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The Grief That Gets No Flowers: Invisible Loss, Relapse, and What Families Can Do About It

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You remember what happened before they relapsed. A job finally going well, then gone. A friendship carefully rebuilt, then dissolved. A visit to the old neighborhood that reminded them, with sudden precision, of the distance between who they were supposed to become and who they were now. Nothing died. Nobody sent flowers. The world kept moving in three days, and then — not right away, but eventually — so did the using.

That gap between a loss too real to survive and a world that has no ceremony for it has a name in bereavement research, and recent studies document it as a contributing factor in both the beginning of substance use and the collapse of sobriety long after it is established. Families who understand this are better positioned to offer what invisible grief most consistently needs and most rarely receives: a witness. Understanding what that research says will not fix anything on its own. But it will change the question you can ask — and sometimes that is the thing that changes everything.

To understand what the research actually establishes — and where it must be held with appropriate caution — it helps to trace what each study contributes separately before asking what they suggest in combination.

What the research found

In 2026, researcher Verty, publishing in the *Journal of Loss & Trauma*, reported findings from a qualitative study of forty-one Black adults who had reported opioid misuse. Using reflexive thematic analysis of participants' own accounts, Verty's team did not ask what the researchers expected to find. They asked what the participants

described. What they described was not a single wound but a layered accumulation across three distinct phases. Before addiction began, many participants had experienced childhood trauma and early disruptions — losses of safety and attachment that received no acknowledgment or support. During active use, they experienced the loss of what the study terms "idealized adulthood": the version of a life they had once believed was still possible for them, now gone. And during recovery — even in remission — participants described losing recovery capital: the interpersonal relationships and stability that sobriety requires in order to hold.

Three phases. Three distinct categories of grief. In each, the losses were what bereavement literature calls *disenfranchised*: real, felt, mourned privately — but unrecognized socially, unaccompanied by the rituals and support structures that deaths receive. No flowers. No time off. No one sitting with you through it. Verty's analysis found that these losses shaped participants' drug use across all three phases: "whether it was the initiation of their use, the duration of their use, or their remission or relapse" (Verty 2026). The researchers frame drug use as appearing to function as a coping mechanism for grief that had nowhere else to go — and draw the clinical implication that recognizing a non-death loss as a *loss* opens the possibility of addressing the underlying grief rather than only its expression in substance use. That framing is interpretive, built from what participants described rather than from an experimental design capable of establishing causal direction; it is a therapeutic lens, not a proven mechanism.

This is not an excuse. It is a proposed lens. And a lens can be tested.

When sobriety breaks

For families, the fear that matters most is not that their loved one uses. It is that they get sober — genuinely sober, building something real over months and years — and then lose it. That is the break that is hardest to

name and hardest to survive: not early stumbling but the collapse of something carefully constructed.

In 2023, researcher Ware and colleagues published a qualitative study in *Substance Abuse: Research and Treatment* examining electronic health records of 153 adults with alcohol use disorder who had received a peer support intervention at a Baltimore emergency department and had at some point achieved a sustained period of abstinence ("Prior Periods" 2023). Using template analysis methodology, Ware's team identified themes in open-ended text that clinical staff had entered into those records — documenting, in staff's own words, how long abstinence had lasted, what had sustained it, and what had ended it. The most common recorded abstinence length was between one and five years. These were not fragile early periods. They were years of built life.

Among the relapse trigger categories Ware's team coded from those staff notes was a specific entry: "family (non-death)" events. Not deaths — but family losses without ceremony, the kind that arrive without bereavement leave or casseroles, the kind the world expects you to absorb and move on from. "Family (non-death)" was one of five identified trigger categories alongside death of a loved one, social, economic, and treatment-related reasons. The study does not quantify how frequently it appeared relative to the others, and it does not establish that these events caused the end of sobriety — it documents that clinical staff recorded this category as present among the themes in what patients described.

These two studies use different frameworks and different methods. Verty develops a grief-based interpretive model from participants' direct accounts; Ware codes trigger categories from clinical staff notes, with no grief framework applied. They are not measuring the same thing. What they share is a direction: in both, the loss of a family relationship or family stability — without a death to mark the loss — appears in the record of what was happening when drug use changed. Verty's participants described non-death losses as affecting their drug use across

all three phases of the arc; Ware's clinical records document "family (non-death)" as one of several coded categories among the triggers that ended abstinence sometimes lasting years. Both datasets point toward the same terrain without either one establishing that grief caused the relapse — they trace a pattern, and in qualitative research, patterns are a starting place for understanding, not a final account of mechanism.

Relapse, viewed through this lens, is not simply a decision against recovery. It may, in at least some cases, reflect a response to grief the world did not recognize as requiring support — a possibility the research raises without resolving.

The Ware study also tells families something hopeful that can get lost in the fear: sobriety of one to five years is real and achievable. People do this. After relapse, people return and do it again. Recovery is not a myth. It is a sustained, difficult, humanly possible thing — made harder, the research suggests, by invisible grief, and made more possible when that grief receives some form of witness.

A pattern that runs deeper

The connection between unaddressed grief and destructive behavior — including substance use — is not confined to addiction research. In a review published in the *International Journal of Prisoner Health*, researcher Leach examined whether high rates of recidivism in incarcerated populations could be linked to traumatic grief ("Could Recidivism" 2008). Leach defines traumatic grief specifically as arising from "interpersonal trauma experienced as a betrayal of attachment" — a distinct clinical construct, different from the disenfranchised non-death loss Verty describes and from the trigger categories Ware's team coded from staff notes. Leach observed that many people cycling through the justice system had experienced losses and traumas throughout their lives without ever receiving support or intervention, and proposed a relationship between this accumulation and the maladaptive behaviors —

substance use among them — that characterize their trajectories after release. In Australia, the review noted, recidivism rates had been documented as high as 77 percent — a figure Leach suggested may be connected in part to grief that was never addressed.

Families reading this are not necessarily dealing with incarceration. But the dynamic Leach describes runs parallel to what Verty documented in addiction and what Ware's clinical records captured in trigger terms. The review does not establish causation — it is theoretical, asking whether the pattern holds — and traumatic grief in Leach's clinical sense does not map directly onto either of the other two frameworks. What these three bodies of research share is a direction of attention, not a unified mechanism: each, in its own context and with its own constructs, orients toward unaddressed loss as part of what is happening when behavior becomes destructive and hard to interrupt.

The objections that deserve real answers

A reasonable person could raise three separate challenges to this framework, and all three deserve direct engagement.

The first: isn't framing relapse as grief-driven simply another way to avoid accountability? Recovery requires people to take responsibility for their choices, and an architecture that traces every relapse to an unwitnessed loss may give people a route around that responsibility. Families, moreover, have also lost things — often things their loved one's addiction took from them — and being asked to function as grief witnesses while still absorbing those losses is another unfair demand on people who have already given everything.

The research does not argue that loss excuses harm. Verty's framework is explicitly therapeutic: recognizing a non-death loss as a *loss* is what makes treatment possible, because it allows drug use to be addressed as a coping mechanism rather than an inexplicable behavior. That is not the same as saying nothing was the person's responsibility. Understanding

what drives a behavior is what makes interrupting it conceivable. Accountability and understanding are not opposites; understanding is often what makes genuine accountability possible, because it locates where the work actually needs to happen. As for families' own losses: families of people with addiction also carry disenfranchised grief. The relationship they expected is not the relationship they have. The future they imagined is not the future they are living. Nothing in this research asks those losses to be erased. Holding both — understanding the invisible losses shaping someone's use while also acknowledging the invisible losses their use has caused you — is not a contradiction. It is the actual terrain this situation occupies.

The second challenge is sharper, and in some ways harder. If "disenfranchised grief" is broad enough to encompass any difficult experience — a lost job, a failed friendship, a court date, an unwelcome memory — then it potentially explains every relapse retroactively and predicts none in advance. A concept that can be applied after the fact to any event, with no criteria for what would *not* count, does not give families anything usable. It gives them a language for explaining the past without a map for the present. If anything hard can be reframed as grief, the framework changes nothing.

Verty's three-phase typology answers this objection directly, and the precision of the answer is what makes it worth examining. The study does not present grief as an undifferentiated explanation for everything that hurts. It identifies three specific, nameable categories — pre-addiction loss (childhood trauma and disrupted attachment), loss of idealized adulthood (the version of a future someone once believed was still possible), and loss of recovery capital (the relationships and stability that sustaining sobriety requires) — and maps each to a distinct, identifiable phase of the addiction arc. The categories are narrow enough to name in a conversation and specific enough to locate in a person's actual history. A family member does not need to wonder whether every

setback qualifies. The question becomes targeted: Did something happen to the relationships and stability that were holding this recovery in place? That is a question with a specific, answerable object.

The third challenge sits at the level of research design, and it is the strongest of the three. None of these studies establishes that grief causes relapse. Verty's thematic analysis captures what forty-one participants described about their own histories — it cannot rule out that people experiencing relapse retrospectively frame their histories in terms of loss, rather than loss having driven the relapse. Ware's template analysis codes what clinical staff recorded in emergency department notes — it documents a category's presence among described triggers, not its causal weight relative to other factors. Leach's review is theoretical, examining whether the pattern could hold, not demonstrating that it does. A third variable — chronic stress, economic precarity, disrupted social networks — might drive both the grief and the substance use, making them correlates rather than cause and effect. This article does not evade that limit: the causal direction that the grief-and-relapse framing implies is not established by any of the studies cited.

What these studies do establish — separately, using different methods, and without converging on a single mechanism — is that unaddressed loss appears repeatedly in the landscape surrounding substance use: in what participants say about their own histories, in what clinical staff record as trigger themes, and in a theoretical framework applied to a related population. Whether that pattern reflects causation, correlation, or retrospective framing remains genuinely open. The practical question for families is not whether grief has been proven to cause relapse. It is whether attending to invisible loss — asking about it, acknowledging it, not moving past it — changes anything in the space where they can actually reach someone. The research raises the possibility without guaranteeing the outcome.

What recognition is and is not

None of this places a therapeutic obligation on families. Verty's clinical implications are addressed to providers — the study's framing is that treatment professionals who recognize non-death losses as genuine losses can help clients explore grief and address drug use as a coping mechanism. The extension to families is not a research finding; it is an inference. Providers and family members occupy different roles, and families are not equipped to substitute for clinical care or peer support. What the research suggests for families is something smaller than clinical intervention and more durable than technique: the possibility that acknowledging what someone lost — naming it as a loss, not minimizing it or moving past it — matters in ways that may not be measurable but are grounded in what the research consistently finds people needed and did not receive.

Verty's three-phase framework also suggests that grief does not end when sobriety begins. Some families find this the most disorienting finding: they expected sobriety to be an arrival, a resolution. The research describes it as a continued journey through accumulated loss, some of it more visible now that the substance is no longer in the way of feeling it. Understanding this prepares families for the moments — a job that falls through, a friendship that ends, a court date that brings back who someone used to be — that carry real loss even when nothing has died.

What families can offer in those moments is not therapy. It is recognition: the understanding that what just happened may be a loss, that the person they love may be grieving something the world will not acknowledge, and that asking about it is not the same as excusing what follows. For someone whose grief has been invisible — whose losses have never received the social acknowledgment that death receives — having a loss recognized as real is not nothing. For some people, in some moments, it is the first time anyone has confirmed that what they were mourning counted.

The question worth asking

Think again of what happened before the last relapse: the job, the friendship, the neighborhood, the gap between who they were supposed to be. Research now suggests those were moments of grief without ceremony — and that they needed to be mourned, and weren't, because nobody had the language for them or the social permission to use it. The loss of an idealized adulthood does not come with a funeral. The loss of recovery capital — the relationships and stability that make sobriety sustainable — arrives in pieces, too small and too numerous for any ceremony.

Families cannot give that recognition retroactively. But they can change the question they ask. "Why aren't you trying harder?" assumes the problem is effort. "What happened that you couldn't tell anyone about?" assumes the problem may be unsupported grief. The evidence, across the research examined here, points toward the second assumption as worth exploring — without guaranteeing that grief is always what it will find.

That question does not fix anything alone. It does not substitute for treatment or peer support or the long work of recovery. But it offers what invisible grief most consistently needs and most rarely receives: a witness. Someone who sees the loss for what it is, even when the world has no ceremony for it, even when nothing died, even when no one else noticed.

In the frightening, exhausting work of loving someone through addiction, that witness is not a small thing to be.

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