could still be experienced when the two worlds clashed.

Other aspects of family life also influence the approach to the sibling, including closeness and distance in relationships, family boundaries – that is, how open or closed the family is to outside influences – and rules inside the family about who and what can be discussed outside the family. Drug use in a family can cause distance in relationships, and boundaries can become more closed as the family becomes more private, especially if they are feeling judged or embarrassed by the drug use. Talking outside the family and talking inside the family can stop, sometimes functioning to keep hope alive or reduce the overall conflict and tension in the household. The difficulty about not sharing what is happening is that family members find it hard to know what to do to help and it is very difficult to understand what is happening. It also means that when the sibling died, a shared meaning of their death was not possible; therefore, different stories can emerge, which can also cause conflict and/or distance in relationships.

The parents set the family approach to the sibling, determining whether the sibling continued to be included in family events or they ignore the drug use and not talk about it and/or to continue helping the sibling. Some could not do much for the sibling directly, so they helped the parent help the sibling or they helped the sibling’s children. Everyone in my study recalled numerous attempts by the family to help the sibling.
For the people in my study who found a way to continue being with, and including the sibling in family events, there was a “realisation that acceptance doesn’t mean approval”. This approach removes the drug use from being a problem, something to be fixed; in a way, it leaves the drug use with the person and means other parts of the sibling can have the spotlight, “so it wasn’t that he was completely off his face 24/7. He still had the essence of himself”. It doesn’t mean there will not be clashes with the drug world; it means that these can be laughed about and shared, for example, remembering “walking around town when he was strung out on speed … that’s just what it was and that was my brother, you know, the funniness and the craziness ... just the wildness”.

_The nexus: family, drug use and bereavement_

I had thought there would be one nexus, that is, the intersection of family, drug and alcohol, and bereavement. However, there was not one nexus and now I realise I was naïve to think there would be; instead, I know now there are multiple ways to understand. Therefore, I will finish by looking at the nexus by drawing on the enlightening, often jolting, statements made by people in my study.

In this next part, I make no excuse for meandering backwards and forwards between the sibling relationship and the family, and drug use and bereavement, because the siblings contributing to my study experienced all of these things in varying degrees. I have considered each commonality separately and that has been useful for the purposes of deepening an understanding. However, when this depth of understanding is applied back to the whole of the experience for the people who generously contributed to my research, a more expanded view from the sibling horizon is evident.

For this last section, I begin with the story of my grandfather’s funeral, where nobody spoke of my grandfather as I knew him. My grandfather was a round man with a round face, woolly grey hair and bifocals perched on the end of his nose. He was a smiley man but not cuddly or warm. I knew he was an only child. In fact, until I was nine years old, I knew his father as well – my great-grandfather – a cartoonist who played an ancient push-pedal organ that he allowed me to also play. I knew my grandfather liked a drink and could get quite raucous at times. He never played games or spoke to me as if I was a child, even when
I was young. I would say he was interested in me but was not very grandfatherly; he was not someone I went to for comfort. As a child, my family spent countless hours with him in small twin-engine planes flying to country towns, followed often by driving vast distances on dusty dirt tracks in the back of a Landcruiser looking at things – farmland, trees or animals – and meeting farming folk and their children in remote rural settings. I did know he was a professor of botany, worked at a university and travelled a lot for his work. He brought me dolls and coins from all over the world and probably inspired my desire and love for travel. This sums up some of the key ways I knew him. At his funeral, I heard about other ways of knowing my grandfather. His children (my aunts and uncles) spoke of their relationships and childhood memories of him, affectionately and respectfully. His colleagues spoke about him with great admiration regarding his achievements and the fact that he had discovered and named a eucalypt after himself. I realised I learnt more about my grandfather at his funeral than I had in my whole lifetime. This was probably because he had lived a whole lifetime before I was born. This memory is now 27 years old, yet it has stayed with me because I was struck by the different ways there are to know a person; while all that other information about my grandfather was fascinating, I just knew him as my grandfather, not some rogue aerial botanist dedicated to his work, often to the exclusion of his family. I mention this story because it reminds me that there are always different ways to know another person, depending on when and where our paths cross. How I will know another person will be determined by my horizons at the time and, therefore, my situatedness, prejudices, traditions, historicity and the understandings shared at the time.

This research is focused on sibling experiences. The sibling relationship begins in the family; therefore, I have come to realise that before looking further afield, the initial focus needs to be with the family and developing an understanding of the family’s culture. This is especially true because drug use and death in families are considered family affairs (Trimmingham, 2009; Nadeau, 2001a). There are peculiarities with every family that are useful to understand, that is, how the family does its business. Each family is different; there are rules, roles, responsibilities and subsystems all governing aspects such as how close family members are, how open the family is, and their ability to talk to one another, together and outside the family. Family culture shapes what family members can do and how they do it.
within the family, for example, as stated earlier, circumstances may influence who is talking – about what – in the family, and relationships in the family will circumscribe who can talk to whom and about what; for example, siblings may share a lot of information between themselves than with their parents. Both drug use and death in a family will also have disruptive effects on the family culture, challenging some rules, for example, keeping secrets might change (Petronio, 2010) and family roles and tasks can also change (Mayer et al., 2013). For example, some people in my study became an ‘only child’ (Funk et al., 2018). However, what remains clear is that family culture is usually well established before the drug use and/or bereavement occurs and, therefore, will influence who, what, when, where and how the family members respond.

Relating the story of my grandfather’s funeral is relevant in that it tells me there are different ways to know people. When a drug and alcohol clinician meets a person (the sibling), their view of the sibling will be very different to how the family knows them. They will only know the sibling because of their drug use, at a particular point in the sibling’s life and drug use; therefore, their primary view of the sibling is through a drug and alcohol horizon. I contend that even when a drug and alcohol service’s focus is on families, it remains from the drug and alcohol horizon and, therefore, is usually trying to educate families and in some ways change how the family responds to the sibling. In a sense, this is a one-dimensional view. Adding the view from the family horizon could allow for numerous other aspects of family culture and ways that the sibling is known in the family, to enrich any work with the families, which could be helpful in the drug and alcohol field.

Interestingly, some families did not give the sibling’s drug use as much attention as they did to other ways of knowing the sibling. The focus seemed to be more on the relationships, the role the sibling had in the family and their participation in the family. For example, parents would ignore the drug use in order to have the sibling around. Further, the way in which the sibling was known with the family, the roles and expectations of the sibling, could also influence the sibling’s behaviour in a positive way. Many people in my study said their sibling behaved as expected at family events and the family tolerated things such as not being able to contact the sibling and/or them “nodding off on the couch”. In Schafer’s
(2011) study with people in drug rehabilitation, they “felt like they were ‘wearing masks’ in order to maintain their secret addiction”; this could also be read as they kept their drug use a secret in order to maintain their relationships with the family. By keeping the drug use a secret, the sibling conceals information that would impact on the family; therefore, the act of keeping a secret is protective (Orgad, 2015; Vangelisti et al., 2001). It also means the sibling continues to contribute to family life. In the longer term, this could be beneficial given most people ‘mature out’ of drug use (Schutte et al., 2006). When the dominant way the sibling is known in the family features, more fond sentiments like: he was a “likable fellow, so we always wanted him to be part of our lives”, rather than the negatives of drug use, then both family and sibling are able to retain relationships. The drug use could be secret or known, but it is not taking central stage and overriding the way the sibling is known in the family. For example, when Helen was packing up her brother’s apartment, she says, “we just laughed because it was like, fucking herbal tea, it’s like, he’s shooting up heroin, but oh, I’ll have some herbal tea to come down”. Her brother was well-groomed and many people did not know about his drug use. Sally says she “could access the essence of her brother independently of the drug use”. Tony explains his approach as, “I don’t condone it; I can’t condemn him for it … you’re there to support them with their problem”. Orford et al. (2010) identified the “putting up with it” approach as one of three approaches that families take to cope with drug use (p. 72). Importantly, the siblings in my study who managed to take this approach did not express regrets when their sibling died. This approach, when looking from the family horizon, protects family relationships, and when looking from a drug and alcohol horizon, ongoing family connections may well contribute to the notion of ‘maturing out’ of the drug use (Dawson et al., 2006).

The way the family knows the sibling is different to how the sibling is known elsewhere. There can be no doubt that seeing the sibling in the drug-using world can be experienced as frightening. It is a very different way of knowing their sibling – the “dark scary part of him that could take money and be secretive”. The confidence and comfort of knowing the sibling in the family context is confronted and challenged. It is disruptive for other family relationships, for example, there was tension at home, “it would be like living in a volcano … money would go missing from my wallet” or “someone would turn up at home, saying he
owed them lots of money”. At other times though, their sibling being in the drug-using world was more of an annoyance, for example, when peers who also used drugs appeared and the drug-using relationship was given priority – “you’d be planning to go for a walk or whatever and it would all be dissolved”. However, annoyances and disappointments in this instance were more likely to be forgiven in favour of maintaining the relationship; “we spoke every couple of days”.

What was interesting was that every person in my study talked about protective ways of being in their family, whether to protect themselves, their sibling, parents, or more broadly, their family as a whole. Many people in my study knew about their sibling’s drug use before their parents; therefore, they protected the sibling relationship by not disclosing the sibling’s secret to the parents. Not talking in the family about the drug use – ignoring the drug use – could be considered protective in that it prioritises the relationship with the sibling rather than the drug use, which means the sibling can continue with active family membership. I note this is probably only possible though while the sibling’s drug use is not too confronting and their behaviour is, more often than not, consistent with the ways of being in the family.

Many of the people contributing to my study were fiercely protective of their parents and family, when family life (culture) or the parents were blamed for their sibling’s drug use, saying things such as family upbringing and the parents had nothing to do with their sibling’s drug use. Their protectiveness is fanned by the knowledge that their parents already blame themselves. This type of approach from drug and alcohol services – family is the reason for drug use – is unhelpful as it alienates parents and family from the services that could provide assistance. When I look at this further, when only one child in the family is using drugs, it is curious how family has been targeted as the culprit. In my study, Tony exemplifies this, saying, “I have thought of my brother and myself, the same kids, in the same household, with the same parents, with the same environment but we made different choices and those different choices have ended up, way down the track, so divergent”.
Another way people in my study were protective of their parents was by prioritising their parent’s grief over their own (Marshall, 2013). As Karen says, “parents get the attention at such times [death of a child] because they are the ones feeling the greater loss”. However, I note this approach is couched in a society that has, to an extent, disenfranchised sibling bereavement. This is supported by DeVita’s (2004) observations that there are no sibling bereavement cards for sale in shops and Marshall and Winokuer’s (2017) conclusions that sibling bereavement as an overlooked experience and “society has no narrative for this loss” (p. 195). Levy’s (1984) work on hyper- and hypo-cognised emotions is helpful here as well. He contends that emotions are shaped by culture and, as such, language, which is used to describe different types of emotion and how to interpret, deal with and evaluate the emotion in a social context. The absence of a social narrative suggests that sibling bereavement is a hypo-cognised emotion; therefore, the experience might be explained as ‘losing a limb’ or feeling ‘lost’ and treated as something else, for example, a physical ailment rather than a deep sorrow (Levy, 1984). The upshot is, sibling bereavement is both a ‘less-than’ experience socially and, when being protective of their parents by prioritising the parent’s grief, then their bereavement is also a ‘less-than’ experience personally.

This less-than bereavement is added to by other losses, for example, the loss of a shared future and extended family for their children – it would “have been nice to have a brother with a wife and kids”. Loss of the family was akin to “the whole family fell apart” or “someone is missing”. The other major loss is the parents as they were, as Ellis (2002) writes in her autoethnography, “I’m going back to the town of my childhood, but not back to childhood innocence. That dissolved when my brother died. Returning home was never the same after that. My mother will not be able to soothe my pain; she can’t handle her own” (Ellis, 2002, p. 389).

Sometimes, being protective of parents led people in my study to undertake tasks relating to their sibling’s death, from identifying their sibling, organising the funeral, packing up the sibling’s belongings and negotiating autopsies, through to excluding “junkie skanks” from the funeral. This level of involvement is protective, but also speaks of the connection with
the sibling and desire to honour/participate/assist/help, especially if they were not able to make a difference during their sibling’s drug use.

Taking on a task such as packing up a sibling’s room was protective, but also a deeply intimate activity and speaks to the connection between siblings. The relationship with the sibling is often referred to as enduring. The sibling’s relationship originates in the family context often from birth order and is fundamental to identity formation; hence, remaining connected to siblings (even after death) is about knowing ourselves in the world (Attig, 2001). The depth of the sibling relationship is emphasised by the detailed memories of their last time together. Every person in my study had memories of their sibling, with many recounting details of their last time together. These memories invariably emphasised relationships, being together and hope. As Attig (2001) says:

> When we think of those who have died in our lives, we notice how an ongoing relationship with them in memory takes place alongside our other relationships. Their legacy in memory consists of their lifetimes, remembered moments, episodes, periods, and stories, none of which is canceled (sic) by death (p. 47).

Adding to the notion, the enduring relationship is a collection of memories which are not necessarily ordered chronologically but exist in a more fluid state, moving from the past to the present. As one person says, “I think about him quite a lot, especially with my own kids, because I think of what we did at that age. When you’ve got kids, you’re obviously linking it to when you were a kid”. By beginning with the past, when the person was alive, aspects of the sibling can become a part of the bereaved person’s present and future identity (Hedtke & Winslade, 2017).

Memories of their sibling’s death cannot be understated; awful images are conjured, that they prefer not to revisit and these memories also transport them to that time – with the full force of emotion – as if it happened yesterday. Their sibling’s death changed the world as they knew – “everything sort of went up and landed maybe slightly differently”. Their sibling’s death made death a reality and made drug use lethal. Many in my study did not expect their sibling to die, such as, “I thought he was invincible ... I never imagined life
without him”. DeVita-Raeburn (2004), sister of the ‘boy in the bubble’, shines a light here, saying her brother’s death was the “shock of the impossible” (p. 12) because there was a normalness to her brother’s illness. When the sibling dies, death is a reality – it can happen to anyone when you do not expect it. This shifts from their sibling to others, including their own children. As one person says, “I guess I’ve just got this fear ... I don’t want to lose him [my son] like mum lost my brother. Yeah, so it impacts the way I treat him”. Consequently, many talked about their sibling’s death influencing how they now parent their own children, where nothing is taken for granted.

I also emphasise that every person in my study wanted to help their sibling with drug use but did not necessarily know what to do. Many sought guidance and would have liked to know more; as one person says, “I think the system tends to overlook ... the family ... it would be more useful perhaps to see who else is around in that family to influence – not just the parents”. There is a message here for drug and alcohol services and policy makers.

Given the strong desire to both protect and help, being helpless must be agonising; this is borne out by those who did not find other ways to be with their sibling. After the death many of the people in my study said they regretted not remaining in contact with their sibling and not doing enough to help, urging other siblings in a similar situation now to “stay connected ... I should have stayed in touch”, “do what you feel is right”, “do as much as you can” because “you can’t help them when they’re dead”.

The final way to protect their sibling after death is to not allow their sibling’s life to be judged by how they died; as Kathryn says, a “person’s life is sort of denigrated by the virtue of how they died, it totally overlooks who they were”. Numerous people do not disclose the cause of their sibling’s death to others as a means of protecting their sibling and family from judgement and also protecting the memory of their sibling (Walter & Ford, 2018). For many in my study, although their sibling died for a drug-related reason, they said it was very important that I understand their sibling was not a drug addict – “he wasn’t a junkie”, he was a “recreational user”. The stigma, stereotypes and subsequent judgement from others about their sibling, themselves, their parents and family make sharing how their sibling died
simply too hard. In a sense it’s a double blow. Sibling bereavement is already considered
disenfranchised, that is, not acknowledged socially. As one person said, there was no
reading material that she could find on sibling bereavement. A sibling dying for a drug-
related reason is a type of death that is also described as disenfranchised because the death
is stigmatised and perceived as self-inflicted (Walter & Ford, 2017). As Jacqui says, “we
stigmatise the user and the families”. The sibling’s bereavement is further disenfranchised
by the way their sibling died, making options for support more limited socially. Bringing this
situation back to the family context where the person also considers their bereavement
less-than their parents personally, then this makes for a very solitary experience to be
endured.

In summary
What is apparent here is that when I look from one horizon, the view can be deep but
inevitably is also constrained and, more likely, in a sense, to be one dimensional. By looking
at the overlap of two horizons, it is possible to generate new insights and rich multilayered
understandings, which are grounded in the subtle intricacy and interconnectedness of
relationships. The only thing to add here is that further analysis – by slicing through the
transcripts in other ways using other horizons – would provide a different complexion again
and with further insights, as long as the conditions of understanding are maintained and the
hermeneutic circle is in play. Human experience is not simple, repeatable or truly reducible.
The phenomenon of understanding is an unrepeatable shared event that can only be
achieved by holding yourself open to hear something new, recognising that in the process
we project from a particular position informed by our historicity, traditions, situatedness
and, therefore, our prejudices, and we will only learn more if we are willing to risk what we
know, in order to know more, knowing that we can never know all there is to know.

Limitations of the study
This qualitative research project is underpinned by Gadamer’s philosophical hermeneutics
and, as such, is concerned with interpreting the experiences of people interviewed.
Interpretations are dependent on the questions being asked at a point in time, and I know
that with distance, that if I or someone else was to interpret these interviews again, other
understandings would come forward.
Gadamer (1975/2004) argues that there is not one correct interpretation, rather multiple interpretations of subject matter are always possible. This is the primary limitation of any research project guided by Gadamer’s philosophical hermeneutics, multiple interpretations are always possible. Hence, what is presented in the thesis are my interpretations situated in a particular point in time. As noted, (above) our horizons are not static and are continually changing when we are open to new experiences. Therefore, there is the potential for endless understandings because our understandings develop and our situatedness changes (Gadamer, 1975/2004). Given that endless understandings are possible, and there is never one right interpretation, I acknowledge that these interpretations are mine only at one point in time. However, by acknowledging this fact I also I embrace the idea that a variety of meaningful understandings are also possible. As Moules et al. (2015) contend that “the very thing that adds merit to this kind of research is that which restricts it” and that “hermeneutic research is sometimes constrained by its very openness that resists solid conclusions” (p. 180).

A secondary limitation is that it remains possible that other prejudices remain concealed from the interpretations presented. Gadamer (1975/2004) uses the term prejudice in a neutral literal manner, including both positive and negative values. In the act of understanding, we project from our prejudices, thereby testing them, opening the prejudices to revision in the context of the new experience. Gadamer (1975/2004) explains that to notice a prejudice, it must be provoked through questioning, then through acknowledgement, the prejudice is foregrounded and essentially suspended. It is only when we are unaware that the prejudices continue to influence interpretations. Gadamer contends that, even with reflection, we can never really know the entirety of our prejudices and cannot stand external to our own situation no matter how much reflection we do. However, he would also argue it is important to try to be open and continually question what supports our standpoint and interests, in doing so the horizon of understanding will expand (Gadamer, 1975/2004).

Having accepted that multiple interpretations are possible, I have implemented strategies to protect the integrity of the research project. I have meticulously maintained the ethical
standards required by HREC. Throughout all aspects of the project, I have worked towards achieving an internal coherency and consistency with Gadamer’s hermeneutics (Zaidi & Larsen, 2018; Crowther et al., 2017). In terms of analysing the interviews, I have been careful to ensure the interpretations make sense. To this end, I identified commonalities within the interviews, then critically reflected and questioned if each commonality makes sense in the context of the person’s bigger story, and repeated the same reflective process by then locating each commonality within the bigger context of all the stories (Laverty, 2003; Crist & Tanner, 2003). As much as possible I have endeavoured to ensure that Gadamer’s (1975/2004) conditions of understanding and the hermeneutic circle have been present in every interpretative activity, deliberately drawing on, and making explicit my own subjective forms of knowledge, as well as theoretical knowledge to deepen and expand understandings of the experiences. The combination of practice wisdom, rigorous reflectivity and theory are held with the words of the people interviewed to reach the interpretations presented. That these interpretations then make sense in the context of the broader project and the specific interviews, is exemplified by quotes offered in each findings chapter. The reader will make their own interpretations of the information presented, drawing on their own subjective knowledge, and decide if my interpretations are plausible, resonating with their own and the participants’ experiences.

As a qualitative project the research presented cannot be measured by criteria governing quantitative research projects. By its very nature a hermeneutic study is not generalisable, objective, or repeatable. Instead, the veracity of hermeneutic work lies in its truth value and the power of interpretations to “offer faithful and recognizable descriptions of the topic and ring ‘true’ to others (Moules et al., 2015, p. 174). Hence, the interpretations presented are potentially transferable to everyday practice, and add to the existing literature. This thesis lays bare that sibling bereavement when your brother or sister dies for a drug-related reason is an intricate experience, informing social workers in direct practice, and can be used as a springboard to further deepen understandings in practice and/or research. The explanatory power of the interpretations throughout the thesis make an important contribution to the existing literature in the fields of bereavement, drug and alcohol, and family work.
Recommendations

Arising from my research, I make seven recommendations. I address social workers in these recommendations because one of my aims is to further inform (broaden) social work practice theories; however, these recommendations are equally relevant to others working in the helping professions such as psychologists, psychotherapists, occupational therapists, mental health workers, drug and alcohol workers, other community welfare workers. These recommendations provide guidance for the social work profession as a whole encompassing educators, governance bodies, organisations and individual social workers as well as showing areas for further study. The recommendations are more broad than specific intentionally because implementation will be determined by context.

To ensure consistency with philosophical hermeneutics every recommendation emphasises the importance of understanding through listening carefully, reflecting on experiences and exploring together from different standpoints. Each recommendation begins with an italicised statement followed the recommendation and the reasoning for the recommendation arising from the research.

Recommendation 1

There are always multiple ways to understand a situation.

By looking at a situation from different standpoints, different understandings are possible, and therefore, different ways to support and/or act. Therefore, social workers should explore people’s situations from a range of subject matters until a way is found that is helpful to the those in front of us.

Reasoning for the recommendation

Gadamer tells us that our situatedness, historicity, traditions and prejudices all shape our horizon and how we view the subject matter. By analysing the interviews intentionally from three different horizons, it has been possible for very different views on the same experience to come forward, as the questions we ask from a particular horizon shape the answers we will receive. Essentially, when we shine a spotlight on the same experience at a different angle, different aspects of the experience are illuminated. Working in this manner provides deeper and multilayered understandings of the same experience. One view is not
necessarily better than the other – rather, this process keeps us nimble, open to hearing more, reflecting and willing to learn something new.

Recommendation 2

**Sibling bereavement is significant.**

As social workers are likely to hear about the death of a sibling they should explore and validate sibling bereavement. This is achieved by lingering in the experience and enquiring about the enduring nature of the relationship, any ongoing sadness, memories linking the past to the present, what tasks they may have undertaken on behalf of the family around the time of death, how they make sense of their sibling’s death and their own bereavement including protectiveness of parents, subsequent family changes and whole of family loss, the lack of a future with their sibling and other secondary losses.

Reasoning for the recommendation

For the people participating in my study, having their sibling die and experiencing the subsequent bereavement was an intense life-changing event that continued to stay with them. There were flow-on changes in their lives and within their families, with most feeling protective of their parents. One of the things that stuck with me during the recruitment phase of the project was when some health professionals suggested that I attempt to recruit people to the study by passing information to other helping professionals, because bereaved siblings often attend counselling for reasons other than the bereavement. I took the advice and drew more people to the study by advertising through the Australian Association of Social Workers.

Recommendation 3

**Sibling bereavement when death is drug-related is disenfranchised personally and socially.**

As social workers working with people (siblings) whose bereavement has been disenfranchised, social workers must validate, honour and provide opportunities for their experiences to be expressed for understanding and the meanings made to come to the fore.

Reasoning for the recommendation

Sibling bereavement, on its own, is described as a disenfranchised bereavement in that it is barely validated or supported socially. There is no narrative for the loss and there is limited
language to describe the hypo-cognised emotion in a social context, meaning the bereavement will usually be described as something else, for example, a physical ailment, and silenced. When sibling bereavement is coupled with a stigmatised death, which a drug-related death is, then this too is a disenfranchised bereavement equating to an invalidated experience that is not supported socially and, again, silenced. Hence, there are two ways that the sibling’s bereavement when their brother or sister dies for a drug related reason is disenfranchised socially. The sibling themselves, in my study, then prioritised their parents’ grief over their own; this further subjugated their bereavement as ‘less than’ on a personal level, a view that was then reinforced by their bereavement being disenfranchised socially in a circular manner.

**Recommendation 4**

*Drug use in the family can be stressful for siblings as well as other family members.*

*Social workers should ensure that siblings are given access to information and support so they can make informed decisions about their relationship with their brother or sister, and how to make sense of what is happening in their family.*

**Reasoning for the recommendation**

All the people in my study tried in different ways to assist their brothers or sisters before some withdrew from the relationship. The siblings in my study were neglected/overlooked by drug and alcohol services and the other services. The role of siblings needs attention by services as they are a potential resource.

**Recommendation 5**

*Family culture is significant and protective for people who use drugs.*

*Social workers should know the various ways the sibling who uses drugs is known in their family, how do they contribute, who are they close to, what is their role, who do they talk to? What does family membership mean to the family and the sibling? How confronting is the drug use for the family, how disruptive and how has the family been responding, what has been useful, what is tolerated, and how do we make sense of these responses given the family culture? Social workers should explore how protective ways-of-being occur in the family, such as protecting themselves, their brothers/sisters, parents or the entire family, and how do they protect the relationships, for example, siblings keeping confidences.*
value of emphasising family is to protect and strengthen family relationships, and to collaborate with the family where possible, as ongoing connections may contribute to the sibling ‘maturing out’ of the drug use.

Reasoning for the recommendation
We need to acknowledge that most people begin life in a family setting; family life shapes who we are in the world without us even realising. My study has been focused on bereavement and drug use. In the drug and alcohol field, this means extending the view from the isolated individual using drugs, at just one point in time of their life, back to their family; but not to take the alienating or blaming approach that the family is the reason for the drug use – which so many people in my study mentioned. We must seek to understand the family for the potential resource they are – they know the sibling intimately and are probably doing things for protective reasons. Drug use is a family affair, so the family need to be invited to collaborate with the sibling in a manner that is consistent with the family culture.

Recommendation 6
The sibling relationship and impact of drug use will in part be determined by the broader family culture.
Social workers should explore thoroughly options with people to promote new understandings including the idea that acceptance does not mean approval, that not condemning the sibling does not mean condoning the drug use, and actively explore the benefits of maintaining connection in the relationship within the existing family culture, mindful that each family culture has its own intricate idiosyncrasies.

Reasoning for the recommendation
Family life is multilayered, a rich tapestry of interwoven roles, positions, responsibilities, relationships and rules, determined by interactions, systems and boundaries within and outside the family, and changing in response to events and developmental life stages. There cannot be simple approaches to such complicated and unique family culture. We need to collaboratively work with siblings to help them understand family life. We can gently enquire about the family and how the sibling’s drug use manifests. For example, in my
research I heard that some siblings seemed to live in two worlds – the drug-using world and the family world – and the act of keeping these worlds separate meant the sibling relationship could be emphasised rather than the drug use, even though the inevitable clashes would occur and were difficult to endure. The key is that everyone in my study wanted and tried to be useful – to help – but some did not know how. One of the ways that some succeeded was by shining a spotlight on the relationship rather than the drug use. When the drug use is in the spotlight, it was tortuous for the siblings to endure because of their inability to affect change. I heard that the people who withdrew from the relationship then suffered terribly when their sibling died, ravaged by guilt and regret.

Recommendation 7

*There is a stigma around drug use, drug-related death and bereavement.*

*Social workers must challenge silences, secretiveness and stigma as oppressive practices that are self-reinforcing, negating the ability to speak and share experiences of drug use and bereavement, and access social supports.*

Reasoning for the recommendation

Drug use is judged negatively and stigmatised in our society. In my study I heard how negative aspersions, such as drug use is self-inflicted, can extend from the individual to siblings and the family as a whole. The legal status of a drug and method of drug use affects judgements, and can influence subsequent protectiveness, which can manifest as secretiveness and/or silencing. When someone dies for a drug-related reason, that person can be defined by their death, yet there is so much more to a person than their drug use. To prevent harsh judgements, people in my study did not routinely speak about their sibling’s death and, therefore, their bereavement – they grieve in silence, often without support.

The recommendations above, from a Gadamer’s philosophical hermeneutics, centre around language. They incorporate listening carefully, exploring, and looking at the same situation from different standpoints. In addition, striving to validate the experiences, and then establishing mutual understandings and meanings, prepares for the possibility to learn something new, thus expanding the horizon.
I think it fitting to finish with a quote from Gadamer:

One of the most essential experiences a human being can have is that another comes to know him or her better. This means however that we must take the encounter with the other person seriously because there is always something about which we are not correct and are not justified in maintaining. Through that encounter with the other we are lifted above the narrow confines of our own knowledge. A new horizon is disclosed that opens onto what was unknown to us. In every genuine conversation this happens (Gadamer, 1993/2001a, p. 49).
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Appendices

Appendix 1: Ethics approval letter from CSU HREC Letter of Introduction
Appendix 2: Letter of introduction
Appendix 3: Consent Form
Appendix 4: Example of Interview topics and questions
Appendix 5: Community resources
Appendix 6: Participant basic demographic information
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Appendix 8: Tables representing horizon analysis
Appendix 1: Ethics approval letter from CSU HREC

18 July 2013

Ms Julie Perrin  
“Elysium”  
Dalton Road  
Gunning NSW 2581

Dear Ms Perrin,

Thank you for the additional information forwarded in response to a request from the Human Research Ethics Committee (HREC).

The CSU HREC reviews projects in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Research Involving Humans.

I am pleased to advise that your project entitled “Experiences of sibling bereavement when death is drug related; a qualitative study” meets the requirements of the National Statement; and ethical approval for this research is granted for a twelve-month period from 18 July 2013.

The protocol number issued with respect to this project is 2013/133. Please be sure to quote this number when responding to any request made by the Committee.

Please note the following conditions of approval:

- all Consent Forms and Information Sheets are to be printed on Charles Sturt University letterhead. Students should liaise with their Supervisor to arrange to have these documents printed;
- you must notify the Committee immediately in writing should your research differ in any way from that proposed. Forms are available at: http://www.csu.edu.au/__date/assets/word_doc/0010/176833/ehre_anunrep.doc (please copy and paste the address into your browser);
- you must notify the Committee immediately if any serious and or unexpected adverse events or outcomes occur associated with your research, that might affect the participants and therefore ethical acceptability of the project. An Adverse Incident form is available from the website: as above;
- amendments to the research design must be reviewed and approved by the Human Research Ethics Committee before commencement. Forms are available at the website above;
• if an extension of the approval period is required, a request must be submitted to the Human Research Ethics Committee. Forms are available at the website above;
• you are required to complete a Progress Report form, which can be downloaded as above, by 16 May 2014 if your research has not been completed by that date;
• you are required to submit a final report, the form is available from the website above.

YOU ARE REMINDED THAT AN APPROVAL LETTER FROM THE CSU HREC CONSTITUTES ETHICAL APPROVAL ONLY.

If your research involves the use of radiation, biological materials, chemicals or animals a separate approval is required from the appropriate University Committee.

The Committee wishes you well in your research and please do not hesitate to contact the Executive Officer on telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries.

Yours sincerely

[Signature]

Julie Hicks
Executive Officer
Human Research Ethics Committee
Direct Telephone: (02) 6338 4628
Email: ethics@csu.edu.au
Cc: Dr Susan Mluck Dr John Healy Associate Professor Wendy Bowles

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007)
Appendix 2: Letter of introduction

Dear

I am a student in Doctor of Social Work degree at Charles Sturt University. I am writing to generate interest in my research project. I want to explore a sensitive topic. I am interested in contacting people who have had a brother or sister die for a drug related reason, over 5 years ago.

What my research is about

My research title is: Experiences of sibling bereavement when death is drug related; a qualitative study.

This is an important topic that has not been given enough attention. The experience of sibling bereavement when death is drug related is an unexplored phenomenon. This qualitative research project aims to explore siblings’ bereavement experiences to:

a) Develop a rich understanding of the participants’ experiences by capturing:
   • reflections of initial experiences and meanings of sibling bereavement and any changes to these experiences and meanings over time;
   • stories of connection to the sibling who died; family processes around meaning making and experiences of growth, hope and resilience, and
   • bereavement experiences when the sibling’s death is drug-related; including the experience of living with drug use.

b) Inform social work practices in bereavement, drug and alcohol, and working with families.

Participation involves being over 18 years old, speaking English, not being vulnerable in terms of being cognitively impaired, intellectually disabled or suffering with a mental illness, and it is 5 years or more since your sibling’s death and your brother or sister’s death was drug and/or alcohol related. When someone’s death is ‘drug related’ it usually means people whose death occurs through the use of illicit and/or licit drugs, and/or combinations of drugs.

It also means being interviewed by me, which will take approximately 1 – 2 hours. This will be done at a mutually agreeable time. The interviews will be more conversational than a question and answer type of interview. I will have a list of topics which I will give to you to discuss.

All interviews will be digitally recorded so your experience is captured accurately. You will be given the option of reading your interview transcript. In order to protect your confidentiality your personal information (for example, your name) will not be used on the recording, in the transcript or when the report is being written up. Instead I will use a pseudonym.

Two days after the interview I will make a follow-up phone call to see if there is anything you would like to add or delete, and to reflect on the experience of the interview process.

If you are interested or want to know more about the project let me know!

Ring or text me on 0402262168 or email me at Julie@karunacentre.com.au to express your interest. This is not the same as committing to participate it just means that I can explain the research project.
in more detail, answer any of your questions and provide you with more detailed information on the project.

I look forward to hearing from you soon.

Best wishes

Julie Perrin
Appendix 3: Consent Form

Consent Form

Research Project Name:
Experiences of sibling bereavement when death is drug related; a qualitative study.

Chief Investigator:
Julie Perrin Student Number: 69004928
Phone Number: 0402262168 Email: Julie@karunacentre.com.au
Student in Doctor of Social Work degree at Charles Sturt University Wagga Wagga Campus.

Supervisor:
Dr Susan Mlcek
Phone number: 02 63384187 Email: smlcek@csu.edu.au

I …………………………………………………………………………………………………….. (full name) of
……………………………………………………………….……………
………………………… (full Address)
Can confirm that:

• My sibling’s death was over 5 years ago and drug related;
• I meet the inclusion criteria for participants;
• The purpose of the research project has been verbally explained to me by the Chief Investigator;
• I have read the information sheet (Attachment 2) on the research project with the Chief Investigator and
  retained a copy of the information sheet;
• I have had the opportunity to ask questions and have received satisfactory answers;
• I have been provided with information on community resources;
• I understand that any personally identifying information will be de-identified for the purpose of interviews,
  transcripts, the NVivo data base, reporting, publishing and storage of the data;
• I understand the Chief Investigator’s legal obligations to report illegal activities and names, and her duty
  of care and the limits this places on confidentiality;
• I understand that during the project all paper and electronic information pertaining to the project will be
  stored in a lockable filing cabinet at the Chief Investigator’s home, and that these items will be stored in a
  de-identified manner;
• I understand that all information/data pertaining the research project will be de-identified and archived
  with the CSU research office in locked storage containers for 20 years. I understand that identifying
  information (for example, this consent form) will be stored electronically and password protected.
• In signing this form I am voluntarily consenting to participate in this research project. I understand that I
  am free to withdraw my consent to participate in the research at any time, and that if I do I will not be
• subjected to any penalty or discriminatory treatment. I also understand that I can stop the interview at any time.

• I understand that this research project has been approved by the Charles Sturt University’s Human Research Ethics Committee.

I understand that if I have any complaints or concerns about this research I can contact:

Executive Officer

Human Research Ethics Committee

Office of Academic Governance

Charles Sturt University

Panorama Avenue

Bathurst NSW 2795

Phone:   (02) 6338 4628

Email:   ethics@csu.edu.au

Signed by:   ..........................................................  Date:  .............................................
Appendix 4: Example of Interview topics and questions

Interview topics and examples of questions that might be asked

Demographic information about you:

Name/ pseudonym
Address
Phone number, mobile number and email address
Gender
Age
Working
Living arrangements
Qualifications
Voluntary work

Genogram family of origin

Names, ages, gender, who had good relationships, living arrangements

What led you to want to participate in this study?

I understand that your brother/sister engaged in drug use, can you tell me more about that?

- Type of drugs
- Time using
- Thoughts/effects about drugs self, family, sibling
- Responses self, family, sibling
- Views from outside the family

Can you tell me about the circumstances of your brother or sister’s death?

- Sequence of events

What was it like for you when your brother sister died?

- Thoughts, feelings, behaviours - talking
- effects/responses self
- messages about grief
What was it like for your family?

- Father, mother, other brothers and sisters, differences
- Thoughts, feelings, behaviours - talking
- Effects/responses others
- Now and then

What did you notice about others outside the family?

- Responses, stigma
- Now and then

What has happened since that time?

- Changes self, family
- Memories/legacies
- Frequency thoughts, feelings
- Hopes, growth, resilience

Advice for others about the experience?
Appendix 5: Community resources

Community Resources

The majority of these services are located in the Canberra and surrounding area. The community resources noted below have primarily been found on the Citizens Advice Bureau data base [http://www.citizensadvice.org.au/](http://www.citizensadvice.org.au/) the quality of these services or suitability different people e.g. fees has not been assessed. There are also numerous counsellors in private practice, too many to list here, you can seek a referral with a mental health plan to these services through your General Practitioner.

Support groups/organisations

Al-Anon Family Group - Canberra

**Phone:** 02 6249 8866

**Location:** Room 1.11, Lvl 2, Griffin Centre, Genge St, Canberra ACT 2601

**Email:** agso@alphalink.com.au

**Web:** [www.al-](http://www.al-)

Canberra After Suicide Support Group

**Phone:** 02 6282 6658

**Mail:** PO Box 78, Woden ACT 2606

**Email:** ourcanberra_cass@yahoo.com.au

**Web:** [www.ourcanberra.com/Canberra_After_Suicide.html](http://www.ourcanberra.com/Canberra_After_Suicide.html)

Quest for Life Foundation

**Phone:** 02 4883 6599

**Fax:** 02 4883 6632

**Location:** Ellsmore Rd, Bundanoon NSW 2578

**Mail:** PO Box 390, Bundanoon NSW 2578

**Email:** info@questforlife.com.au

**Web:** [www.questforlife.com.au](http://www.questforlife.com.au)

The Compassionate Friends ACT and Queanbeyan Inc
Family and Friends for Drug Law Reform

Families and Friends for Drug Law Reform was formed as a direct result of heroin related deaths in the Australian Capital Territory. It believes that prohibition laws are more the problem than the solution. It seeks alternative laws and policies that substantially reduce the deaths and minimise the health and social harm to users, families and society. FFDLR believes society should help people come through any drug using experience alive and as healthy as possible. In other words FFDLR is about promotion of life and wellbeing. This is more important than being "drug free". [http://www.ffdlr.org.au/](http://www.ffdlr.org.au/)

**Internet resources**

*These internet resources contain information on bereavement and provide links to other useful websites.*

**The Compassionate Friends**


**Australian Centre for Grief and Bereavement**

[www.grief.org.au](http://www.grief.org.au)

**Mal and Dianne McKissock service**


**White Lady Funerals**

**Phone:** 02 6299 2627
Location: 91 Crawford St, Queanbeyan NSW 2620
Email: cwalters@whiteladyfunerals.com.au
Web: www.whiteladyfunerals.com.au

Tobin Brothers Funeral Directors
Phone: 02 6295 2799
Fax: 02 6297 8952
Location: 75 Canberra Av, Kingston ACT 2604
Email: cwalters@tobinscanberrafunerals.com.au
Web: www.tobinscanberrafunerals.com.au

Grief counselling on-line

Telephone services

Family Drug Support Helpline
Phone: 1300 368 186
Fax: 02 4782 9555
Mail: PO Box 7363, Leura NSW 2780
Email: admin@fds.ngo.org.au
Web: www.fds.org.au

Lifeline Canberra
Phone: 02 6247 0655
Fax: 02 6257 4290
Location: Lvl 1, Novell House, 71 Northbourne Av, Canberra ACT 2601
Mail: GPO Box 583, Canberra ACT 2601
Email: office@act.lifeline.org.au
Web: www.act.lifeline.org.au

Generalists and Grief Counselling services

Community Health Intake line
Phone: 02 6207 9977
Fax: 02 6205 2611
Location: Lvl 3, 1 Moore St, Canberra ACT 2601
Mail: ACT Health, GPO Box 825, Canberra ACT 2601
Email: healthact@act.gov.au
Web: www.health.act.gov.au

Junction Youth Health Service
Phone: 02 6232 2423
Fax: 02 6232 2424
Location: Cnr Scotts Crsg & Cooyong St, Canberra City ACT 2601
Mail: PO Box 287, Civic Square ACT 2608
Email: junctioninfo@anglicare.com.au
Web: www.thejunction.org.au

Canberra Mens Centre
Phone: 02 6230 6999
Fax: 02 6257 1223
Location: Room 3.01, Griffin Centre, Genge St, Canberra ACT 2601
Mail: GPO Box 1753, Canberra ACT 2601
Email:cmc@menscentre.org.au
Web: www.menscentre.org.au

Grief Resource Service
Phone: 0408 992 916
Mail: PO Box 5022, Chisholm ACT 2905
Email: lerc@ozemail.com.au
Web: www.heathershealinghaven.vpweb.com.au

ACT Womens Health Service
Phone: 02 6205 1078
Fax: 02 6207 0143
Location: Lvl 1, ACT Health Bld, Cnr Alinga St & Moore St, Canberra ACT 2601
Mail: PO Box 825, Canberra ACT 2601
Web: www.health.act.gov.au

Grief and Loss Support Program - St Johns Care

phone: 02 6248 7771
Fax: 02 6262 6665
Location: 43-47 Constitution Av, Reid ACT 2612
Mail: GPO Box 219, Canberra ACT 2601
Email: stjohnscare@velocitynet.com.au

Faculty of Health Clinics, University of Canberra

Phone: 02 6201 5843
Fax: 02 6201 5666
Location: Lvl B, Bld 12, Room 40, University of Canberra, Monana St, University Dr, Canberra ACT 2601
Email: healthclinic@canberra.edu.au
Web: www.canberra.edu.au/healthclinic

ANU Psychology Clinic

Phone: 02 6125 2795
Fax: 02 6125 0499
Location: Psychology Bld 39, Gnd Fl, ANU, Cnr Daley Rd & Science Rd, ANU ACT 0200
Email: enquiries.psychology@anu.edu.au
Web: www.anu.edu.au/psychology

Salvation Army Counselling Service

Phone: 02 6248 5504
Fax: 02 6257 8154
Location: Suite 3, Southwell Park Offices, 9 Montford Cr, North Lyneham ACT 2602
Web: www.salvos.org.au
## Appendix 6: Participant basic demographic information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age at study</th>
<th>Age at death</th>
<th>Sib relationship</th>
<th>Sib age or younger</th>
<th>Sib brother or sister</th>
<th>Sib age when died</th>
<th>Drugs</th>
<th>Place of death</th>
<th>How died</th>
<th>Years since death</th>
<th>Year of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kathryn</td>
<td>29</td>
<td>23</td>
<td>Close</td>
<td>Older</td>
<td>Brother</td>
<td>27</td>
<td>Prescription Benzodiazepine (Diazepam), Heroin</td>
<td>Family home</td>
<td>Accidental overdose</td>
<td>6</td>
<td>2008</td>
</tr>
<tr>
<td>Sally</td>
<td>34</td>
<td>27</td>
<td>Close</td>
<td>Older</td>
<td>Brother</td>
<td>31</td>
<td>Poly drug Alcohol Amphetamine Cannabis</td>
<td>Train/bus station</td>
<td>Accidental overdose</td>
<td>7</td>
<td>2007</td>
</tr>
<tr>
<td>Tony</td>
<td>56</td>
<td>41</td>
<td>Close</td>
<td>Younger</td>
<td>Brother</td>
<td>40</td>
<td>Alcohol Heroin Cannabis</td>
<td>Home</td>
<td>Alcohol related</td>
<td>15</td>
<td>1999</td>
</tr>
<tr>
<td>Lorraine</td>
<td>36</td>
<td>21</td>
<td>Close</td>
<td>Older</td>
<td>Sister</td>
<td>23</td>
<td>Poly Amphetamine Cannabis Alcohol Ecstasy</td>
<td>Train Tracks</td>
<td>Suicide</td>
<td>15</td>
<td>1999</td>
</tr>
<tr>
<td>Vera</td>
<td>51</td>
<td>24</td>
<td>Close</td>
<td>Older</td>
<td>Sister</td>
<td>25</td>
<td>Opioids Alcohol</td>
<td>Hospital</td>
<td>Overdose</td>
<td>27</td>
<td>1987</td>
</tr>
<tr>
<td>Vera</td>
<td>51</td>
<td>34</td>
<td>Not close</td>
<td>Younger</td>
<td>Sister</td>
<td>33</td>
<td>Opioids Alcohol</td>
<td>Hospital</td>
<td>MVA</td>
<td>17</td>
<td>1997</td>
</tr>
<tr>
<td>Stan</td>
<td>43</td>
<td>28</td>
<td>Distant</td>
<td>Younger</td>
<td>Brother</td>
<td>24</td>
<td>Prescription Benzodiazepine (Diazepam), Heroin alcohol</td>
<td>Flat</td>
<td>Overdose</td>
<td>15</td>
<td>1999</td>
</tr>
</tbody>
</table>

| Krisie      | 29           | 13           | Close            | Older              | Brother              | 29               | Party drugs OS | Accidental overdose | 17         | 1997           |
| Lilian      | 57           | 20           | Distant          | Interstate        | Older                | 21               | Alcohol Cannabis | Unsure | Suicide | 17            | 1997           |
| Krystal     | 42           | 22           | Close            | Younger            | Brother              | 21               | Heroin | Flat | Suicide overdose | 19            | 1995           |
| Isobel      | 60           | 30           | Close            | Older              | Brother              | 35               | Heroin Cocaine Cannabis | Family home | Accidental overdose | 30           | 1984           |
| Karen       | 49           | 30           | Close            | Older              | Brother              | 39               | Heroin | Hospital | Overdose | 19            | 1995           |
| Judy        | 62           | 47           | Distant          | Younger            | Brother              | 40               | Heroin Alcohol Cannabis | Home | Alcohol related | 15            | 1999           |
| Josie       | 41           | 19           | Close            | Older              | Brother              | 24               | Cannabis Amphetamines Heroin | Unsure | overdose | 22            | 1992           |
| Jacqui      | 50           | 35           | Distant          | Younger            | Sister               | 29               | Heroin | Street | Murdered | 15            | 1999           |
| Helen       | 46           | 30           | Close            | Older              | Brother              | 35               | Heroin Cannabis | Flat | Overdose | 15            | 1999           |
| Gina        | 51           | 31           | Close            | Older              | Brother              | 33               | Heroin | Flat | Overdose | 20            | 1994           |
| Donna       | 49           | 43           | Distant          | Younger            | Brother              | 27               | Poly | MH | IV related health | 7            | 2007           |
| Connie      | 49           | 31           | Close            | Interstate        | Older                | 33               | Cannabis heroin | Flat | Accidental overdose | 18           | 1996           |
| Carl        | 61           | 45           | Distant          | Younger            | Brother              | 40               | Alcohol Heroin Cannabis | Flat | Alcohol related | 15           | 1999           |
| Amy         | 38           | 32           | Distant          | Younger            | Brother              | 28               | Heroin Amphetamines cannabis LSD | Street | Overdose | 6            | 2008           |
| Alice       | 61           | 42           | Distant          | Younger            | Brother              | 39               | Heroin | Hospital | overdose | 19            | 1995           |
Appendix 7: Genogram example
## Appendix 8: Tables representing horizon analysis

### Bereavement horizon table

<table>
<thead>
<tr>
<th>Topics in conversation comprising my bereavement horizon</th>
<th>Distinguishing between the familiar and the new, and identifying connections or relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topics</td>
<td>Commonalities in topics</td>
</tr>
<tr>
<td></td>
<td>Familiar</td>
</tr>
<tr>
<td></td>
<td>New</td>
</tr>
<tr>
<td>Experiences around the time of death</td>
<td>Bereavement horizon</td>
</tr>
<tr>
<td></td>
<td>Bereavement &amp; sibling relationship in family context</td>
</tr>
<tr>
<td></td>
<td>Bereavement &amp; drug and alcohol use</td>
</tr>
<tr>
<td>Memories of finding out</td>
<td></td>
</tr>
<tr>
<td>Notions of disbelief</td>
<td></td>
</tr>
<tr>
<td>Memories of the last interaction</td>
<td></td>
</tr>
<tr>
<td>The awfulness of death</td>
<td></td>
</tr>
<tr>
<td>Not saying goodbye</td>
<td></td>
</tr>
<tr>
<td>A sense of relief</td>
<td></td>
</tr>
<tr>
<td>Rituals around death</td>
<td></td>
</tr>
<tr>
<td>Viewing sibling in death</td>
<td></td>
</tr>
<tr>
<td>Putting items in the coffin</td>
<td></td>
</tr>
<tr>
<td>The funeral</td>
<td></td>
</tr>
<tr>
<td>Deciding who attends the funeral</td>
<td></td>
</tr>
</tbody>
</table>

### Drug use horizon table

<table>
<thead>
<tr>
<th>Topics in conversation comprising my drug and alcohol horizon</th>
<th>Distinguishing between the familiar and the new, and identifying connections and relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Topics</td>
<td>Commonalities in topics</td>
</tr>
<tr>
<td></td>
<td>Familiar</td>
</tr>
<tr>
<td></td>
<td>New</td>
</tr>
<tr>
<td>Noticing things</td>
<td>Drug and alcohol horizon</td>
</tr>
<tr>
<td></td>
<td>Drug and alcohol use &amp; sibling relationship in family context</td>
</tr>
<tr>
<td></td>
<td>Drug and alcohol use &amp; bereavement</td>
</tr>
<tr>
<td>Not finishing education</td>
<td></td>
</tr>
<tr>
<td>Money issues</td>
<td></td>
</tr>
<tr>
<td>Variable work</td>
<td></td>
</tr>
<tr>
<td>Changeable living arrangements</td>
<td></td>
</tr>
<tr>
<td>Unavailable</td>
<td></td>
</tr>
<tr>
<td>Evidence of drug use</td>
<td></td>
</tr>
<tr>
<td>Knowledge of the sibling’s drug use</td>
<td></td>
</tr>
<tr>
<td>No knowledge of sibling’s drug use</td>
<td></td>
</tr>
<tr>
<td>Find out about types of drugs used by sibling</td>
<td></td>
</tr>
<tr>
<td>Overdose from drug use</td>
<td></td>
</tr>
</tbody>
</table>
## Family horizon table

<table>
<thead>
<tr>
<th>Items comprising my family horizon</th>
<th>Distinguishing between the familiar and the new, and identifying connections and relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Items</strong></td>
<td><strong>Familiar</strong></td>
</tr>
<tr>
<td><strong>Associated aspects</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Words of people participating in the study are in “”</strong></td>
<td></td>
</tr>
<tr>
<td>Family structure</td>
<td></td>
</tr>
<tr>
<td>Parental alliance</td>
<td>Sibling relationship in family context &amp; bereavement</td>
</tr>
<tr>
<td>Eldest child ‘parentified’</td>
<td></td>
</tr>
<tr>
<td>Being the eldest sibling</td>
<td></td>
</tr>
<tr>
<td>Being the younger sibling</td>
<td></td>
</tr>
<tr>
<td>Closeness and distance of relationships</td>
<td></td>
</tr>
<tr>
<td>Family boundaries</td>
<td></td>
</tr>
<tr>
<td>Talking inside and outside the family</td>
<td></td>
</tr>
<tr>
<td>Family response to drug use</td>
<td></td>
</tr>
</tbody>
</table>