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# Grief Experiences of Mothers after a Child's Death from a Drug Overdose

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Abstract

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## Abstract

Research on young adult deaths primarily focuses on other causes of death such as homicide, suicide, and accidents. There is very little research surrounding maternal bereavement when the cause of death is from a drug overdose. The purpose of this phenomenological study was to explore the perceptions, attitudes, and lived experiences of grieving mothers who had a biological, adopted, or stepchild die from a drug overdose when the decease's age was between 18 and 25. Guided by Le Poi Devin's multidimensional grief theory, the study sought a better understanding to assist mental health and other healthcare providers in developing individualized treatment of mothers' suffering grief. Study participants included 11 women who had a young adult child die a minimum of 2 years ago. Virtual semi structured, open-ended, phenomenological interview questions were used to explore the research questions of the overall grief experiences, physical symptoms, emotional expressions, and coping mechanisms. Using NVivo 12 software, a four-stage interpretive phenomenological analysis method was used to analyze the data. Thematic analyses revealed 6 main themes: (a) initial grief reactions to the loss, (b) support system and coping mechanisms, (c) spiritualty and religious changes, (d) adapting to the loss over time, (e) emotional responses and physical reactions, and (f) overall grief experiences. The positive social change implication includes information that may help understand a mother's special needs and circumstances as they make efforts to navigate through life after losing a young adult child to a drug overdose.

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# Dedication

I dedicate this dissertation to my wonderful daughter Andréa Wisher. You were always supportive and very understanding when I was not able to attend some events, or may have been too busy to do some of things you wanted to do. Your love, inspiration, understanding, and encouragement helped to empower me and get me through the times when I wanted to give up. Being a role model for you was the driving force behind my ambition- I love you, Andréa.

This is also dedicated to my forever loves, my grandmother Delores "Doodie" Quail-La Salle and my father Albert "Butch" Harris, Sr. They both had big hearts and were willing to help anyone. They may not have known this, but I got my loyalty and sense of service of helping others from them. Their deaths caused unexplainable sorrow. This led me to wanting to understand grief reactions and experiences, which was the impetus of this study.

In loving memory of Janet Boyd-Harris, who was the sole person who convinced me to pursue a doctoral degree. I thank her for always being my voice of reason, she is deeply and truly missed.

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# Chapter 1: Introduction to the Study

According to the Centers for Disease Control and Prevention (CDC, 2013b), bereavement affects millions of Americans every year. In 2014, there were over 2.5 million deaths in the United States (CDC, 2015). When a person dies, there is usually someone left behind to mourn for them and grieve their loss. The survivors may be children, spouses, siblings, colleagues, friends, or parents. Fundukian and Wilson (2008) defined *bereavement* as the experience of losing a loved one to death, whereas *grief* refers to the response or reaction individuals have to the death. The process of bereavement can lead to various physical and emotional responses, such as low immunity from stress, and depression, or complicated grief (Golden & Dalgleish, 2012; Herberman-Mash et al., 2013).

Parents who have experienced the death of a child often described the event as their worst nightmare and fears becoming known (Alam et al., 2012). Parents of deceased children find themselves being forced to navigate through the loss while finding new ways of adapting, coping, and settling into a new normalcy after what is often viewed as an unnatural order of life. The recently bereaved parents also find themselves experiencing uncertainty about the future (Alam et al., 2012). Any future plans, hopes, and dreams the parents have for their children end when the child dies. Therefore, a void exists which is filled with ambiguity because dreams of attending graduations, weddings, and major life milestones are no longer options. The emotions, experiences, and doubts are more powerful when the death is unexpected and sudden such as a death from a drug overdose.

Numerous studies address parental bereavement when the death is from natural causes or suicide (Feigelman et al., 2011). However, parental bereavement regarding a child's death from a drug overdose has been neglected in the literature (Feigelman et al., 2011). Over the past couple of years, studies on drug-related parental bereavement have slowly started to emerge (Valentine et al., 2016). Even with this new emergence, there is still a lack of research regarding this subject, which has led new researchers to focus more on this topic. However, these recent studies have yet to address maternal bereavement following the death of a child from a drug overdose nor do the recent drug-related studies focus on the lived experiences of this population.

There is a need for a qualitative phenomenological study that addresses parental bereavement from the bereaved mother's point of view to give a better, more complete understanding of the phenomenon of losing a child to a drug overdose. Additionally, there is a gap in the literature on maternal bereavement when the cause of death is a drug overdose. Rostila et al. (2014) posited that sudden and unexpected deaths such as suicide are different and more difficult to process compared to a bereavement following a natural cause of death such as cancer. Therefore, the lived experiences of mothers after the death of their child from a terminal illness may differ from mothers after the death of their child following a drug overdose. If scholar practitioners are to help those suffering from bereavement and grief, then it is essential to learn and understand all types of bereavement and the differences in the lived experiences.

In this chapter, I discuss the existing literature related to parental or maternal bereavement. Important areas of focus were taken into consideration to include previously identified gaps in the literature, such as various causes of death and the role of

a support system which may include immediate family, extended family, and others. Additionally, Chapter 1 will present the study's background, problem statement, purpose, research questions, conceptual framework, nature, definitions, assumptions, scope and delimitations, limitations, and significance, concluding with a summary.

## Background

The grieving process is complex, private, and unique to the individual who is grieving. Factors such as the relationship to the deceased, the circumstances surrounding the death, and the bereaved person's support system play an important role in the grief response and gaining some sense of normalcy after the death (Greeff et al., 2011). Healthy coping strategies and strong social support systems are paramount to adapting to the loss of a loved one. However, when an individual's child dies, the trajectory to normalcy is not easily attainable, nor is it any longer the goal. Price and Jones (2015) posited that adapting to the loss over time will naturally occur; however, returning to normalcy is no longer pragmatic and the parents should find a healthy balance of living life without their child while holding on to the *continuing bonds* concept, which refers to having an ongoing inner relationship with the deceased. This goal is more attainable than trying to find normalcy because nothing will be normal or the same again (Price & Jones, 2015). Another goal is attempting to obtain balance and identifying healthy options while adapting to life without their child.

The feelings of grief and sense of loss following the death of a child are seemingly more devastating and longer lasting than the grief and sense of loss following the death of other family members (Giannini, 2011). Grief is a biological, psychological, and sociological response to loss; therefore, the lives of parents following the death of

their child are permanently changed. This type of loss leads to unimaginable difficulties in functioning across numerous aspects of their life (Neimeyer et al., 2006). Past studies indicated that the process of grieving is specific to the individual and is as unique as the biopsychosocial constructs following the death (Essakow & Miller, 2013; Giannini, 2011).

The path and difficulties of grief from a child's death depend on countless factors, including the cause of death, the age of the child when the death occurred, stigmatization, and lack of support (Feigelman et al., 2011). These variables may intensify the grieving process of the bereaved while worsening the grief. If the bereaved has a specific role such as that of mother, versus a nonspecific role such as that of a cousin, the grief associated with the bereavement process may also intensify (Meert et al., 2011).

In this phenomenological study, I explored the experiences of bereaved mothers following their child's drug-overdose death. Existing literature does not focus on the subpopulation of bereaved mothers identified in this study (Feigelman et al., 2011; Parker & Dunn, 2011). The gap in research on the lived experiences of mothers after their child dies from a drug overdose was not the only impetus for this study. To foster social change, the present study aimed to promote awareness that drug overdose deaths are on the rise, have lasting impact, and to stress the importance of individualize interventions.

In recent years, this nation has seen a significant increase in drug-related deaths (CDC, 2018). Drug-related deaths, specifically opioid-related deaths, are affecting populations that have never been impacted before. Nonetheless, drug-related deaths leave the bereaved mothers experiencing intense feelings of guilt and self-blame regarding the

death of their child (Templeton et al., 2017). These feelings may influence the experiences and grief processes of bereaved mothers.

Feelings of guilt and perceptions of failing to keep their child safe may lead to experiencing increased pain and suffering connected to grief (Feigelman et al., 2009). The sudden and unexpected death of a child that occurs unnaturally and beyond the age associated with sudden infant death syndrome (SIDS) may affect the grief process (Feigelman et al., 2009). Exploring the lived experiences of bereaved mothers when their young adult child dies following a drug overdose may unlock specific issues not found in past and more generalized studies, which is aligned with the aim of my phenomenological study. Additionally, this exploration is consistent with other qualitative studies that explore parental bereavement (see Parker, 2011; Umphrey & Cacciatore, 2011).

There is a need for a phenomenological study to explore parental bereavement following a drug-related death specifically from the mother's perspective. Previous researchers have examined parental or maternal bereavement when the cause of death was not drug related; however, there is a dearth of literature on drug-related parental bereavement (Feigelman et al., 2011). Additionally, there is a need for a phenomenological study that addresses bereavement related to this cause of death because past studies focused on other causes of death such as homicides, suicides, natural causes, and motor vehicle accidents. The need is there because various causes of death may provoke a different grief response and impact the lived experiences differently.

The introductory section of this chapter highlighted several factors influencing the course of parental bereavement. Dent et al. (1996) provided foundational research on

parental bereavement after the death of a child. The focus of their study was about parents' satisfaction with the hospital staff (Dent et al., 1996). Other more recent studies focused their explorations on both parents and not specifically the mother. For example, Umphrey and Cacciatore (2011), and Walijarvi et al. (2012) recruited participants who were parents and other various family members after the death of a child. Parker and Dunn's (2011) study was the first recent study to provide insight into maternal bereavement. However, the participants' children were ages 11 to 17 at the time of their death and the study did not explore drug-related deaths. Nonetheless, these generalizations or missing pieces allowed for identification of the gap for my present phenomenological study on the lived experiences of mothers following the drug overdose death of their young adult child.

## Problem Statement

The impact of a child's death has far-reaching effects on parents, family members, and friends with an increased risk of developing into complicated grief. Even though researchers have studied SIDS, suicides, homicides, automobile accidents, and natural causes such as terminal illnesses; most of the research regarding the lived experiences of parental bereavement focused on suicide completions (Feigelman et al., 2011). According to Corr and Corr (2012), past researchers suggested that individuals who experienced the death of a child were confronted with overwhelming deep emotions and physical changes. However, a person's stress response, reactions to, and concepts of death vary depending on numerous factors, such as cause of death and relationship to the deceased (Corr & Corr, 2012).

In conducting searches on parental bereavement, the research showed that the lived experiences of mothers who had a young adult child die from a drug overdose has not been studied thoroughly (Feigelman et al., 2011). The literature search using the terms *bereavement, grief, paternal, maternal, mother, drug overdose,* and *children deaths* only found three qualitative studies about drug overdose deaths in young adult children (e.g., da Silva et al., 2007; Feigelman et al., 2009; 2011; Guy, 2004). In addition, the CDC (2013a) reported that despite the growing number of drug overdose deaths; there is a lack of research to explain the impact of these types of deaths on the surviving parents, specifically the surviving mothers. The current literature does not address the lived experiences of mothers after their young adult child dies from a drug-overdose when the age of the decease at the time of death was between 18 and 25-year-old (see Feigelman et al., 2011).

## Purpose of the Study

The purpose of this phenomenological qualitative study was to explore the perceptions, attitudes, and experiences of grieving mothers who had a biological, adopted, or stepchild die from a drug overdose when the age at the time of death was between 18 and 25. This age range was selected because a gap exists for this age range and this cause of death (see Feigelman et al., 2011; Meert et al., 2011; Parker & Dunn, 2011). The focus of this phenomenological study was to explore how mothers perceive the death of their young adult child, and experiences with their emotional responses, physical health, and practicality, which refers to their day-to-day coping.

## Research Questions

Creswell (2014) described qualitative research questions as open-ended, nondirectional, and ones that evolve. He goes on to suggest that central questions are broad in nature and explore a central phenomenon or concept. The following research questions for this phenomenological study were:

RQ1: What are the perceptions and experiences of mothers who loss a young adult child from a drug overdose?

Sub question 1a: What are the physical symptoms experienced by mothers following the death of a young adult child from a drug overdose?

Sub question 1b: What are the emotional expressions experienced by mothers following the death of a young adult child from a drug overdose?

RQ2: What are the coping mechanisms used by mothers following the death of a young adult child from a drug overdose?

## Conceptual Framework

In this phenomenological study, I used Le Poi Devin's (1981) multidimensional model of grief also known as the multidimensional grief theory (MGT). Le Poi Devin developed MGT in the early 1980's while working with Murray Parkes at St. Christopher Hospice. Le Poi Devin strived to develop a model of grief that would enable those working with bereaved individuals to understand the individual construct of grief (Payne et al., 1999). Le Poi Devin's model initially coined multidimensional adjustment to loss and change was developed to examine the grief from a biological, psychological, and social functioning construct. One of the primary goals of the model was to provide the opportunity for a patient to share his or her experiences of grief throughout the grieving

process while developing coping strategies to include accessing supportive resources (Fish, 2014).

In her work, Le Poi Devin conceptualized grief as a process of concurrent change along seven dimensions (Parkes, 1996). The full seven dimensions are emotional, social, physical, lifestyle, practical, spiritual, and identity (Kaplow et al., 2013; Payne et al., 1999). The three of the seven dimensions my study focused on was emotional, physical, and practicality, which refers to day to day.

Counselors who attended Le Poi Devin's training courses on bereavement used Le Poi Devin's model widely. Her model remained unpublished because of her sudden death in 1989 (Payne et al., 1999). It was not until later when in 1996 Parkes published the model in his book *Bereavement: Studies of grief in adult life*. Payne et al. (1999) published the full clinical use of the model. Rubin et al. (2012) suggested that her research provided inspiration and contributed to other grief theory models. Additionally, the multidimensional grief model gained traction in later years with Kaplow et al.'s (2013) work with the military; more of this theory will be discussed in Chapter 2.

The MGT uses dimensions described as the main areas of life that may be affected by a loss. The use of the seven dimensions of loss allows for those offering support or counseling to understand the individual and their grief reactions (Payne et al., 1999). The model helps scholar practitioners to understand those who are grieving, their circumstances, their issues, and the availability of resources to assist with coping. Kaplow et al. (2013) supported Le Poi Devin's model by conducting a study of military personnel and their families about death and loss using the MGT and showing that the grief process and reactions to grief are fluid and not linear or one dimensional.

## Nature of the Study

My study followed a qualitative research method, involving the use of the phenomenological approach model (see Pringle et al., 2011). I explored introductory interpretive analysis of the perceptions, attitudes, and experiences of mothers who loss a young adult child to a drug overdose. Purposive sampling was used to recruit the participants from a support group by posting the letter of intent (see Appendix A) on the bulletin board and on social media sites. The grief support group has four locations in the state of Delaware. The support groups are specifically for bereaved parents who had a child die from a drug overdose regardless of the substance type.

The participants of the support group's children died when the child's age at the time of death was between the ages of 12 to 35. Although this is the age range for the support group, I used the age range of 18 and 25 at the time of death for my study. The 18 to 25-age range was chosen for the present phenomenological study because this age range along with drug overdose deaths is missing from the literature (see Feigelman et al., 2011; Meert et al., 2011; Parker & Dunn, 2011). The bereavement support group meets at two locations in southern and central Delaware. Because of the COVID-19 pandemic, it was necessary for me to expand in the northern area of Delaware due to low interest at the other two locations.

My goal was to obtain a sample size of no more than 12 participants. It was not necessary to recruit more participants because theoretical saturation was met at the 11 recruited participants. I used purposeful sampling in my study. Palinkas et al. (2015) suggested that purposeful sampling is often used in qualitative research. They went on to suggest that this form of sampling is best used for studies exploring a phenomenon or

lived experiences. Convenience sampling is another form of sampling often used in qualitative studies (Creswell, 2014). I did not use convenience sampling because it is prone to selection biases and sampling errors (see Etikan et al., 2016).

Participants of this phenomenological study included bereaved mothers who had a child die between the ages of 18 and 25 years old at the time of death. The age at the time of death criterion was intentional because previous research focused on child deaths from in-utero through age 18 (see Meert et al., 2011). Earlier research focused on SIDS and the death of young children while others focused on young adult deaths when the cause of death was suicide, homicide, and accidental deaths, but not drug overdoses (Parker & Dunn, 2011).

Semi structured audio recorded interviews and personal narratives were used to uncover the experiences. The narratives helped to explore their perceptions and helped to examine various aspects of the loss. The maximum number of participants was limited because of the time constraints involved in interviewing participants, transcribing, and analyzing the data.

Creswell (2014) defined *qualitative research* as an inductive method of inquiry, which is consistent with my objectives to explore perceptions and lived experiences of bereaved mothers. This exploration was based on the multidimensional grief theory while using individual recorded narratives during the data collection process. Gilrane-McGarry and O'Grady (2011) posited that an individual's experiences are often complex and differ based on experiences, interactions, and relationships. My study was appropriate for the phenomenological approach because it captured the experiences, perceptions, and attitudes of the participants. In addition, exploring the participants' narratives allowed for

thorough and unbiased considerations of their experiences (see Pringle et al., 2011). Research using a qualitative method helps to cultivate significant individual experiences while identifying emerging themes (Pringle et al., 2011). This helped me to facilitate the process for the bereaved mothers while providing them an opportunity to tell their stories.

## Definitions

*Bereavement*: Bereavement is defined as the state of experiencing a loss (Buglass, 2010).

*Child/Children*: For the purposes of this phenomenological study, the term child or children will be defined as an individual who is between the ages of 18 and 25 years old.

*Emotional expressions*: Feelings that are felt internally and can be psychological such as depressions, or feelings that can be seen outwardly such as crying or laughter.

*Grief*: Grief is the mental, emotional, psychological, and somatic/physiological experiences, or effects of experiencing the loss or death of something or someone (Granek, 2010).

*Maternal bereavement*: For the purpose of the phenomenological study, maternal bereavement is the term used for a woman who identifies as a biological mother, stepmother, or adopted mother and is affected by the death of a child.

*Mourning*: Mourning is a period in which a death is mourned often displayed as expressions of symbolism such as wearing black or actions such as crying, holding traditions, or rituals (Gassin, & Lengel, 2014).

*Parental bereavement*: Parental bereavement is the overarching term of someone who is a parent being affected by the death of a child (Giannini, 2011).

## Assumptions

I made several assumptions in this phenomenological study. The two primary assumptions were that the participants of the study represented the population of bereaved mothers and they experienced bereavement differently. Secondary assumptions were that the participants were reliable historians who were able to accurately recall the experiences, events, and emotions of the loss at the time of death in recent days and weeks after the loss occurred. In addition, I assumed the participants were honest, practiced integrity, and represented themselves truthfully in being bereaved mothers who loss a child to a drug overdose when the child died between the ages of 18 to 25.

I assumed that various factors including the child's age at the time of death and the type of relationship the survivor had with the deceased affected the participant's bereavement differently. For example, the loss of a biological child may be different from the loss of an adopted child or stepchild. Another assumption was that one's support system may influence the bereavement process.

## Scope and Delimitations

The research problem that was addressed in this phenomenological study focused on the lived experiences and perceptions of bereaved mothers while documenting their individual narratives. These narratives included the experiences and perceptions after the death of their child and the affect the loss had on their emotional responses, physical health, and daily coping strategies. The narratives of the bereaved were audiotaped transcript analysis of virtual semi structured interviews with the participants. The scope of this phenomenological study included bereaved mothers who had a young adult child die from a drug overdose and the deceased was between the ages of 18 and 25 at the time

of death. The death occurred 2 years or later, therefore, all participants were at least 2 years beyond the date of the child's death. The scope of this study was another delimitation because it reduced the participant pool to individuals who identify as women, who had a child die between the ages of 18 and 25 years of aged from a drug overdose and the deaths had to occur 2 years or longer ago.

A demographic delimitation was that the participant was required to speak English. I determined the ideal number of participants was 12; however, more would have been recruited if theoretical saturation was not met. Twelve is the recommended number to gather enough data and themes while not diluting the process (Creswell, 2014). The study had 11 participants and theoretical saturation was met, which was evident by the number of common themes. Klein and Westcott (1994) posited that the participants could be generalized to a larger population. For this to happen, there was not a criterion exclusion on race, ethnicity, marital status, socioeconomic status, or any other descriptors other than the ability to speak English and self-identifying as a mother, stepmother, or adopted mother. My study has transferability potential as it pertains to researching other age groups of the deceased children. Le Poi Devin's work was used as the framework for my phenomenological study and other parental grief theories were considered, however, they were not included. The unused theories include stage based, attachment theory, and dual process model (see Bowlby, 1969; Kubler-Ross, 1969; Stroebe & Schut, 1999). It was the specific nature and focus of my study which determined that multidimensional grief theory was the best theory to explore and uncover the lived experiences of bereaved mothers.

## Limitations

The primary limitation of this phenomenological study was the design. There is a weakness in the design because I used purposeful sampling, not random sampling. Therefore, it may not be as general to the population as it could be. Also, the sample size in qualitative sampling is smaller than the sample size of a quantitative study (see Creswell, 2017).

I remained neutral using objective tones throughout the entire interview process. Creswell (2014) suggested one of the key points of qualitative research is to seek authenticity and credibility and not validity or reliability. To ensure credibility, the participants had the opportunity to review their own transcripts for accuracy and clarification of any points. They each had the opportunity to review the findings prior to them being finalized. These points and other factors of ensuring reliability are described in detail in Chapter 3.

## Significance

Past studies revealed a need for more information regarding drug overdose deaths and the bereaved parent or family figure. Feigelman et al. (2011) concluded that the literature on bereavement is missing an empirical understanding of how bereavement affects mothers' physical and emotional health following the death of a young adult child from a drug overdose. Drug overdose deaths are part of media headlines practically every day and continue to be a social issue. The CDC (2015) reported that illicit drug usage is increasing and the rate of drug-related deaths alone nearly quadrupled between 2002 and 2013.

The implications of positive social change for this phenomenological study were to raise and promote awareness of drug overdose deaths and provide a platform for mothers who did not have a voice about their lived experiences after the death of a young adult child following a drug overdose. This could lead to additional prevention techniques and public service announcements like how the Mothers Against Drunk Drivers campaign influenced the prevention of driving while intoxicated. In addition, addressing this issue could help support systems such as family, friends, healthcare, and mental health providers to understand how mothers endure and describe the deaths of their young adult child from a drug overdose while providing grieving mothers an opportunity to share their lived experiences.

## Summary

This chapter introduced the topic of exploring the individual experiences of bereaved mothers as a phenomenon (see Thompson et al., 2011). To explore this phenomenon, a subpopulation of bereaved parents, the cause of death, and age at the time of death who are not represented in current bereavement studies needed to be identified. The gap in the literature was identified because most research focuses on parental bereavement, or the death of a child who was under the age of 18 years old at the time of their death (see Essakow & Miller, 2013; Titus & de Souza, 2011).

In this phenomenological study, I attempted to increase awareness of scholar practitioners regarding the coping strategies of bereaved mothers. I also attempted to improve understanding of how bereaved mothers perceive their own experiences of having loss a young adult child following a drug overdose and whether the loss affected their physical health and emotional responses.

In this phenomenological study, I focused on the experiences, perceptions, and attitudes of grieving mothers and I attempted to determine if addressing each dimension had an impact on their grief process. Phenomenological research was identified as the best option for this study to receive accurate reporting of these experiences. Additionally, the most effective way to collect the data was through semi structured interviews with women who met a specific criterion of being a bereaved biological mother, stepmother, or adopted mother.

My goal for this phenomenological study was to fill a gap in the parental bereavement literature and improve the understanding that grief reactions and experiences are individualized. These grief reactions and experiences may depend on numerous factors including the cause of death, the age of the individual at the time of their death and the relationship to the deceased. This gap also included a subpopulation of bereaved mothers following the death of a young adult child after a drug overdose. Chapter 1 included the introduction to the study, the background, the problem statement, the purpose of the study, research questions, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, significance, and a concluding summary. The next chapter is an analysis of the current literature, search strategy, theoretical foundation, review of the literature and key concepts related to the current study, a summary, and conclusion.

# Chapter 2: Literature Review

Most individuals will experience the death of a family member at some point in life. While death is universal and consistent, the grief process is complex due to a myriad of individual and social influences. For example, the grief process can be associated with physical illness, emotional distress, and social isolation (Fundukian & Wilson, 2008). Findings in bereavement and grief literature suggests the grieving process is very individualistic, therefore; the therapeutic intervention and support systems should be individualized (Thompson et al., 2011).

There have been several attempts to understand the constructs behind grief and bereavement, these attempts have led to various grief theories and research about various types of grief. In turn, researchers have study grief and bereavement based on the causes of death such as natural causes, terminal illnesses, suicides, homicides, and automobile accidents. These causes of death affect all age groups and can happen at any age including young adult children. However, most of the research regarding maternal grief focused on suicide attempts (Feigelman et al., 2011). Even though there is a rise in drug overdose deaths, there is a lack of research to explain the impact drug overdose deaths has on the surviving mothers (Valentine et al., 2016).

In this current study, I addressed the gap in the literature regarding a specific population of bereaved mothers who had a child die from a drug overdose. Additionally, past and current maternal grief studies have not addressed the lived experiences and perceptions of mothers after their young adult child died from a drug overdose when the age of death was between 18 and 25 years old; therefore, this current study will address this gap.

The purpose of this phenomenological qualitative study was to explore the perceptions and experiences of grieving mothers after a biological, adopted, or stepchild dies from a drug overdose when the child was between 18 to 25 years old at the time of death. The focus of my study was to learn how mothers perceived the death of their child and to record their perceptions of their experiences regarding their emotional expressions, physical health, and daily coping strategies. This gives voice to a population whose voice has been limited because of the lack of exploration about drug overdose deaths. It could better assist mental health practitioners in providing individualized and effective treatment, and it could promote awareness to assist family and friends to help be a support system.

In this chapter. I will review the current literature regarding types of grief, specifically maternal bereavement. The chapter includes the literature search strategies used to research the type of grief and bereavement. The terms *grief* and *bereavement* are used interchangeably. Then, the theoretical foundation proposed in this study will be discussed including my rationale for using it. Next, I will provide a review of the current literature relating to maternal bereavement as it applies to the three of the seven dimensions from the theoretical foundation of multidimensional grief theory and how various causes of death affect maternal grief. The chapter will conclude with a summary of the major maternal bereavement themes in the literature.

## Literature Search Strategy

The search strategy for this literature review was comprised of identifying scholarly peer-reviewed journal articles pulled from the academic databases of Spicata, PsycINFO, PsycARTICLES, ERIC, Medline, PubMed, CINAHL, SAGE Full-Text

Collection, and SOCINDEX with Full Text. The keywords to search included *child death and qualitative, child loss, substance or drug overdose, maternal grief, concepts of grief, models of grief cope, grief history, theories of grief, coping,* or *coping strategies, religion and death, spirituality and death, suicide, homicide,* and *motor vehicle accidents*. Many of the articles obtained were from *The Journal of Death Studies, Omega: Journal of Death and Dying,* and *The Journal of Loss and Trauma.* This detailed search helped to uncover gaps in the current literature where the need to explore this topic within this population was identified.

## Theoretical Foundation

The theoretical foundation for this study was Le Poi Devin's multidimensional grief theory (MGT) model (Blackman, 2008). Le Poi Devin theorized grief as a process of synchronized change meaning the bereaved individuals would simultaneously experience changes as they go through the grief process. She theorized that this change process occurred in seven dimensions of an individual's lived experience (Payne, 1999). These seven dimensions include emotional, social, physical, lifestyle, practical, spiritual, and identity (Kaplow et al., 2013). Le Poi Devin believed if individuals could identify the underlying issues of each dimension, then they can gain understanding of their circumstances and reactions to bereavement (Kaplow et al., 2013). The bereaved, their support system, and healthcare providers (Chentsova & Zisook, 2005) can use this model throughout the grief process.

Due to Le Poi Devin's untimely death in 1989, few studies have used the MGT model in bereavement studies. In their study, Kaplow et al. (2013) used MGT which they described as a newly developed model, to explore the key features of military related

grief experiences, which included grief following combat death. They had three primary goals in using this grief theory, which were (a) to see if the role of the theory guided efforts to describe, explain, predict, prevent, and treat maladaptive grief in military service members, children, and families; (b) the relevance of multidimensional grief theory for addressing both losses due to physical death as well as losses brought about by extended physical separations to which military children and families are exposed during and after deployment; and (c) a focus on military-related grief as a much-needed complement to an already-established focus on military-related posttraumatic stress disorder (PTSD). Toller (2008) supported Le Poi Devin suggesting parental bereavement is multidimensional and that parental grief is driven by specific mourning that impacts the entire parental experience, lasting throughout the life of the parent. Toller suggested this multidimensional process in parental bereavement involves shifting identities, roles, and relationships, as well as the loss of what could have been or possibilities.

My study used MGT as the theoretical foundation because I sought to uncover the perceptions and experiences of mothers regarding their physical symptoms, emotional expressions, and coping mechanisms after the drug overdose death of a child. These three components of grief directly align with three of the seven dimensions of multidimensional grief theory. The research questions listed later in this study explore three of the seven dimensions of multidimensional grief theory. The three in this study are the emotional dimension, physical dimension, and practicality dimension under the guided lens of the MGT to explore if grief emerges, persists, worsens, or recedes as it relates to an individual's physical state, emotional responses, and daily coping.

## Parental Bereavement

Before delving into maternal bereavement, which was the primary focus of my study, it is important to look at the past literature of parental bereavement. *Parental bereavement* is a term referring to a state of existing and living following the death of a child. Parental bereavement can morph into many forms and can be accompanied with many issues such as not adjusting to the loss physically and emotionally, not using healthy coping mechanisms, lacking the ability to move forward, or identification issues, (Giannini, 2011; Harper et al., 2011; Toller, 2008; Wijngaards-de Meij et al., 2007). In my study, I look at the dimensions of physical, emotional, and practicality.

Grief literature is not new and there is an abundance of it, however, research into how parents adapt after the loss of a child is limited primarily because of the sensitive nature of the topic (Hooghe et al., 2012; Hynson et al., 2006). Even though, a 2006 phenomenological study reported participants who experienced parental bereavement were happy for the opportunity to participate in bereavement research because the interview process acted as an important therapeutic cleansing (Hynson et al., 2006). Literature searches showed there is extensive research regarding various grief models including coping strategies. Harper et al. (2011) suggested the application of these models for grieving parents prove difficult because there is limited data about the effectiveness of this population. The problem with recent literature regarding parental bereavement primarily lies with discrepancies between adjustment concepts and possible outcomes (Giannini, 2008; Paletti, 2008).

## Factors Affecting Maternal Bereavement

There are various forms of bereavement experienced by individuals to include parental bereavement, paternal bereavement, sibling bereavement, bereavement from violent deaths, and maternal bereavement. In reading grief studies, the primary goal of most researchers is to have a better understanding and insight into the bereavement and grief process. This concept of looking at the complete grief process is too broad for my current study. However, in reviewing some of the findings in the grief literature as highlighted in the next sections, this broad concept may assist in forming the current study. There are numerous causes of death, which leads to maternal grief such as natural causes, suicide, and homicide. Although there are different causes of death, maternal grief experts agree that a death of a child affects a parent's physical and psychological health (Dias et al., 2018; Li et al., 2003; Song et al., 2010; Walsh, 2007). However, these same experts have varying theories regarding the causes of complicated grief citing that the cause of death does not solely influence the type of grief. Influencing types of grief include the specific circumstances surrounding the death, the cause of the death, or the age of the child when they died. Research also had varying findings on the most effective types of intervention techniques to use with bereaved parents such as support group therapy, individual therapy, and rituals to remember the deceased (Boelen & Hoijtink, 2009; Chambers & Chan, 2000; Debiec & LeDoux, 2006; Flenady & Wilson, 2008; Harvey et al., 2008). Other factors include coping strategies or adapted grieving skills as well as spiritual, cultural, and religious beliefs affecting maternal bereavement, which are all part of multidimensional grief theory. The next two sections discuss drug-related

deaths and ages at the time of death, the lack of literature in these two areas assist in supporting the gap of my current study.

**Bereavement from Drug-related Deaths**

A search was completed using the terms *bereavement, grief, maternal, mother, drug overdose,* and *sudden loss* to specifically find literature about drug overdose deaths. This search produced three qualitative studies, which focused on drug-related deaths (e.g., da Silva et al., 2007; Feigelman et al., 2009, 2011; Guy, 2004). da Silva et al. (2007) conducted a study in Brazil where six bereaved family members participated. The researchers focused on the family unit and whether they knew or did not know the deceased was a substance user; however, their focus was not on maternal bereavement. In 2004, Guy conducted an English pilot study in the United Kingdom of four bereaved family members. The participants of his study included parents, grandparents, and siblings as a family unit where he conducted case studies to examine the lived experiences of four families following the death of a family member from a drug overdose. Their study did not focus on maternal bereavement, nor did they focus specifically on the mother's perceptions of the death or their experiences regarding physical health, emotional expressions, and coping strategies as I have done with the current study. Feigelman et al. (2009) explored the mechanisms parents used to cope after a suicide or drug overdose of a child. Their study eventually expanded into an exploratory, comparative study in 2011 where they compared maternal bereavement after a drug-related death to other causes of death. Their study was conducted in the United States and the only one of its types conducted in this country. Although their study looked at drug-related deaths, it did not delve into the perceptions of the mothers

regarding emotional expressions, physical health, and coping strategies. Nor did their study specifically look at the age at the time of death as I did in the current study.

The search of the literature showed substantial research on the maladaptive effects of substance use in individuals who are addicted or dependent upon substances. There was limited literature on the experiences substance misuse has on family members. Orford et al. (2013) suggested those having an emotional bond to the substance user have been largely neglected in research. Orford et al. suggested research is scarcer on family members who are bereaved following a drug overdose death even though drug-related deaths are on the rise. The United Nations Office of Drugs and Crime (UNODC) reported deaths relating to drug overdoses are highest in North American compared to any other continent. These deaths accounted for approximately one in every 20 deaths among persons ages 15 to 64 (UNDOC, 2015). The UNODC (2015) statistics showed that in Europe, approximately one in 110; in Africa, one in 150; in Asia, one in 100, and in South America, one in 200 deaths are drug related. Despite these alarming figures, there is limited research about the impact drug-related deaths have on those who were emotionally tied to the substance user. There is still a lack in research dedicated to maternal grief after a child succumbs to a drug overdose. Out of these four studies, none of them focused specifically on the grieving mothers as it relates to losing a child from a drug overdose. In my study, I focused on this subpopulation of mothers.

**Bereavement from the Age of Child at Time of Death**

It was important to discuss age at the time of death because most child death literature include minors under the age of 18. Death literature about adult children is scarce especially when the topic is about drug overdose deaths. The deceased child's age

at their time of death is one variable that is overlooked or generalized in current maternal bereavement literature (Cacciatore & Flint, 2012; Giannini, 2011; McBride & Toller, 2011;). Giannini (2011) interviewed five married couples who were bereaved by the death of their child. The study explored communications and social interactions over the course of their grief and their healing process. In the study, the age of the deceased children at the time of death ranged from 3 to 22 years of age. Snowball sampling was used and the participants were recruited from a variety of organizations offering grief support. The common themes found included compassion, acknowledgment, and inclusion. The researchers defined *compassion* as the ability to listen and empathized with the bereaved. *Acknowledgment* involved thinking about and communicating about their loved one to and from parents and their supporters. *Inclusion* was defined as supports including the bereaved in their lives. The researchers found that inclusion was a significant factor in whether the bereaved parents became socially isolated or not (Giannini, 2011). In comparison, my study specifically looked at drug-overdose deaths and specifically looked at cases where the age of death was between 18 and 25 years of age.

Hunt and Greeff (2011) used a qualitative method in exploring the lived experiences of 22 parents. The ages of the deceased in their study ranged from newborns to adulthood. The factors associated with grief included events leading up to the death, events following the death, and the cause of death. The researchers coded the participant's grief reactions as cognitive, emotional, behavioral, physical, spiritual, and relational. It was reported that parents reacted strongly to how they were informed of their child's death when they did not have time to prepare. Their study did not focus

solely on adult children's deaths, their participants were not solely mothers and they did not focus specifically on drug-overdose deaths. My current study focused on all three, which further supports the claim of there being gaps in grief research. As mentioned before, there is a broad range in the ages of the children at the time of death in grief and death literature. The literature also shows various causes of death from suicide to natural causes, however, there is limited research on drug overdoses specifically showing the impact on mothers. The following sections of this chapter will review the literature about causes of death affecting maternal bereavement. It was important for the current study to show there is an abundance of literature available regarding these causes of death and how these deaths affect maternal bereavement to further solidify the existing gap of there being limited literature about drug overdose deaths and its effects on maternal bereavement.

**Bereavement from Suicide**

Tal-Young et al's. (2012) study reported that the commonalities among the participants was that suicide often creates a long-term trauma as the parents battle to understand how their child could have committed such an act. They reported that therapeutic interventions sometimes fail parents because they lead parents to discovering missed warning signs from when their deceased child was living. Psychological pain is more prevalent in suicide related deaths. The term *psychache* was created to describe this form of psychological distress. *Psychache* is a complex concept because a person completing a suicide is considered to have completed their psychache whereas the surviving parent is at the beginning of theirs (Cobain & Larch, 2006; Hall et al., 2018). Cobain and Larch (2006) and Alaverdova (2011) described stages of grief as initial shock

followed by denial; forms of anxiety and variations of panic; intense anger and blame towards self and others; resistance and avoidance; immobility and isolation or withdrawal; and transition to a final state of being, which could lead to the feelings of long-term trauma.

Although there may not be a specific way to grieve, it is inherently clear that grieving individuals must go through most stages of the grief process to heal or adapt. Regarding suicide, the initial shock and denial stage involves difficulty in believing their child died from self-inflicted harm (Alaverdova, 2011; Cobain & Larch, 2006). Anxiety and panic are the physical responses to a sense of helplessness and lack of control while feelings of anger and blame is a conduit for the helplessness. Avoidance and forms of resistance is a form of cognitive protection to temporarily forget the death occurred. Withdrawal and immobility involve emotional and physical responses, which can be described as disorganized, disoriented, or not being able to function normally. Participating parents in the 2006 study described their experiences as a series of events where the first year they felt like they were in a frozen abyss and the second year was considered the defrosting period. Cobain and Larch (2006) suggested that a prescription for health and successful healing include social supports, memories, laughter, improving the parents' physical and emotional health, increased activities such as sports and hobbies; and forgiveness of oneself, forgiving of others and ultimately forgiving the deceased child.

**Bereavement from Motor Vehicle Accidents (MVA)**

Motor vehicle accidents (MVAs) can result in a sudden loss; sometimes death is not instant. This could lead the surviving parent ruminating about whether their child

suffered prior to the death (Murphy et al., 2003; Stebbins & Batrouney, 2007). Ovstedal et al. (2017) reported by using The Global Status Report on Road Safety from the World Health Organization (WHO) that over 1.2 million people die in road traffic crashes every year and young people between the ages of 18 to 25 years are overrepresented in traffic fatalities. Motor vehicle accident deaths from intoxication involves distinct challenges for the grieving parents. Sprang and McNeil (1998) conducted research about the post reactions of families following fatalities involving alcohol-related deaths. They surveyed 171 family members; it was reported that many individuals found distinct complications in survivors undergoing the grief process

Ovstedal et al. (2017) conducted a study in Norway where the researchers interviewed 24 individuals from 15 families who had a son or daughter die from being in a traffic accident. Similar to other studies, the participants' grief process went through several stages of grief including the effect the loss had on family events, loss of a young life, and a new normal for the surviving family member. The parents reported the grief is more devastating during the first few years and the sense of being overwhelmed never disappears, however, over the years there is some acceptance and coping.

**Bereavement from Homicide**

When a person makes the decision to end another's life, practically everything people believe is questioned. Like suicide, family survivors of homicide victims are shattered (Armour, 2007; Cobain & Larch, 2006; Goodrum, 2005). Grief felt by homicide survivors is more difficult than with other forms of death. Armour (2007) and Goodrum (2005) noted that the participants reported interference of the grieving process by the persistent involvement from law enforcement officials. Additionally, the violent and

unexpected nature of homicide deaths impedes normal grief for survivors (Armour, 2007).

Goodrum (2005) described the interaction between emotions and thoughts when individuals are informed of the homicide death of their loved one. Prior to his 2005 study, there was a lack of research regarding the impact homicide death notifications had on the surviving family. It was found that the bereaved family member emotions vacillated from trying to suppress their emotional pain to extenuating emotional turmoil. The thoughts of these individuals during the homicide death notification range from assisting the bereaved through the trauma or adding to the traumatic event. Murphy et al. (2003) reported that parents who had a child murdered experienced higher levels of mental and emotional strife compared to other surviving family members. This is primarily due to the parent replaying the events which often leads to PTSD, complicated grief, and difficulty with moving through the grieving process. The following section of this chapter will review the types of grief found in bereavement studies. My study addressed drug overdose deaths, so it was important to review the types of grief the participants may have experienced to understand their perceptions and experiences.

## Types of Grief

The type of grief researched in the current study are *sudden loss, complicated grief, normal/uncomplicated grief, and anticipatory grief*. All of them are rooted in the foundation of bereavement and grief studies. All types of grief show how individuals respond to loss and the type of loss. The types of grief highlighted below show how individuals respond to loss physically, emotionally, and socially. The literature about the types of grief supports my current study because I looked at the experiences and

perceptions of bereaved mothers and the affects the loss had on their physical health, emotional responses, and coping mechanisms.

**Sudden Loss**

Sudden loss grief is important to the current study because drug-overdose deaths fall into this type of loss except for the deceased going into a coma first or being on life support, which would prolong the death. Loss from a *sudden death* refers to an unexpected death that occurs without warning. This type of loss could be from a natural or unnatural cause and in some cases could have been prevented (Brywiewicz, 2008; Murphy, 2008) such as death from a drug overdose. As scholar-practitioners, there are various aspects to consider regarding this type of death. The surviving family members often will experience feelings of guilt about not preventing the death, a sense of helplessness, unresolved business, unrealistic thoughts about the loss, and having to deal with involvement of medical professionals and legal authorities (Brywiewicz, 2008; Murphy, 2008; Parker & Dunn, 2011). Brywiewicz (2008) conducted a phenomenological study with five participants who experienced the sudden death of a loved one. There were five emerging themes uncovered when the data was analyzed. These themes included (a) lack of empathy from hospital staff, (b) the need for closure, (c) acknowledgement of the loss, (d) the need to help others, and € unanswered questions from law enforcement and healthcare personnel about the loss.

**Complicated Grief**

In comparison to uncomplicated grief, the percentage of individuals bereaved from complicated grief is significantly lower occurring in approximately 10% to 20% of those individuals (Enez, 2018; Miller, 2009). *Complicated grief* is defined as failure to

evolve from serious or acute stage of grief to an integrated one. As a result, an individual remains in the acute stage for an extended period and sometimes indefinitely (Miller, 2009). Complicated grief symptoms include severe separation distress such as recurrent emotional pain, extended intense yearning for the departed, persistent and intrusive thoughts of their loved one, and traumatic distress such as bitterness and anger (Allen et al., 2013; Eisma et al., 2013; Miller, 2009; Thimm & Holland, 2017). Typically, these experiences of traumatic distress and intense separation last beyond the normal six-month period associated with normal grief. Those with complicated grief find themselves in a repetitious loop where it negatively affects major aspects of life. It is also accompanied by inescapable sadness and anxiety. There is also an intense sense of shame, fear, and unfamiliarity (Allen et al., 2013; Eisma et al., 2013; Miller, 2009; Thimm & Holland, 2017). Some of the beliefs are rooted in bizarre thoughts where these types of mourners do not want the suffering to end because they believe that it ties them to their loved one and by enjoying their life or moving on means, some form of betrayal.

Complicated grief disorder is characterized as having negative symptoms or maladaptive behaviors after experiencing a traumatic loss (Miller, 2009). Along with the aforementioned symptoms, some of the maladaptive behaviors consist of over-participation in activities related to the deceased or the other end of the spectrum of excessive avoidance of these activities (Allen et al., 2013; Eisma et al., 2013; Enez, 2018; Miller, 2009; Thimm & Holland, 2017). Other behaviors include severe preoccupation such as extended hours visiting the cemetery, constantly rearranging belongings, or persistent daydreaming. Those with complicated grief may estrange themselves from

family, friends, and associates (Allen et al., 2013; Eisma et al., 2013; Enez, 2018; Miller, 2009; Thimm & Holland, 2017).

Complicated grief unlike normal grief can be identified using the Inventory of Complicated Grief (ICG) Scale (Castro & Rocha, 2013). If an individual score ≥ 30 on the ICG six months or more after the death, then they would be considered having complicated grief. Not only is complicated grief indicated by the emotional responses, it is also associated with physical impairments and negative health consequences (Castro & Rocha, 2013). Studies have reported that complicated grief promotes sleep disturbances and increases risks of hypertension, substance use, cancer, cardiac disease, and suicidality (Eisma et al., 2013; Thimm & Holland, 2017).

Studies reported that individuals who experienced complicated grief will be at a greater risk in developing it whenever there is a loss. In addition, those with a history of mental illness such as depression are more likely to experience complicated grief (Eisma et al., 2013; Thimm & Holland, 2017). McSpedden et al. (2017) reported that women who perceived to have a social support system had less symptoms and behaviors of complicated grief. It was also posited that parents specifically mothers experienced complicated grief when bereaved by the death of a child. My current study focused more on complicated grief as it tends to develop more often in the population of the current study. Mothers bereaved by the death of their child often experience complicated grief than any other group as stated above.

**Uncomplicated Grief**

*Normal, uncomplicated grief* and *non-pathological* grief are used interchangeably (Zisook & Shear, 2009). Hamilton, in a 2016 National Institutes of Health article reported

that *grief* is often characterized as being normal or uncomplicated, and abnormal or complicated. Zhang et al. (2006) posited the typical grieving process can be remarkably agonizing for the bereaved, however, most individuals are able to recover from the emotional pain associated with grief and heal from their loss (Linde et al., 2017). Linde et al. (2017) and Zhang et al. (2006) suggested the majority of individuals who suffer from grief undergo normal or uncomplicated grief. Armour (2007), Arnold and Gemma (2008), and Rogers, Floyd, Seltzer, Greenberg, and Hong (2008) all posited that regardless of the type of grief; those bereaved by the loss of a child have life-time affects.

Past researchers have attempted to outline concrete stages of grief; however, current researchers have recognized that the various stages are fluid and differ from person to person and based on many factors such as experiences, actions, and reactions. Paulus and Varga (2015) and Penman et al. (2014) suggested that in normal grief, support from family, friends or spiritual guidance can help fill the gap. This type of support system can be extremely helpful after a traumatic loss, such as death by suicide, death of a child, or death by unnatural causes such as homicide. The participants of my study could fall into this category as it addresses children's deaths. A strong support system as highlighted in the practicality dimension of MGT in my current study could help prevent complicated grief from forming.

**Anticipatory Grief**

*Anticipatory* grief is defined as grief that occurs in response to an expected loss. This type of grief is different from the others mentioned in this research because it affects not only the individual diagnosed with the terminal illness, but their family, friends, and loved ones too (Johnson et al., 2017). Lindemann coined the phrase anticipatory grief and

reported that this type of grief has many characteristics meaning there is anticipatory grief in preparing for the death of a loved one and the person who is dying experiences anticipatory grief of their impending death (Lindemann, 1944). As it relates to this current study, anticipatory grief can present itself in drug-over dose deaths when a mother is waiting for her child to die from an overdose because they have over-used drugs in the past resulting in medical interventions or they continue to relapse.

Anticipatory grief could have a profound impact on the grief process and help prevent complicated grief from forming. Costello and Hargreaves (2008) and Overton and Cottone (2016) stated anticipatory grief provides an opportunity for adjusting to the impending loss and preparing for the death. In 2004, Seecharin reported that mothers who had a child die suddenly experiences more intense grief reactions in comparison to a mother who had a child die from a terminal illness. This intense reaction could be attributed to the fact that parents bereaved by a sudden death did not have the opportunity to prepare for the loss. A mother having a child die from a drug-overdose may not experience as a sudden loss as highlighted under the sudden loss section because her child was an ongoing substance user and she anticipated the loss.

## Summary and Conclusions

In this literature review, I looked at parental bereavement; specifically, maternal bereavement and the multiple factors affecting maternal bereavement such as drug-related deaths, age of child at the time of death, suicide deaths, homicide deaths, and motor vehicle accident deaths. Parental bereavement focuses on the loss of the child and the impact that loss has on the surviving parent. Whereas maternal bereavement focuses specifically on how a loss affects the mother. The maternal grief process is influence by a

multitude of factors such as the relationship between the mother and child, the age of the child at the time of the death, and the cause of death. Other influences discussed in the literature review is the type of grief experienced by the mother, which may be directly related to the type of loss such as sudden loss or anticipatory loss.

Maternal bereavement is complex with many factors that can influence the trajectory of the emotional and physical responses while affecting the bereavement timeframe. Not fully understanding or ignoring these factors such as the cause of death, social interactions, relationships, and child's age at the time of death could very well have negative long-term effects. While understanding and paying attention to these factors allows us to see how individualistic a loss of a child affects a person exclusively.

Recent literature has shown some progress in the understanding of maternal bereavement, however, there is very little research regarding maternal bereavement after a child dies from a drug overdose. There is still more work to accomplish in this area especially with the rise of drug-related deaths. It is more imperative than ever that the professionals and scholar-practitioners promote awareness and understanding in this area in order to support those parents specifically mothers grieving from this specific loss.

The next chapter explores the proposed method for studying lived experiences and perceptions in the bereavement process for mothers mourning the death of a child. Chapter 3 will introduce the research design, rationale, the role of the researcher, methodology, instrumentation, the data collection process as well as the data analysis process, and issues with trustworthiness and ethics. Chapter 3 also includes the appendixes of the documents used in the study.

# Chapter 3: Research Method

The purpose of this phenomenological study was to explore the perceptions, attitudes, and experiences of grieving mothers who had a biological, adopted child, or stepchild die from a drug overdose when the deceased was between ages 18 and 25 at the time of death. My intent for this study was to provide a first-person interpretation of the phenomenological experience of bereaved mothers, which could help explain the potentially life-changing variables of their grief. The primary focus was to uncover the full spectrum of their experiences from the moment of first notification about their child's death to where they currently are in the grief process. Additionally, my goal for this study was to present how grief affects the physical symptoms and emotional expressions of these mothers, as well as the coping mechanisms used in grief recovery.

Discovering how the mothers selected for their study experience grief required thorough consideration of the details associated with this specific loss. This review includes a specific inquiry to verify that the child's age was 18 to 25 at the time of death and the cause of the death was a drug overdose. I chose these two criteria because my review of the literature revealed an abundance of research where the child's age at the time of death spans from birth to 18 years (see Essakow & Miller, 2013; Meert et al., 2011). Additionally, there is ample literature about various causes of death; however, research about death from a drug overdose is limited (Feigelman et al., 2011). Narrowing the selection criteria of the present study to include mothers of deceased children in the identified cause of death and age range may offer an understanding missed in the other comprehensive studies (see Feigelman et al., 2011). As identified in Chapter 2, these

comprehensive studies are by da Silva et al. (2007), Feigelman et al. (2009, 2011) and Guy (2004).

In this chapter, I described the research design and rationale and address the significance of this qualitative phenomenological study. An overview of the role of the researcher, including data collection tools and potential biases characteristic to this type of method, is introduced. This chapter also provides the methodology, including participation selection, interview questions, data collection, and data analysis. Ethical issues and issues of trustworthiness discussed along with a final summary of the entire chapter.

## Research Design and Rationale

The decision to use the phenomenological approach was based on a comparison against grounded theory, which I originally considered for this study. Researchers use grounded theory when the aim of a study is to develop theories once emerging themes from the data are uncovered (Creswell, 2014). Omar et al. (2010) posited that, with grounded theory, a researcher can begin to understand the data through the exploration and categorization of emergent themes. Afterwards, researchers can make connections and develop hypotheses for more exploration. The grounded theory model provides a researcher with opportunities to explore the interpersonal and social experiences of the participants (Creswell, 2014); however, that was not the goal of the present study.

Another possibility I considered for this study was the ethnographic methodology, which allows for the exploration of the experiences of a specific social group or culture. Prior to several changes, the present study was initially going to focus on the lived experiences of African-American mothers. Schensul and LeCompte (2012) suggested an

ethnographic study can only be fully conceptualized if there is long-term engagement with the group. I decided against the use of ethnographic methodology because (a) I did not have sufficient available time to immerse myself into one group and (b) this methodology did not align with the goals of the study because a diverse participant pool was necessary.

Creswell (2014) suggested that using a phenomenological design in a qualitative research study allows for participants to describe their own experiences. In the present study, I explored the experiences and perceptions of grieving mothers. The phenomenological design was appropriate because the research questions, objectives, and goals aligned with this type of design. This methodology allowed me to visit the world of the participants and facilitate data collection through semi structured interviews where each participant's experiences was recorded, transcribed, and analyzed (see Creswell, 2014).

Audio-recorded semi structured interviews was conducted with mothers who loss a child from a drug overdose. Semi structured interviews and open-ended questions were appropriate for this phenomenological study because this type of interview and these types of questions fostered a forum to garner the type of information needed for this approach. Creswell (2014) described qualitative research questions as open-ended, nondirectional, and evolving. Central questions are broad in nature and explore a central phenomenon or concept (Creswell, 2014). The research questions and the questions that were prepared for the semi structured interviews helped frame the objectives of the present study and allowed for guidance in the exploration of the lived experiences of the bereaved mothers.

The sample size selected involved 11 participants. I planned to recruit more participants if theoretical saturation was not met; however, saturation was met with the 11 participants as indicated by the numerical responses within the themes (see Creswell, 2014; Moser & Korstjens, 2018). As suggested by Moser and Korstjens (2018) and Palinkas et al. (2015), purposeful sampling was used because the study is qualitative in nature. Palinkas et al. (2015) reported that this form of sampling is best used for studies exploring a phenomenon or lived experiences. Data analysis was based on the interview transcripts and was managed using NVivo 12, the latest version of NVivo qualitative data management software (see Edhlund & McDougall, 2019). NVivo 12 was used to create and categorize themes based on the most common terms and phrases that presented themselves during the study analysis.

The following research questions guided this phenomenological study:

RQ1: What are the perceptions and experiences of mothers who loss a young adult child from a drug overdose?

Sub question 1a: What are the physical symptoms experienced by mothers following the death of a young adult child from a drug overdose?

Sub question 1b: What are the emotional expressions experienced by mothers following the death of a young adult child from a drug overdose?

RQ2: What are the coping mechanisms used by mothers following the death of a young adult child from a drug overdose?

In addition to the above research questions and sub questions, there were some broader open-ended questions to help guide the interview. The questions were not asked in any order because, as posited by Moser and Korstjens (2018), in individual interviews,

the sequence of interview questions depends on the participants and how the interview unfolds. Moser and Korstjens also suggested that the interview should be allowed to evolve as a dialogue and not a strict question and answer interview. In their study, the interviews focused on how the loss of their child affected the participants and their perceptions and attitudes towards that loss. In my current study, the questions helped me understand the relationship between the mother, their closeness, and any mother/offspring dynamics that could affect the bereavement. Some questions involved the cause of death itself, such as what type of substance was used, where was the child when they died, and who were they with when the death notification was received, as well as other questions surrounding the death. Other open-ended questions about physical and emotional health changes, social supports, and coping mechanisms or therapeutic interventions were asked to help guide the phenomena and the concepts of the study. Some of the semi structured interview questions included the following:

- How were you informed of your child's death?
- Tell me what it was like for you to experience the loss of a child.
- What do you recall regarding how you felt emotionally?
- What changes have you experienced with family and friends since your loss?

The full list of semi structured interview questions can be found in Appendix B.

The decision to use a phenomenological methodology was based primarily on my focus of the study and the research questions. My goals for the study were consistent with the exploration of the lived experiences, perceptions, and attitudes of this population of bereaved mothers. A phenomenological framework allowed for the discovery of various

information that are not normally uncovered or may have been generalized in past studies about parental bereavement.

## Role of the Researcher

In the role of the researcher for this current study, I remained an impartial observer throughout the processes of data collection, data analysis, data interpretation, and data reporting. This was important considering I am a licensed professional counselor of mental health in the state of Delaware who is certified in grief counseling. There are several key tasks for researchers involved in a phenomenological design (Creswell, 2014). One of them includes the examination of the phenomenon from every perspective until an integrated construct is uncovered within the related experiences (Moustakas, 1994). According to Creswell (2014), researchers must not provide any explanation or definition of the data, but they must describe or explain the information as it has been given during the data collection process as not to skew the implied meaning of the participants. The researcher is responsible for ensuring the design of the study, participant selection, data collection, data analysis, and written summaries are executed fairly and equitably while ensuring no harm or duress to the participants (Creswell, 2014).

As the researcher in this study, I remained objective, yet sensitive and empathic to the mothers who shared their stories of loss. As recommended by Wall et al. (2004), I maintained a diary after each interview to memorialize my personal reflections, expectations, and feelings that needed to be confronted to ensure unbiased description of the data. Additionally, I worked with a licensed psychologist throughout the study to process feelings or emotions that could lead to any biases. The researcher needs to establish boundaries and recognize any limitations during the early stages of the study in

order mitigate risks to the participants (Creswell, 2014). This is equally important because my own grief experiences could pose a threat to remaining objective. My personal grieving experiences to a drug-related death involved the death of my father, who was killed by his neighbor who was intoxicated from phencyclidine (PCP).

Any biases occurring because of these reasons were addressed immediately. I attempted to identify and examine any perceived biases through journaling, a therapeutic session with my current and personal licensed psychologist, discussed with colleagues, and consult with university faculty not limited to my university chair or committee member.

## Methodology

### Participation Selection

Participant selection included a purposive sampling of women who self-identified as a biological, adoptive, or stepmother who were over the age of 18 and who had a young adult child between the ages of 18 to 25 years die from a drug overdose. Examples of this type of loss included drug overdose deaths from illicit drugs, prescription drugs, accidental overdoses, or suicidal overdoses. Participants were recruited from grief support group and because of COVID-19, participants were recruited through social media pages specifically created for this study. Snowball sampling was available as an additional recruitment strategy and was used as word-of-mouth referrals opportunities with two of the 11 participants. A family member of one and a friend of the other participants saw my recruitment letter on social media and sent it to them. The geographic location for the participant selection is the state of Delaware located in the United States. All participants were within a minimum of 2 years beyond the date of the

loss, spoke English, and had access to outpatient services in addition to the grief support groups. Individuals who had or have a personal or professional relationship with me was not eligible to participate in the study.

It was determined that the ideal number of participants was 12; however, more would have been recruited if theoretical saturation was not met (see Creswell, 2014). I determined 12 was the perfect number to gather enough data and themes while not diluting the process. Unfortunately, due to the COVID-19 pandemic, recruitment efforts were impacted. Eleven and not 12 participants were recruited; however, saturation was met with the 11 recruits. Klein and Westcott (1994) posited that the participants could be generalized to a larger population. For this to happen, there is not a criterion exclusion on race, ethnicity, marital status, socioeconomic status, or any other descriptors other than the ability to speak English and self-identifying as a biological mother, adoptive mother, or stepmother.

After obtaining approval from Walden University's Institutional Review Board (IRB# 05-14-20-0229291), 11 participants were recruited using purposive sampling from the grief support groups, social media, and word of mouth. The recruitment was accomplished by disseminating during support groups and posting on social media the letter of intent (see Appendix A) to potential participants. An email account was created and social media blasts was posted on various social media platforms to advertise the study and to assist with the recruitment of the participants using the letter of intent (see Appendix A). Other methods of information dissemination to the above methods included detail information about the study, a solicitation letter, social media page, telephone, and email contact information all using the letter of intent. Those interested in participating in

the study was instructed to contact me by email or telephone to obtain an informed consent and the qualifying survey. Those who met the criteria from the qualifying survey was contacted to schedule an interview. The interviews were conducted via Zoom and WebEx. There initially was an in-person option, however, recruitment started around the same time the COVID-19 pandemic began. Therefore, all in-person options were suspended.

**Instrumentation**

I created a list of questions that was asked during the semi structured interviews (see Appendix B). The questions were developed to collect information from the participants about the present study's subject matter and were derived from the primary and secondary research questions. Some demographic information was collected and used as a method for identification only, and possibly for future studies. The participants were informed of and the demography was not used in data analysis. Creswell (2014) posited demographic information helps researchers to detect parallels among experiences of the participants that could lead to better understanding of the phenomenon.

Creswell (2014) suggested open-ended questions will help the participant provide a comprehensive account of their experiences related to the research. In the present study, I designed the open-ended questions to uncover the participants' experiences and perceptions of their post loss, physical health, emotional expressions, and coping mechanisms. Some of the questions were about the notification of death experience, however, most of them were about post notification and the impact on their daily lives. Participants were allowed to ask clarifying questions especially defining terminology.

**Data Collection**

After reading the letter of intent (see Appendix A) and contacting me; the volunteers were given an informed consent along with the qualifying survey. The informed consent was required before the qualifying survey was collected because the data collection began with the survey. The data collection was ongoing during the semi structured interview, and did not exceed more than 2 hours per participant. The semi structured interviews were guided by the two primary research questions and the two secondary research questions.

The semi structured interviews were further guided by the open-ended questions created by me, which was developed from the primary and secondary research questions. The forms of data used for the present study included an interview protocol (see Appendix C) for continuity, which was a step-by-step procedure, semi structured interviews (see Appendix B), which were audio recorded and notes taken during the interviews. Each audio recording and the corresponding notes was assigned a numeric code. The numeric code served two purposes, (a) to provide confidentiality by protecting the identity of the participants and (2) for organization to assist with the data analysis process.

The present study had the potential for re-exposure to grief or trauma, therefore, the participants received a packet to include outpatient providers and other grief support groups in the area (see Appendix D). I provided the participants the opportunity to debrief after the semi structured interviews. After the semi structured interviews were completed, the participants received contact information about how to obtain the results of the study once finalized. The audio tapes, notes, and all related paperwork was secured

in a fireproof safe during transport and remained in the fireproof safe in my home office when not analyzing. Interview transcriptions were stored on a password-protected external hard drive in a separate locked fireproof safe.

**Data Analysis Plan**

Data analysis began after the completion of the first semi structured interview. I decided to have the interview transcribes and I analyzed the data after each interview was completed. This alleviated the concerns of losing data due to hardware malfunctions. A professionally trained and 15-year experienced transcriptionist assisted in transcribing the audio recordings from each interview and I reviewed the transcripts. The transcriptionist signed a non-disclosure confidentiality agreement. The primary data for the present study was the individual narratives of the participants from the audio recorded semi structured interviews. NVivo 12 software and hand coding was used for data coding and the management of data. There were no incomplete interviews from equipment malfunctions or from participants not being able to complete the interviews.

There are four phases of the data analysis process the researcher should follow according to Willig (2013). The first phase involved me reading the individual narratives after they were transcribed to understand meaning for each of the participants. This step was important for me to understand or interpret the experiences of the participants (see Willig, 2013). After reviewing the transcripts, I determined a second review of the transcripts was not necessary to uncover meanings, determine labels, and identify themes as they emerged from the data. In qualitative research, meanings represent detailed elements of the participants' experiences and when everything is formed together, it represents the phenomena of interest. Then the meanings are explored within the context

of the research questions after the themes emerge. Next, the themes were clustered, which allowed me to make connections among the narratives from the interviews. Lastly, tables summarizing the themes and occurrences were created to represent the lived experiences, perceptions, and attitudes of the participants in connection to being a bereaved mother (see Willig, 2013).

## Issues of Trustworthiness

The present study's credibility was based on specific strategies used to ensure the accuracy of the recorded data. The plan was to use three strategies to assist me with the study's trustworthiness. Creswell (2014) described one strategy as peer consultation, which allows an experienced colleague to meticulously analyze and question all parts of the data collection and interpretations. I enlisted a retired clinical psychologist who maintains current licensure, holds a Doctor of Philosophy degree, and has over 20 years of teaching doctoral level students provide me with peer consultation. The second strategy was to use an informal member or participant checking. This allowed me to obtain the participant's feedback regarding established themes and missing content (see Creswell, 2014). I used this method with each of the participants as I was the only coder. These two strategies helped to mitigate issues of trustworthiness because of having one coder.

The third strategy I used was reflective journaling, which required me to write down personal insights, thoughts, and techniques I had during the interviews and throughout the research process. This technique was important because it allowed for relevant information to be recorded that could possibly influence the research process. Dependability of the present study could be addressed through the audio recorded

narratives and the maintaining of the notes. Using a trained and experienced transcriptionist who does not have any relationship to me, the participants, or the study; and who did not have any predetermined expectations of the study, or its outcome adds to the dependability of the research.

**Ethical Procedures**

Walden University IRB Approval (IRB# 05-14-20-0229291) was obtained before any data collection began. Prior to any data collection, all participants received and signed an informed consent which outlined their rights, information about the research, the research questions, and potential risks associated with participating in the study. The informed consent also included the participant's right to refuse to participate in any parts of the study or withdraw from the study at any time. After contacting the potential participants, but prior to any data collection; a list of outpatient providers and community-based grief support groups and organizations was provided to them (see Appendix D). This helped the participant address any issues that could arise from revisiting the events surrounding the death of their child. Although the list is not all-inclusive, it included providers and groups for the insured (private, Medicaid, and Medicare) and the uninsured. Additionally, the list included support groups and organizations that provide free services regardless of the insurance status. Although I am a licensed mental health therapist, I did not provide therapy nor engage in a therapeutic session with any of the participants. I also provided the participants with administrative contact information for Walden University.

I ensured the data was always secured during the research process. The privacy and confidentiality of the participants remained intact throughout. The participants were

assigned a numeric code, which was placed on the audio tape, journal, and notepad. I used a new and different tape, journal, and notepad for each of the participants. I kept a fireproof locked safe in my vehicle for transport. Upon arriving to my home office, when I attended the virtual sessions at my business office; I transferred the audio tape, journal and notepad to a fireproof locked safe inside my home office. The transcriptionist transcribed at my home office or my business office. The transcriptions saved all information on a password protected flash drive, which when not in use was locked in the fireproof safe. When hard copies were printed, they were assigned the corresponding numeric code and placed in a fireproof safe. The entrance of the home office is secured with a lock and key and I am the only one with access. The transcriptionist only had access when I was present. The data will be maintained in the same locked office, locked fireproof safes, which is inside my home for a period of 5 years after the conclusion of the data review and analysis. After 5 years, I will destroy the documents and the tapes using a shredding company and all electronic data will be erased and reset to manufacturers settings.

## Summary

Chapter 3 included the research design, rationale, role of the researcher, methodology, instrumentation, data collection, the data analysis plan, issues with trustworthiness, and ethical procedures. The research design is a qualitative method with a phenomenological inquiry. Two primary research questions and two secondary research questions provided the foundation for the semi structured interview questions. The first research question addressed the overall arching premise of the current study of what are their lived experiences, perceptions, and attitudes. The sub questions to the first primary

questions answer the physical experiences and emotional expressions experienced by a bereaved mother. Responses to the second primary research question uncovered what coping mechanisms were used during the grief process. Their responses to the primary and secondary research questions provided a comprehensive understanding of bereaved mothers who participated in the present study.

The research questions and data analysis represented the use of an inductive method of discovering emerging themes that should be evident and consistent across the cases. The exploration of maternal bereavement for mothers who experienced the death of a young adult child from a drug overdose, when the child was between the age of 18 and 25 years at the time of death may appear difficult for the participants. The documentation of the lived experiences of the participants was achieved through in-depth semi structured interviews that was audio recorded. This chapter outlined the care that was taken to protect the privacy, identity, and confidentiality of the participants. Security methods outlined in the chapter included storage during transport, storage of sensitive information in the home office, use of a transcriptionist, and password protected computer related equipment. Additionally, care was taken to ensure the participants had resources in case participation in the study prompted re-exposure to the grief process.

# Chapter 4: Results

As the researcher, I conducted this qualitative study to explore the grief experiences of the subpopulation of bereaved mothers, who are not well represented in the current literature when the cause of death of their young adult child was from a drug overdose. The participants who were the focus of my study represented a gap in the literature. This gap included bereaved women who identified as a biological, adopted, or stepmother who had a young adult child die and was between the ages of 18 to 25 years at the time of death. Participants included mothers who navigated the death of their child and who wanted to share their experiences.

The lived experiences of these bereaved mothers was explored by using interpretive phenomenological methodology which included in-depth narratives. These narratives were documented by facilitating a series of open-ended questions by way of semi structured interviews. The lived grief experiences of each participant was captured through the data I collected. In doing so, I was able to use the interview structure to explore the individual experiences as it pertained to physical symptoms, emotional expressions, social and familial experiences, and day to day coping. Additionally and remaining consistent with the theoretical foundation for this study, MGT, I documented if grief emerged, persisted, worsened, or receded as it related to the participants physical state, emotional responses, and daily coping. The research questions that were applicable to this study were as follows:

RQ1: What are the perceptions and experiences of mothers who loss a young adult child from a drug overdose?

Sub question 1a: What are the physical symptoms experienced by mothers following the death of a young adult child from a drug overdose?

Sub question 1b: What are the emotional expressions experienced by mothers following the death of a young adult child from a drug overdose?

RQ2: What are the coping mechanisms used by mothers following the death of a young adult child from a drug overdose?

In researching to write the literature review, I found an abundance of literature about parental bereavement. However, many of the studies did not specifically focus on maternal grief and those that did included children from ages of in-utero to 18 years (e.g., Essakow & Miller, 2013; Titus & de Souza, 2011). The literature has limited research on drug overdoses being the cause of death. The gap in the research provided an opportunity for me to expand on the current literature while helping to inform clinical practice to foster more effective ways to support this population.

Chapter 4 began with a summary and reiteration of the purpose of this phenomenological study. The setting where the data collection took place is discussed specifically regarding any influence the setting may have had on the participants. I provided information about basic demographics including the specific substance used and the length of time since the death occurred. I extensively gave attention to the data collected during the interview process followed by the data analysis, which includes coding and themes. Next, issues of trustworthiness are discussed followed by a thorough account of the findings as outlined by the primary and secondary research questions.

## Setting

IRB approval occurred after the onset of the COVID-19 pandemic when face to face restrictions were already in place and at that time information about the Coronavirus was emerging. The state of Delaware, in which my study was conducted issued an emergency order on March 12, 2020 (Declaration of a State of Emergency - Governor John Carney - State of Delaware, 2020). Therefore, the setting for this study was the virtual environment of web conferencing using the secured online platform of Zoom and WebEx Conferencing. The participants were in their residence at the time of the interviews. The original plan was to conduct face-to-face interviews with each participant; however, it was changed due to the Coronavirus restrictions. Early recruitment efforts proved to have poor responses and many of the respondents did not meet the study's criteria. Therefore, the original geographic boundaries of Kent and Sussex counties were expanded to include New Castle County, which is the third and last county in the state of Delaware. Although the interview location was changed because of the pandemic, it proved to be a positive change allowing for participants to be in a comfortable and familiar environment of their home. Overall, the participants shared that their place of residence was convenient, familiar, and more controlled by them. However, this setting may have been more prone to distractions such as family members, pets, and entertainment. In one interview of the 11, a participant was distracted because her mother-in-law with early onset dementia kept knocking on the door, and another's husband inquired about a household item.

## Demographics

A total of 11 participants were recruited for this study. All participants were female, over the age of 18, and spoke English. The relationship to the young adult child included eight biological mothers, two adoptive mothers, and one stepmother. The length of time since their child had died varied between 2 years and 8 months and 11 years and 10 months. See Table 1 for a summary of the official cause of death, gender of decedent, and time since the death occurred. Table 2 represents the decedents age at the time of death.

**Table 1**

*Length of Time Since Death, Gender of Decedent, and Official Cause of Death*

| Participant Number | Length of Time since the Death | Gender of Decedent | Cause of Death |
|---|---|---|---|
| 01 | 4 years, 4 months | Male | Prescription Opioids, Alcohol, Cocaine |
| 02 | 7 years | Male | Heroin, Methamphetamine |
| 03 | 7 years, 2 months | Female | Heroin, Methamphetamine |
| 04 | 11 years, 10 months | Male | Cocaine, Alcohol, prescription stimulants |
| 05 | 10 years | Male | Prescription Opioids, Alcohol, Cocaine |
| 06 | 6 years, 2 months | Male | Heroin |
| 07 | 11 years, 4 months | Male | Heroin |
| 08 | 3 years, 7 months | Female | Prescription Opioids, Alcohol, Heroine |
| 09 | 3 years | Male | Heroin |
| 10 | 2 years, 10 months | Male | Heroin, Methamphetamine |
| 11 | 4 years, 11 months | Male | Heroin |

**Heroin related death was from intravenous (IV) use.*

**Table 2**

*Age of the Child at the Time of Death*

| Young Adult Child's age at time of death | Participants *n* |
|---|---|
| 18 to 20 years | 2 |
| 20 to 22 years | 7 |
| 22 to 24 years | 1 |
| 25 years | 1 |

## Data Collection

Prior to consent and any data collection, this study was explained through an introductory letter describing the need for participants for a grief research study (see Appendix A). Thirty-two individuals responded to the introductory letter and were sent the consent form and qualifying survey. Twenty-six of the 32 respondents returned the consent and the qualifying survey, therefore; initial data collection included 26 respondents. Upon verifying the consent and reviewing the qualifying survey, 14 of the 26 respondents met the criteria for participating in the study and 12 did not meet the criteria. See Table 3 for a summary of the criteria exclusions for the respondents. After verifying the respondents met the criteria of the study, I contacted the respondents by their preferred method they listed on the qualifying survey. Three of the 14 respondents did not return my telephone call or reply to my email. I made three separate attempts to contact each of them. Therefore, after the qualifying survey, the remaining data collection included 11 participants who responded to the introductory letter, consented, met the study's criteria, scheduled the interview, and participated in the study.

The interviews were conducted via Zoom or Cisco WebEx video and teleconference during a date and time that was convenient for the participants. The

interviews were audio recorded using Zoom or the Cisco WebEx platform. The participants had a choice if they wanted to use the camera option in order to see me during the interview. All recordings were audio only even if a participant chose to use the camera option and each participant was reminded the interview would be audio recorded. I used my licensed Zoom and professional Cisco WebEx platform accounts which are HIPAA compliant, ensures privacy and confidentiality. The participants were sent a Zoom or WebEx link along with a toll-free telephone option in case of any technological difficulties. Upon completion of each interview, the recordings were loaded in the format of a Moving Picture Experts Group Layer-3 Audio (MP3), and saved to a password encrypted portable flash drive for transcribing purposes. Each participant participated in one interview as no follow-up interviews were necessary. The duration of each interview varied from 57 minutes to 122 minutes, and did not exceed 2 hours.

Difference in the original data collection plan, included face-to-face semi structured interviews for participants residing in Kent or Sussex counties Delaware. I received IRB approval during the 2020 COVID-19 pandemic. Therefore, the video conferencing was already part of my IRB approval. After several months of only having seven participants then recruiting one more for a total of eight, I expanded the study to include New Castle County which is the third and last county in Delaware that was not included in the original data collection plan. Even though the study expanded to the third county, I still used the original organization's bulletin boards outside the support group areas as they have locations throughout Delaware and social media platforms were still used. Other than expanding to all of Delaware, there were no other changes made to the original data collection plan. In expanding to the third county, the number of participants

went from eight to 11. Boyd (2001) posited that 10 participants or research subjects is sufficient to reach saturation and Creswell (2014) recommended long interviews with up to 10 participants for a phenomenological study. Other than a few interruptions in the participant's home, all interviews were completed and there were no unusual conditions during the data collection process. See Appendix B for the full semi structured interview questions to include the study's primary and secondary research questions. The data analysis section of this study will not outline all questions asked during the semi structured interviews as I will focus on the research questions.

**Table 3**

*Study Exclusion Criteria*

| Reason Respondent was excluded from the study | Participants *n* |
|---|---|
| Not biological, adoptive, stepmother | 3 |
| Did not speak English | 1 |
| Did not live in Delaware | 2 |
| Knows the researcher | 1 |
| Decedent's length of death was less than 2 years | 5 |

## Data Analysis

The data analysis process began with a thorough review of the interview transcripts and each interview was transcribed and analyzed within 48 hours of conducting each of the semi structured interviews. Identification of labels and meaning resulted after the initial review of the transcripts. The latest version of NVivo (12) was used to review each transcript while coding into descriptive nodes (codes), which allowed me to look for emerging patterns. Themes were identified after the nodes were created, this occurred because I was able to explore responses that were similar or consistent

across multiple participants. In using NVivo, I was able to create text queries to identify and organized common themes within all the data. This allowed for review of each node, while uncovering the number of participants who identified positively with the labels within in each node. In using NVivo and this method, it allowed me to remain consistent with the data analysis plan discussed in Chapter 3 regarding the four phases of the data analysis process according to Willig (2013).

Willig (2013) posited that the steps used in a data analysis process includes a preliminary review and full immersion of the recorded data. During the initial stage of discovery, I maintained notes regarding first thoughts and impressions. After completion of the preliminary review, I read the transcripts a second time to identified emergent themes of the data. I only worked on one interview at a time and completed each one from beginning to end before starting another transcription. The identified themes were developed via nodes or codes in NVivo 12. In still being consistent with Willig , query searches were completed to compare and link common themes and any meanings associated with the themes. The last stage of data analysis I completed was identifying, labeling, and keeping the most significant common themes while disregarding the ones that did not resonate as having any shared meaning with the participants. In summary, I followed the readings of each transcript, summarized what participants said, and identified initial themes by looking for repetitions. When all insights could be gained, themes were generated, summarized and analyzed for commonalities and connections.

The interviews were completed from beginning to end with minor interruptions such as one's mother-in-law with early onset dementia interrupted the interview. There were two telephone ringing interruptions and one participant's husband asked where a

food item was. Other than that, there were no other interviews identified as being inconsistent. There were no technical issues with the audio recordings and the transcribing was completed without incident.

## Evidence of Trustworthiness

As described in Chapter 3, the credibility of this research is based on the specific strategies used to ensure the accuracy of the recorded data. A method described by Creswell (2014) known as peer consultation was used and completed by a retired clinical psychologist who maintains current licensure, holds a Doctor of Philosophy degree, and has over 20 years of teaching doctoral level students. We met for two different sessions at two hours each and reviewed the data collection, coding, and the identification of themes. The process I described in the data analysis section was shared with her. Although, her questions for me were of the clarifying nature, there were no issues or concerns articulated about the data collection, data analysis, the coding process, or identifying and group of themes.

In using Creswell (2014), the second strategy was using informal participant involvement of the collected data. Each participant was provided a copy of their completed transcript for review. Additionally, they were encouraged to verify accuracy and interpretation of meaning while providing feedback. They each were given an opportunity for a second meeting to discuss the transcript along with any questions, comments, or concerns they had. At the time of the writing of this chapter, Participant 4 had a concern about the meaning, which required a review of the recording. She wanted to ensure the interpretation conveyed that in spite of all her life difficulties, she loved her son. Other comments or suggestions included sharing their dissatisfaction with

themselves about how they rambled, and used nonlexical words, or informed me of typographical or grammatical errors.

The third strategy discussed in Chapter 3 was about me writing down personal insights, thoughts, and techniques as a way to conduct reflective journaling. This step was critical for me because it allowed me to make a recorded note of anything that could influence the research process. In doing this, I was able to record any good or bad biases that could have influenced the collection or analysis process.

I designed this study to address a gap in the current research that had not been generalized and explored in maternal bereavement. Because of this, the study may not be transferred from drug overdose deaths due to other causes of death. However, the study has transferability when it comes to other age groups of the deceased children. Currently, no change was made to directly influence the transferability of this study.

I provided a description in Chapter 3 of the process that was put in place to address any related issues with dependability. This process included the researcher being the sole interviewer and sole coder. Additionally, a professional transcriptionist was employed to transcribe the audio interview recordings. I did not change any of the aforementioned steps that could have affected the study's dependability.

I remained committed and consistent with following all processes and procedures outlined in Chapter 3. I ensured a list of support groups and outpatient providers was supplied (see Appendix D). I updated the list add support groups and providers in New Castle County Delaware when I had to expand recruitment efforts to that area. I did not provide any therapy to any of the participants and remained neutral throughout. I ensured all data was kept safe and secured, and ensured all privacy and confidentiality was always

maintained. Confirmability included the entire process from documentation, interviews, coding, and peer consultation to analysis and writeups. The change in the venue for the interview went from face-to-face and the interviews were completed virtually via Zoom or WebEx Conference. The meetings were set up by me to ensure the security and privacy. This change was made early and received IRB approval. Outside of the virtual venue, there were no other updates made related to confirmability.

## Results

In reviewing the transcripts, in relation to the semi structured interview questions which were directly related to the research questions,; six major themes emerged from the data. Ryan and Bernard (2003) reported that the number of repetitions to constitute a theme is an open concept that is left up to the researcher to determine. The following analysis serves as a representation of the six primary themes that emerged from the semi structured interview data.

### Emerging Themes from Semi structured Interview Responses

In this current study, I conducted semi structured interviews using open-ended questions to uncover and gather the experiences of the 11 bereaved women who identified as a biological mother, stepmother, or adopted mother and how they coped with the death of their young adult child who died from a drug overdose. The questions were setup in a manner that allowed for free flowing of expression and permitted me to learn information about their experiences including (a) how the grief-stricken mothers responded after hearing about the death of their child; (b) how they physically and emotional felt; (c) who they perceived as their support system, including religious and

spirituality; (d) how friends and family reacted to their grief process; and (e) what type of positive and negative coping mechanisms were used.

Commonalities were uncovered based on the responses from the participants of this study. These shared experiences were divided into six major themes which were (a) initial grief reactions to the loss, (b) support system and coping mechanisms, (c) spiritualty and religious changes, (d) adapting to the loss over time, (e) emotional responses and physical reactions, and (f) overall grief experiences. In the following section, I will provide the six primary themes uncovered through reviewing the transcripts, coding and categorizing the data from the semi structured interviews. The following section includes the participants' testimonies, responses and the tables. Table 4 denotes the occurrences reported by the participants after learning their child died.

**Theme 1: Initial Grief Reactions to the Loss**

**Table 4**

*Initial Grief Reactions*

| Responses | Occurrences |
|---|---|
| Denial/Disbelief/Shock | 11 |
| Physical Pain | 11 |
| Anger | 11 |
| Depression | 10 |
| Guilt | 9 |
| Sleep Disturbance | 7 |
| Avoidance | 6 |
| Isolation | 5 |
| Rumination over the cause of death | 5 |
| Thoughts of Self-Harm | 2 |
| Paranormal Experiences of the Deceased | 2 |

***Participants' Responses to Their Initial Grief Reaction***

Participant 06 stated that:

> It would be one of denial and shock. It was like I was stuck, yet still aware of my surroundings. For a brief moment my heart felt like it stopped and I had this dread that I just couldn't didn't want to go on. I don't know, it was a wave of emotions. I felt guilty about not doing more for him. I guess for the first few days I avoided a lot of people that called.

Participant 10 stated that:

> It was like, it felt like a nightmare, then I felt guilty for thinking he was in trouble again. Looking back, it's amazing how many emotions or feelings and thoughts a person can go through in a matter of seconds. I would say that it was hard falling asleep and difficult getting through the first days. I went from feeling like I wanted to die and I wanted to go and be with my son. It was just really lonely for me, but I didn't help that because I didn't want to be around people and kept to myself for the first few weeks outside of organizing and attending the services. I slept every chance I got and didn't' want to get dress, bathe, cook, I didn't want to do anything.

Participant 02 responded:

> I never felt more alone than I did in that moment. The most painful was having to tell his father and his grandparents. It was like I was reliving the horrible experience over and over again. After I was told, so many things went through my mind. It was beyond horrific, I cried so much, I didn't think my body had so many tears. After seeing his body, my body just starting aching. I never knew I could

> hurt physically, but my muscles ached so badly. I was in shock and I think I was in shock for well over a year. The denial didn't last long especially after seeing his body and I worried a lot, especially about his death.

**Theme 2: Perceived Support System and Coping Mechanisms**

Having a support system and coping strategies was the second theme that emerged from the data. Participants identified what they perceived as their support system during their bereavement and shared numerous coping mechanism they used to cope after the sudden death of their child (see Table 5). Some of these coping mechanisms are positive and healthy such as praying, meditating, having new or renewed faith, finding new meaning with life, and having a supportive partner. Whereas the others are broadly considered maladaptive ways to cope with grief and loss such as vaping, nicotine use, increased alcohol consumption, illicit drug use, binge eating, and being hyper focused on the surviving children. Nonetheless, they aided the individual to deal with the trauma of their loss. The participants identified other family members, close friends, work colleagues, support groups and other healthcare professionals as a source of a support system. Four of the participants reported lack of support from members including spouse or significant other. However, these four reported receiving support from alternative sources such as grief support groups and mental health professionals.

Three of the four participants that did not receive support from family members shared that their coworkers or colleagues at work stepped up when family members did not. All 11 participants received some type of support from friends in their social circle. Nonetheless, the participants openly and honestly described the various ways they managed to cope and their support after the loss, which allowed me to gain more

contextual insight into how, who and what method the support occurred. All of this information is extremely valuable for mental wellness and healthcare professionals as well as advocates for social change in connecting those bereaved by grief specifically those grief stricken due to loss from a drug overdose.

**Table 5**

*Perceived Support System and Coping Mechanisms*

| Responses | Occurrences |
|---|---|
| Support from colleagues/coworkers | 11 |
| Support from friends | 11 |
| Support groups | 9 |
| Exercise | 8 |
| Individual/family counseling | 7 |
| Praying/Meditation | 7 |
| Support from family members | 7 |
| Increased eating/binge eating | 7 |
| Supportive partner | 6 |
| Increased alcohol consumption/Binge drinking | 4 |
| Religion (new or renewed) | 3 |
| Hyper focused on surviving children | 3 |
| Started smoking cigarettes/Vaping | 3 |
| Started using other illicit substances | 2 |

***Participants Who Reported Positive Coping Mechanisms***

Participant 03 stated that**:**

> And I started exercising. So, I was able to keep my mind and body right and I guess even my spirit.

Participant 04 stated that:

> So, I started exercising, it had allowed me to walk, run or lift my frustrations, sometimes I could feel the weight of the grief physically leave me. The endorphins are like no other.

***Participants Who Reported Negative Coping Mechanisms***

Participant 04 stated that:

> I think that is why I turned to smoking weed and some other stuff, it allows me to relax and to escape for the times I didn't feel supportive from others.

Participant 11 stated that:

> The most helpful thing to me I later learned from family therapy was not necessarily helpful for my family, but it was focusing on my surviving children who were teenagers and one was a tweenager.

Participant 01stated that:

> But I would drown my sorrows in alcohol and when I was not drinking, I was eating. So, I would go between binge eating and binge drinking, but more drinking than the eating part of it

***Participants Who Expressed Support Groups or Professional Helped***

Participant 01 stated that:

> I think the biggest and the most support came from the people in my support group. Folks in the support group experienced similar losses like mine so they were the biggest support, but only because they were able to help in a different way.

Participant 01 stated that:

> I was able to ask them what to expect over the first few months and into the next few years. There suggestion helped give me ideas and to work through different scenarios in my head and they provided me with options.

Participant 04 stated that:

> Support groups were not for me- it was the exercise and individual therapy that I said was the biggest support and coping.

Participant 11 stated that:

> At the time hearing that hurt, but it has made our family stronger than ever even though I am divorced. So, even though that helped me cope, family therapy made us a healed family again.

***Participants Who Expressed They Received Support from Family***

Participant 03 stated:

> I think I said this earlier that I didn't realize what a support system I had in my family.

Participant 07 stated that:

> My husband was a huge support of mine. Our son was his biological son and I am the stepmother, however, I raised him since he was 5 years old.

***Participants Who Expressed Colleagues/Friends Helped***

Participant 01 stated that:

> I think I was one of the lucky ones when it came to support. My husband, my family, my friends, my church family, all were great.

Participant 04 stated that:

> My family and friends were there for me and even my coworkers at the restaurant were understanding and checked on me often.

Participant 03 stated that:

> So, it was my friends that helped me cope the most and knowing my coworkers cared got me through my workdays. My friends are wonderful. They love me for me and did not rush the grief, they love me unconditionally.

***Participants Who Expressed Praying/Meditation Helped***

Participant 07 stated that:

> The main thing that has been helpful to me in restrengthen my relationship with God and praying. I went back to church and got right with God. I prayed like I never prayed before and I think part of that may have been guilt for not praying before because perhaps if I did pray, maybe, just maybe this wouldn't have happened.

Participant 03 stated that:

> I realize that now. I never stop going to church, so my church family helped me a lot. I think I said I prayed a lot.

Participant 04 stated that:

> I got into a free support group, then got a job with benefits. I was then able to get a therapist. The support groups were not for me, but the therapy helped.

Participant 01 stated that:

> I prayed like I never prayed before, I prayed for his soul, I prayed that he was lifted up to heaven.

***Participants Who Expressed The had a Lack of Support***

Participant 04 stated that:

> But that changes and people become less tolerant of you, at least that was my perception. I mean they don't say it to you, but you can tell in mannerisms like body language and facial expressions like hear she goes again.

Participant 01 stated that:

> I even went to couples therapy with my husband and individual therapy, but in the end, I got divorced because he just didn't seem to support me.

**Theme 3: Spirituality and Religious Beliefs Changed**

The third theme uncovered during analyzing the interview transcripts was how the participants spiritual and religious beliefs changed after the death of their child (see Table 6). All of the participants shared their thoughts about their religious and spiritual beliefs, and often spirituality and religion were connected and interwoven as a form of support and coping. Considering religion and spirituality is a construct, it was separated from the more tangible coping mechanisms and support system of family, friends and coworkers that is listed above in the second theme section. Even though spirituality and religion were considered separate themes, they were also viewed as supports and coping mechanisms.

Although responses were distinct based on the individuals' responses, there was one similarity in that their beliefs in how they perceived spirituality and religion vacillated at different times throughout the grief process. Five of the 11 participants reported their beliefs decreased but depending on how they were feeling that belief would change without notice. One of the five stated that she did not feel like her religion helped her with her grief. Seven of the participants reported no change in their religious or spiritual beliefs.

Three of those seven reported having a strong religious and spiritual faith rooted in Christianity and shared that God does not make any mistakes and that everything happens for a reason. The other four that did not experience any changes shared they are not overly religious and the loss of their child did not improve or decrease spirituality or religion. Three of the 11 participants shared that they either started going to church, became saved, or started praying and meditating more. The following passages are responses selected from the participants to illustrate their responses about spirituality and religious changes.

**Table 6**

*Spirituality and Religious Beliefs Changed*

| Responses | Occurrences |
|---|---|
| Beliefs enhanced | 3 |
| Beliefs diminished | 5 |
| No change in beliefs | 7 |

*Note: Participant could have more than one response*

***Participants Who Reported Their Beliefs Enhanced***

Participant 01 stated that:

> I think I have a more real and closer connection to God than I had before he died. I don't know- my faith is deeper and it has been restored. I felt that way from the very beginning because I know that God does not make any mistakes.

Participant 05 stated that:

> Yes, this experience strengthens my faith. God doesn't make any mistakes and the good book never lies, I said this before that everyone has a time of when they leave this earth.

***Participants Who Reported Their Beliefs Diminished***

Participant 06 stated that:

> My faith in God is how I was able to cope most days. My faith in the Lord, my savior Jesus Christ has sustained me, it gives me soul sustenance just like food gives me physical sustenance, I would say that at one point in time my faith decreased and that was in the beginning, it changed for a while then I allowed God to speak to me, so it was unchanged and it will never waiver again.

Participant 08 stated that:

> I hated God for a long, long, long time. Even now, my faith has not fully been restored. I grew up in the church and would attend here and there. But I always believed. I am not that believer anymore.

***Participants Who Reported No Change in Beliefs***

Participant 09 stated that:

> I did stop going to church for about 2 months or so because I was angry, I still tithe, I still prayed, I still read the bible. I know it was all according to God's plan. So, even though I stopped going, my faith never wavered.

Participant 11 stated that:

> I really do not care about religion, but so much has happened to me, I was abused, I went through a divorce, I've lost jobs and accidents and then my son was taken

> from me. How can I believe this is all for a reason? So, to answer your question, my faith did not change, I did not have any and I still don't.

Participant 02 stated that:

> I wouldn't say my faith changed; I am a novice Wiccan. I dabbled in it when I was young and I started reading, researching and learning more after my daughter died. So, I would say faith was unchanged, but the need to seek out more was there.

**Theme 4: Adaptation to the Loss over Time**

The fourth theme that emerged from the data uncovered the information of how the participants regarded the concept of time heals all wounds in adapting to the loss of their young adult child (see Table 7). This concept is a cliché and misnomer that is believed by many today. In reviewing the transcripts of the semi structured interviews all participants shared their thoughts, perceptions and experiences about how time is supposed to heal all wounds including grief and sorrow wounds. During the interviews the healing and adapting also known as getting back to normal came up various times during the interviews. The majority of the participants brought up healing with time and getting back to normal when the interviewer inquired about returning to normal, making sense of the death, if the experience changed over time, and when asked about overall perceptions or if they had additional information to provide.

Two of the 11 participants shared that they could not determine if they have adapted to their loss because not enough time had passed since their child died. Four of the participants stated that time did heal and they did not need to make any adjustments in life and they did not feel like there is a new normal or any type of adaption occurred. Five

of the 11 participants reported that no matter how much time passed, they had to find a new normal and new routines even with the smallest of changes such as changing the dinner hour and where everyone sits at dinner. Therefore, some of the mothers did not find the statement of time heals all wounds to be true, they did share that time does aid in the healing process. The following are excerpts from the semi structured interviews regarding adaptation and time.

**Table 7**

*Adaption to the Loss Over Time*

| Responses | Occurrences |
|---|---|
| Adapted to loss | 5 |
| Believes time healed, no adaptation needed | 4 |
| Uncertain/not enough time has passed | 2 |

***Participants Who Adapted to the Loss***

Participant 02 stated that:

> Time does not heal the pain, not all of it. I cannot remember what normal is because it's been over 5 years, but what I do know is that it is not the same, so I guess it means that nothing is normal. I had to adjust; I think my therapist called it adapting. My family and I just found ways to adjust. We shut the door to his room and kept it that way for a while, but that didn't work. So, we turned it into a gym because he loved sports and that was a way of adjusting.

Participant 06 stated that:

> I think adaptation is a natural progression, not just in grief. So, if a person is doing the work regardless if they are grieving or not then they are bound to evolve and adapt and adjust and find a new normal… the work I'm talking about are things like journaling, meditating, therapy, connecting, etc. So, it does not take one to be grieving to adapt… yes, I am a social worker. So, to those that think they do not adapt or adjust or find a new normal is not ready to accept that change is imminent in life. So, I adapted to loss and it was not because time healed me,

***Participants Who Healed Through Time***

Participant 09 stated that:

> I just think it was over time that I felt better. You know that saying that time heals all wounds.

Participant 10 stated that:

> I have said to my therapist, family, friends and many, many, many other people that for me time healed. I did not change routines, I didn't have to find a new normal, I did not have to adapt. Yes, one can debate that I had to adapt to my son dying, but you see, I lost my son a long time ago, years before he died. I lost him as a teenager and I never got him back.

***Participants Who Stated not Enough Time Passed***

Participant 01 stated that:

> It's only been a little over 3 years and I do not think that is a good amount of time to answer you with a definite answer. I cannot truly say Some days I think

> time has healed; some days I think I have adapted. Most days I don't know where I am in regard to this specific area

Participant 08 stated that**:**

> No pun intended, but I don't know, not enough time has passed.

**Theme 5: Physical Symptoms and Emotional Expressions**

A majority of the 11 participants, over 63%, shared they experienced physical symptoms following the loss of their child. All reported these physical symptoms were not persistent and stabilized within 6 months or less after notification of the death. During the initial grief process, these physical manifestations were not recognized as part of the grief experiences. However, it was after consulting with mental health professionals that each participant along with their provider was able to attribute the physical symptoms as a grief response. All participants who reported physical symptoms also noted that the somatic symptoms exacerbated their maladaptive emotional expressions. See Table 8 for reported physical symptoms. The physical symptoms as reported by the participants included coldness, muscle aches, increased energy, and sweating. There were common occurrences related to poor appetite, difficulties with breathing, nausea, and dizziness. The top two most prominent physical feelings reported by the participants were decreased energy and insomnia.

In regards to emotional expressions, all 11 participants shared they experienced some form of emotional expressions that were confirmed by a healthcare or mental health professional. All 11 participants reported experiencing some type of emotional expressions throughout their grief experience. Unlike the report of their physical symptoms, each participant stated their emotional expressions were persistent and lasted

beyond 6 months. Also, unlike the physical symptoms, the emotional expressions were immediately attributed to their loss either by self-discovery or by a healthcare or mental healthcare professional. Table 9 summarizes the emotional expression experienced by the participants.

Uncovering the emotional expressions of the participant began with separately looking at internal emotional expressions and external emotional expressions. There were 15 common occurrences with internal emotional expressions and 6 common occurrences with external emotional expressions. Some of the internal emotional expressions included feeling disgusted with self and others, disassociation, shame, and jealousy. The most prominent common occurrence found included feelings of sorrow, anger, depressed, happiness, and shock. External emotional expressions included physically and verbally lashing out with the most prominent external emotional expressions being crying, laughing, frowning, and smiling.

**Table 8**

*Physical Symptoms Reported by Participants*

| Physical Symptoms | Occurrences |
|---|---|
| Sleeplessness/Insomnia | 7 |
| Low energy | 7 |
| Dizziness | 6 |
| Stomach upset/Nauseous | 6 |
| Breathing difficulties | 6 |
| Poor appetite | 6 |
| Sweating/Night sweats | 4 |
| More energy | 3 |
| Muscle aches/Heaviness | 3 |
| Constantly feeling cold | 2 |

**Table 9**

*Emotional Expression Reported by Participants*

| Internal Emotional Expressions | Occurrences | External Emotional Expressions | Occurrences |
|---|---|---|---|
| Grief/Sorrow | 11 | Crying | 11 |
| Anger | 11 | Laughing | 11 |
| Could not function/Depressed | 9 | Frowning | 9 |
| Happiness | 9 | Smiling | 7 |
| Shocked/Surprised | 7 | Verbally lashing out | 6 |
| Self-Isolated | 6 | Physically lashing out | 2 |
| Worry/Ruminated | 6 | | |
| Envy/Jealousy | 5 | | |
| Feelings of peace/At peace/Contentment | 5 | | |
| Increased paranoia/Feelings of dread | 5 | | |
| Disgusted with others | 5 | | |
| Increased Anxiety | 4 | | |
| Feelings of guilt/Shame | 3 | | |
| Not mentally present/Disassociation | 3 | | |
| Disgusted with self | 2 | | |
| Fear | 2 | | |

***Participants Who Reported Physical Symptom***

Participant 01 stated that:

> I experienced quite a bit of physical issues, I remember being dizzy and wanting to vomit even though I didn't eat a lot during that time. Oh, and I couldn't sleep, I would get like 4 or less hours of sleep.

Participant 05: That's an easy question, I still get the same symptoms around

> his birthday and the anniversary of his death. I lose sleep around a week around the birthday and anniversary, that happened to me when he first died. I guess the no sleep contributes to my low energy. When I do go to sleep, I wake up in night sweats.

Participant 11 stated that:

> I didn't have a lot of energy, I wanted to sleep but I couldn't, there were times I felt sick, I remember not being able to breath sometimes and I felt dizzy a lot but I thought that was from not being able to sleep.

***Participants Who Reported Internal Emotional Responses***

Participant 02 stated that:

> I always felt this, this sorrow and I event felt jealous that other people's children were alive, then I felt ashamed and guilty for thinking that. Other times I was disgusted or disappointed in myself.

Participant 06 stated that:

> I didn't ever think I would be jealous over my friends and my siblings whose kids are still alive.

Participant 11 stated that:

> I think a lot of what I experienced was more mental instead of physical but I always had anxiety issues so I thought most of that was anxiety.

Participant 08 stated that:

> I hated people, I hated myself and I did not care who I impacted. I was mean, I was happy, I was angry

***Participants Who Reported External Emotional Responses***

Participant 02 stated that**:**

> I was always angry lashing out verbally at my mom and dad because I told them they didn't understand even though they were the grandparents.

Participant 02 stated that:

I remember laughing a lot, heck, I remember crying a lot too.

Participant 06 stated that:

Along with being happy and sad, I laughed and I cried.

Participant 08 stated that:

I cried a lot; I laughed a lot. There were times in the beginning that I got so angry I would lash out and hit him (boyfriend) with tears in my eyes.

**Theme 6: Overall Grief Experiences**

In the data collection process, primary research question one was the last question asked regarding their overall perceptions and experiences. During the interview, the final question I asked was "if you could summarize the overall perceptions and experiences regarding the loss of your child, what would you say?" Because this data is from one of the primary research questions, some themes may repeat throughout this section. The overall common occurrences regarding perceptions and experiences are shown in Table 10.

The first research question was, what are the perceptions and experiences of mothers who loss a young adult child from a drug overdose? The participants for this study shared common overall perceptions and experiences after the loss of their child. The top 10 common perceptions and experiences were getting back to a routine helped them through the grief process, experienced depression, support groups aided in the healing, a sense of relief where they no longer had to worry about their child, being shocked, bouts of insomnia, using other professionals helped, feelings of contentment, ascribing a new meaning to life and self-isolation. As previously mentioned, many of the occurrences overlapped among the six themes. Therefore, occurrences in this section may

be found in coping mechanisms, initial grief reactions, and physical symptoms among others because it directly relates to the overall perceptions and grief experiences from being informed of their child's death until the time of the semi structured interview.

**Table 10**

*Mother's Overall Perceptions and Experiences to Child's Death*

| Overall Perceptions and Experiences | Occurrences |
|---|---|
| Getting back to normal helped/Routines | 11 |
| Could not function/Depressed | 9 |
| Using support group helped | 9 |
| Sense of relief/No longer had to worry | 8 |
| Shocked/Surprised | 7 |
| Sleeplessness/Insomnia | 7 |
| Using other professionals helped | 7 |
| Self-Isolated | 6 |
| Found new meaning of life | 5 |
| Feelings of peace/At peace/Contentment | 5 |
| Increased paranoia/Feelings of dread | 5 |
| Not Shocked/Not Surprised | 4 |
| Feeling of want/need to help others | 4 |
| Increased Anxiety | 4 |
| Not mentally present/Disassociation | 3 |
| More cynical or bitter | 3 |
| Feelings of guilt/Shame | 3 |
| Questioning everything about life more | 3 |

***Participants Who Reported Their Overall Perceptions and Grief Experiences***

Participant 03 stated that:

> My overall perception is that I had more support than I thought.
>
> I was selfish and didn't care that my husband loss his daughter and my other kids' loss their sister. I didn't care about other family member feelings or my friends. I guess I shouldn't say I didn't care because I did, it is their loss wasn't as great as my loss in my opinion. As for the overall experience, I think for me in thinking

about your questions it was more emotional for me than physical because for the longest time I felt guilty. I thought it was because of what they call survivor's guilt, but I later learned after working with my therapist that my guilt was from shame because I was actually relieved that I did not have to worry about where my daughter was like I did when she was using drugs. I felt guilt over feeling at peace.

Participant 09 stated that**:**

The perception that I have is that the loss of my son ruined my marriage. It wasn't good before, but his death was the nail that sealed that coffin. I don't have regrets about that. I do regret that my son is no longer with us. Mmmm to sum up the overall experiences, I would say that his death gave me new purpose. Of course, it was not always like that but now I lead support groups and help others, his death will not be in vain. So, the main experiences for me that are powerful is getting back to normal or my new normal without a husband and son, having a new meaning for life and helping others. Oh, I guess I should say that my ex-husband gets a long better than when we were married so maybe that is a good thing too. I just try to look at that silver lining. It's still hard after all these years, but I know it's not impossible.

Participant 10 stated that**:**

Overall perception is that I am not alone and as bad as this may seem, that comforts me. The support group helped because there were people like me suffering from a similar loss, it helped me know that my child suffered from an illness, a disease. My experiences could be summed up as being a roller coaster

> because I was all over the place, I know that is normal too. I was not supported as much as I would have liked from my actual family. I think they may have felt that I did not care about my child, but for me I felt relief. They didn't have to go through the in and out of jail, or rehab, or worrying about where he was or what he was doing. I lost my child a long time before he died.

**Addressing the Research Questions**

The purpose of this phenomenological qualitative study was to explore the perceptions, attitudes, and experiences of grieving mothers who had a biological, adopted or stepchild die from a drug overdose when the age of death was between 18 and 25. The two primary research questions were: (a) What are the perceptions and experiences of mothers who loss a young adult child from a drug overdose? (b) What are the coping mechanisms used by mothers following the death of a young adult child from a drug overdose? The two secondary research questions under primary question one was: (1a) What are the physical symptoms experienced by mothers following the death of a young adult child from a drug overdose? (1b) What are the emotional expressions experienced by mothers following the death of a young adult child from a drug overdose?

There were six themes that emerged from the results of the study, they were (a) initial grief reactions to the loss, (b) support system and coping mechanisms, (c) spiritualty and religious changes, (d) adapting to the loss over time, (e) emotional responses and physical reactions, (f) overall grief experiences. Out of those six themes, the ones directly related to the research questions were themes (b) support system and coping mechanism, (e) emotional responses and physical reactions, and (f) the overall grief experiences. The other four themes of initial grief reactions to the loss, spirituality

and religious changes and adapting to the loss over time overlapped with the primary research question regarding overall experiences.

The first primary research question explored the overall experiences and themes one, three, four and six support the primary research question. Participant's descriptions of their overall grief experiences fluctuated based on where they were with their grief, how they felt supported, who was providing the support and everywhere in between. These overall grief experiences affected and framed the other research questions in how they responded physically and emotionally as well as how they coped with their grief.

The secondary or subsidiary research questions involved the physical symptom and emotional expressions of their grief experiences and was present in the fifth theme. All participants reported having some type of physical and emotional response to their loss. Some of the physical responses included experiencing low energy, difficulties with breathing and dizziness. Many of the participants didn't attribute these physical symptoms to their grief response, however, they learned through mental health providers and support groups that these symptoms were a physical response to grieving. The emotional expressions reported by the participants was broken down into internal and external emotional expressions. Some of the participants reported feelings of anger, fear, peace, laughing, and crying. Many of them reported being confused about the psychological response to trauma and could not understand how one moment they felt happiness and in the next moment they felt sadness.

The second primary research question involved perceived support symptoms and coping mechanism, which was present in the second theme. All participants reported having some type of support from either their partner, family, friends or colleagues at

work. Some reported not feeling supported by others whereas many turned to professional help such as therapists or support groups. Most participants reported having healthy coping strategies that included using professional or support groups. Some of the healthier habits included exercising and meditating. However, a few of the participants reported some unhealthy or maladaptive habits such as binge drinking or use of illicit drugs. All of the themes in the results either directly or indirectly supported this study's primary and secondary research questions.

## Summary

The scope of this study included experiences and perceptions of 11 bereaved women who identified as a biological mother, adoptive mother, or stepmother, who had a young adult child, between the ages of 18 and 25 die from a drug overdose. Through this research, I uncovered the primary themes of initial grief reactions, perceived support and coping, changes in spirituality, physical symptoms, emotional responses, religious beliefs, adaptation to the loss, and overall grief perceptions during the semi structured interviews. The methodology used included an interpretive phenomenological analysis (IPA). In this study, the phenomenon uncovered was grief as described by each participant.

As part of their grief experiences, participants reported both physiological and psychological experiences. These are noted as physical symptoms and emotional expressions. All 11 participants reported having some physical response to their grief, and all 11 reported sorrow and anger for internal emotional expressions, and crying and laughing for external emotional expressions.

Within this study, occurrences of dissociation and depression were identified because of anxiety and shock, this left many of the participants unable to function normally. This specific grief experience shed light on the value of receiving help from others such as an intimate partner, friends, or other family members, and appeared often during the coping mechanism part of the interview. All 11 participants had the same experience of coping and that was getting back too normal or getting back to a routine.

In Chapter 5, I interpreted the findings of the study and briefly compared them to the peer reviewed literature in Chapter 2. This included the most recent research, which is consistent with the focus of this study. I discussed limitations of the study to include barriers faced with the COVID-19 pandemic and recommendations for further research for this specific topic. Implications for social change was explored ensuring not to exceed the boundaries of this study.

# Chapter 5: Discussion, Conclusion, and Recommendations

The purpose of this phenomenological qualitative study with interpretive analysis was to explore the lived experiences of bereaved mothers who are not currently the focus in recent literature. In this present study, I reviewed the audio recorded interviews of women who identified as a biological, adoptive, or stepmother who experienced the death of a young adult child who was between the ages of 18 and 25 years at the time of their death. In reviewing the audio recorded interviews, I explored the narratives of their grief experiences. The following are the research questions used for this study:

RQ1: What are the perceptions and experiences of mothers who loss a young adult child from a drug overdose?

Sub question 1a: What are the physical symptoms experienced by mothers following the death of a young adult child from a drug overdose?

Sub question 1b: What are the emotional expressions experienced by mothers following the death of a young adult child from a drug overdose?

RQ2: What are the coping mechanisms used by mothers following the death of a young adult child from a drug overdose?

I used an interpretive phenomenological methodology analysis to uncover the various emerging themes and occurrences within the collected data. All participants resided in the state of Delaware across the state's three counties and all experienced the sudden loss of their young adult child who was between the ages of 18 and 25 at the time of their death. The prevailing themes identified during the analysis included their grief experiences from notification of their child's death to various points of time after the death and use of coping mechanisms to settling into a new normalcy.

The primary themes and occurrences reflected the research questions and the semi structured interview questions of this study. The primary themes most represented of the lived experiences of the participants included the following:

1. Initial grief reactions to the loss.
2. Perceived support system and coping mechanisms.
3. Spirituality and religious changes.
4. Adaptation to the loss.
5. Physical symptoms and emotional expressions.
6. Overall perceptions of grief.

In reviewing the data and themes, some of the themes were present in each of the research questions responses and present in the semi structured interview questions responses. Even though the primary themes overlapped within the coding of different categories, the overlapping had different numerical responses depending on questions and response. For example, the inability to function could be found in internal emotional expressions and overall grief experiences and perceptions. Overlapping of responses makes sense considering the toll the participants experience in surviving the death of their child.

## Interpretation of the Findings

### Findings: Theme 1-Initial Grief Reactions to the Loss

Based on the findings of this current study, it could be implied that the participants may never fully resolve their grief following the death of a young adult child from a drug overdose. One major commonality was the initial response to hearing about

the death of their child. All 11 participants reported experiencing intense initial grief reactions after being notified about the drug overdose death of their young adult child. Hunt and Greeff (2011) reported that parents reacted strongly to how they were informed of their child's death when they did not have time to prepare. All participants described feelings of denial, shock, anger, and physical pain. Other initial grief reactions included guilt, sleep disturbances, rumination over the cause of death, and thoughts of self-harm. Whereas some participants reported having paranormal experiences, avoidance, and isolation. These findings are consistent with the current literature. Alam et al. (2012) posited the death of a child is the most distressing of all the causes of grief. Feigelman et al. (2009) found that individuals experiencing parental bereavement when compared to other nonparental grief had a greater shock, denial, anxiety, physical symptoms, and anger. Research also supports the findings in that affects one's physical and psychological health (e.g. Dias et al., 2018; Li et al., 2003; Song et al., 2010; Walsh, 2007). Also similar to the findings is Parker and Dunn's (2011) study that reported those experiencing parental bereavement experience guilt, shame, and increased anxiety based on their child's cause of death.

**Findings: Theme 2- Support System and Coping Mechanisms**

Participants of this study shared who they perceived as their support system and the various ways they coped during their grieving process after the death of their young adult child. All participants reported receiving some form of support from their coworkers, colleagues and friends in their social circle. Not all, but some of the participants stated that family members, support groups, and other professionals such as a psychotherapist was instrumental in helping them through their grief. These findings are

also consistent with the literature in that Greeff et al. (2011) reported that a strong support system plays an important role in the grief response and gaining some sense of normalcy after the death. In addition to human support, the participants shared some of the coping mechanism that aided them during their time of bereavement. Some of these coping mechanisms included exercising, praying, meditating, overeating, excessive alcohol use, or illicit drug use. Those engaging in maladaptive coping mechanisms recognized they are not healthy; however, they perceived it helped them process and deal with their grief. Giannini (2011) and Toller (2008) posited that not using healthy coping strategies can impede the grief process including the ability to identify issues in order to move forward.

There were 14 commonalities that emerged from the data regarding coping mechanisms and strategies. Some of them reported by the participants are considered maladaptive behaviors such as binge eating and drinking, use of nicotine or vaping products, being hyper-focused on the surviving children, or use of illicit substances. Whereas others are considered healthier coping habits such as meditating, relying on a supportive partner (spouse) and new or renewed religious faith/spirituality. Sharpe et al. (2012) noted the significance of faith and spirituality as a form of coping loss. Their 2012 study explored the spirituality of African Americans after experiencing a loss because of suicide or homicide. They found that spirituality was useful in coping with a homicide death. Not including the overlapping that will be discussed in the next section, the top four coping strategies reported by the participants were exercising, talking with family members, talking with those within their social circle and using non-support group mental health professionals.

Eight of the 11 participants reported that exercising was helpful during their grief process. Many participants reported exercise helped with feelings of anger, depression, and anxiety. Whereas others reported exercise assisted with not being so isolated and provided some resemblance of normalcy. Exercise has been known to assist in burning of hormones that causes stress and can be effective in managing and stabilizing one's mood (Hovancsek, 2011).

Talking with family members, socializing, or talking with friends, and using mental health professionals were next on the list. Seven participants for each coping strategy reported that the aforementioned was helpful with coping with the loss of their child. Regarding the participant's family experiences, seven of the 11 participants found conversing with family members and family in general supported them in their grief. They found that it was easier to express their feelings to another family member because they shared the loss even though the deceased was not their child. This often helped with feeling less isolative. They also reported not feeling pressured by family about how to grieve and for how long. The participants of this study reported feeling like there were no expectations from family, nor were there any timelines to abide by. Six of the seven participants reported feeling the same way when talking with their partner (spouse) and the post loss strengthen communication and their marital relationship. This is consistent with Cacciatore et al. (2013) study where most of their participants cited significant improvement in their family and partner (spousal) relationships.

Social relationships proved to be helpful for all the participants even in those that reported some issues within their social circle. To explain further, some participants had both positive and negative experiences with friends that were within the same social

circle. Seven of the 11 participants reported a positive change within their social circle. Whereas four of the 11 participants cited distancing from close friends and viewed this as a secondary loss. For the seven with a supportive network of friends, the participants reported several acts or things they found extremely helpful while working thorough their grief. One of the common acts of kindness was present with all seven participants was when friends did something helpful without being asked, or without the friends asking the bereaved. Some examples of these acts were cooking meals, cleaning the home, or some random act such as changing the paper towel holder and other acts that seemed routine to most. Other acts of kindness that assisted in the grief process was when friends helped with the surviving children such as picking them up from school or taking them to and from their extracurricular activities. The participants reported that these random acts of kindness were most helpful during the early months of grieving especially when it was difficult for themselves to complete.

Other helpful social interactions with friends were when friends did not seem bothered by the mothers talking about their deceased child. In turn, the other four participants reported their friends or those in their social circle would often change the subject when the participant started talking about their deceased child. These four stated this avoidance is one of the reasons the friendships were negatively impacted as reported previously. Talking about the loss and sharing memories of the child allows for the bereaved to maintain a connection and decrease isolation (see Hunt & Greeff, 2011).

Individual mental health professionals also aided in being a safe space which allowed for the mothers to feel less isolative and maintain a connection without fear of judgement or feelings of being rushed through the grief experience. Seven of the 11

participants found individual therapy helpful. The seven participants reasons in stating individual therapy were helpful included feelings of validation, a safe haven to express a multitude of thoughts, feelings, and emotions. Learning their thoughts, feelings, and emotions were normal, and not feeling rushed. This study's findings are consistent with the current literature such as Kao (2018) study regarding using psychologist in family therapy grief work. Four of the 11 participants stated they did not find individual therapy purposely; however, two of the four stated support groups assisted. The reason the four participants did not find individual therapy to be useful included not liking the intervention techniques of the therapist, the skill level or experience of the therapist seemed lacking, feelings not being validated, and termination of therapy after just four sessions citing their grief experiences were normal. Some of these reasons seem to be consistent to Hunt and Greeff's (2011) study where the participants reported negative interactions with their mental health professionals. Most interactions with mental health professionals were positive specifically when facilitated by them during grief support groups.

**Findings: Theme 3- Spiritualty and Religious Changes**

In regard to spirituality and religion, seven of the participants reported that there were no changes in their belief system whereas five reported their faith decreased and three shared their faith improved. Most of the participants strongly believed their religious or spirituality beliefs assisted them in coping with the death of their young adult child. Out of the seven that reported there were no changes in their belief system, three of them shared they are devout Christians whereas the other four shared they are not overly religious or spiritual. Of the six (three no changes, but devout and three increase in

belief), they all reported their belief system and faith are one of the reasons they were able to cope with their grief. Paulus and Varga (2015) and Penman et al. (2014) posited that it is a normal grief response to use some form of religious or spiritual guidance to work through the grief process.

**Findings: Theme 4- Adapting to the Loss Over Time**

In this case study, the concept of time heals all wounds or in other words adapting to the loss over time emerged among the 11 participants. Although all responses were individually distinct, it can be implied that all participants experienced some form of adaptation after the death of their young adult child. Out of the 11 participants, two of them shared that it was too soon to determine if they had adapted to their loss. Four of the participants shared that they believe they did not have to adapt meaning they did not make any changes and it was the time since the loss they allowed them to heal. Price and Jones (2015) suggested that adaptation to the loss of a child will organically happen over time, however, it is important for the bereaved to use healthy coping strategies as this adaptation occurs. The other five participants firmly believe that they had to adapt to their loss in finding new routines or rituals such as converting their child's bedroom, changing the seating chart at dinner, or changing traditions during the holidays. Alam et al. (2012) posited that the concept of those uncertain about adaptation or those stating that adaptation did not occur because often parental bereavement is riddle with uncertainty about what the future and even the present holds.

**Findings: Theme 5- Physical Symptoms and Emotional Responses**

Each participant described some of their grief experiences as being physical in nature. There were several common occurrences present in the data representing the

physical symptoms experienced by the participants. Some of the more prominent physical complaints reported included feelings of nausea, dizziness, muscular aches, suppressed appetite, tightness in the chest like heart attack symptoms, and breathing difficulties often associated with panic attacks. A higher number of participants stated the physical pain or symptoms were in the areas of the heart. These reported symptoms are consistent with the study by Cacciatore et al. (2013) and are aligned with physical symptoms of grief reported in various pieces of literature.

The top two common themes regarding physical symptoms included sleeplessness and/or frequent bouts of insomnia and persistent low energy with little to no drive in wanting to do the basic of daily living activities including getting out of bed in the mornings. Circumstantially, these two themes affect each other considerably where individuals who suffer from lack of sleep or insomnia tend to have decreased energy and lack motivation (see Kalmbach et al., 2019). As a result, several the participants reported decreased energy and lack of sleep negatively impacted their mood and attitude towards others.

Similar to the reported physical symptoms; the participants reported various emotional expressions which emerged as common occurrences. I separated the emotional expression into two categories of internal emotional expressions and external emotional expressions. Some of the most common emotional expressions reported for both categories included feeling depressed with often having feelings of happiness, which confused many of the participants. At times they found themselves in a constant state of shock and the participants reported often finding themselves or being told they were either smiling or frowning, which again confused them. The emotional expressions

reported are aligned with Cacciatore & Flint (2012) study discussing behaviors and rituals after a child's death.

The top two external emotional expressions reported by all 11 participants were crying and laughing. The top two internal emotional expressions reported by all participants were intense feelings of grief & sorrow and unwelcomed feelings of anger. Regarding crying and laughing, many of the participants reported being confused and conflicted because one moment they were crying over the loss, and other moments they were happy. Some of the participants reported knowing their emotions would vacillate especially after having fond memories of their deceased child. Others reported learning from a mental health professional or grief support group that these emotions were normal during the grief process. Bergstraesser et al. (2015) discussed how dyadic coping assisted in the grief experiences of bereaved parents. In their study, the participants reported having cathartic experiences and stress the importance of laughter and crying especially laughing and crying together.

In my study, none of the participants were surprised to experience feelings of grief and sorrow, nor were they surprised when they felt anger over their loss. In fact, each participant in their own way reported that the anger helped them get through some tough times because it let them know that things were not normal and it was "OK" to not feel normal to match what they were going through. Some of the participants reported being surprised over being angry at their deceased child and that was an unexpected and unwelcomed emotional expression. These responses from the participants are consistent with the finding of Raitio et al. (2015) where anger along with blame was prevalent in many of the responses regardless of the cause of their child's death.

**Findings: Theme 6 - Overall Perceptions and Experiences**

The first primary research question was about the overall perceptions and experiences of the bereaved mothers. I deliberately wanted to discuss it last during this section because some of the findings overlapped as discussed in Chapters 4 and 5. There were several common occurrences in this section including questioning life, increased anxiety, paranoia, self-isolation, insomnia, and being shocked. The top four common occurrences reported by the participants included all 11 participants stating getting back to normal routines helped, nine participants reported the inability to function/feeling depressed, nine reported that attending grief support groups helped, and eight reported feeling a sense of relief/no longer worrying.

In analyzing the six common themes for this research question, one common thread that was evident was normalcy and adaption to loss. The majority of the participants' overall perception and experiences kept going back to having some semblance of normalcy and adapting to their loss. In this section of the interviews, the participants discussed attempts to live in the reality of their loss to include seeking out support from family, friends, and professionals. Nine of the 11 participants stated that support groups were the most helpful in finding normalcy and aiding in adapting to the loss. Many cited support groups provided structure and a safe space to be open and honest. Additionally, support groups were most helpful because it allowed them to give back to other grieving mothers by sharing their personal grief experiences of loss. Dyregrov et al. (2013) used reports from grief support group members to improve the experience within these groups. The participants in my study noted support groups were particularly comforting and helpful when discussing birthdays, holiday, or other major

family-oriented events. Umphrey and Cacciatore (2011) explored different themes regarding support groups where participants in their study noted discussion of holidays within the support group helped with coping during the holiday season.

Getting back to normal routines was the most helpful as reported by all 11 participants. Although stated differently, all participants agreed that getting back to normal routines is different than feeling normal, or feeling the same. Regarding getting back to normal routines, many participants agreed going back to work, church, and just getting out of the house to go shopping, exercising, among others was the most helpful in feeling less isolated and feeling like themselves. Other routines noted by the participants were doing hobbies such as gardening, knitting, and spinning classes. Socializing was considered a normal routine by 6 of the 11 participants. Some examples of socializing were going to invited events such as parties, traveling sports of their other children, and church functions. The results of all the aforementioned studies cited in this section appear to be consistent with the findings in my present study.

## Limitations of the Study

I began the recruitment of the participants at the beginning of the COVID-19 pandemic. Recruitment of participants was slow for the first couple of months having to expand into other areas of Delaware. This was primarily because of Delaware's state of emergency order and many individuals not being comfortable because of the uncertainty and unknown of the pandemic (Declaration of a State of Emergency - Governor John Carney - State of Delaware, 2020). In order to participate in this study, participants must have experienced the loss of a young adult child who was between the ages of 18 and 25 years at the time of death where the cause of death was from a drug/substance overdose.

In addition, the death had to occur two or more years at the time the data collection started.

The appropriateness for each of the participants was identified based on responses to the prequalifying survey. The cause of death and the year the loss occurred was based on self-report and was not verified through any other method. Additionally, the study results are not generalized to other causes of death or groups of bereaved parents other than those who identified as a mother, stepmother, or adopted mother. These all include potential study limitations such as other causes of death, deaths occurring less than two years, other ages at the time of death, and the relationship to the deceased. One limitation that is noteworthy to include in this section it that I can only assume the participants were psychologically healthy and emotionally stable prior to their child's death. In fact, a similar assumption could apply to the physical symptoms reported, in that I can only assume the participants were physically healthy prior to their child's death.

Issues of trustworthiness were lessened in several ways as discussed in Chapter 3. Each participant received a copy of the interview transcripts with a request to comment if they discovered any inaccuracies that impacted the meaning and analysis of what was recorded. Creswell (2014) suggested this as one of the strategy methods with ensuring trustworthiness. Three participants responded with corrections because of typographical and grammatical errors. Two participants provided feedback that could have resulted in misinterpretation of what they said. Both interviews were reviewed again and only one needed changing. This change did not impact the theme; however, it did impact my interpretation of the participant's meaning. All participants were provided with a copy of a summary with the common themes. All were encouraged to contact me if there were

any concerns with the theme summary (see Creswell, 2014). Four of the 11 participants contacted me to say the summary was accurate with three stating how much participation in the study helped.

## Recommendations

The results of this study included the physical responses, emotional expressions, coping strategies and overall experiences and perceptions of the bereaved participants. The themes uncovered and explored in this study included the memories of an event that meaningfully changed their lives. In reviewing and analyzing the themes, what was made clear by the participants, was the need to be heard and validated related to their grief experiences. This includes family, friends, healthcare and mental health professionals. Many of the participants noted that being with other bereaved parents was helpful because of their understanding of the grief experience when the loss was a child. Further exploration could delve more into the stage's breakdown of emerging, persisting, and worsening of the physical, emotional and practicality throughout the grief experience where this current study did not focus on the breakdown of stages.

Additionally, continued research specific to bereaved mothers is needed specifically when the cause of death is from a drug/substance overdose (see Feigelman et al., 2011). Future research may include the exploration of the themes that emerged and was presented in this study. I particularly would explore many of the maladaptive themes that presented itself such as the bereaved using illicit drugs, vaping, or alcohol as a response to their grief and to cope with their loss (see Mason et al., 2020). The phenomenon uncovered in this study was the need for the support and validation to be

carried throughout the bereaves grief experience and not just support and validate early on when the grief is new.

## Implications

The social change implication for this study included the development or improvement of our understanding to the lived experiences of bereaved mothers. This included the understanding of grief when a child dies along with the physical and emotional experiences. Within trying to understand this phenomenon; raising awareness of drug/substance overdose deaths, the impact these deaths have on mothers, and understanding their specific needs must be addressed.

Raising awareness of drug/substance related deaths is an implication of positive social change for this phenomenological study. In doing this study, it provided a platform for mothers who normally would not have a way to convey their grief experience. As for the specific needs, these could include caring for surviving children or other family members they are responsible for, such as a parent suffering from dementia (see Breen et. Al., 2019). There needs could include addressing daily life demands such as cooking where it may be beyond their ability to accomplish because of their grief.

This study helped me uncover the need for interventions and continued support beyond the first 6 months to the first year of the loss. Many of the participants expressed their spouse, family, friends, and other support systems were helpful and supportive; many reported feelings rushed and not fully validated in their grief response after the first few months. A few reported feelings rushed and not validated by healthcare/mental health professionals outside of the support group setting. Feelings of being rushed and feelings of invalidation may hinder the grief process while placing unrealistic

expectations on the bereaved. Parkes psychosocial transition theory (1998) posited that other's assumptive world views and belief system could increase isolation and worsen the grief experience.

## Conclusion

The gap in literature I explored in my study was bereaved mothers who loss a young adult child from a drug overdose. My goal for this study was to explore the physical symptoms, emotional expressions and coping strategies used by this population and I achieved this. Some common themes within this study supported some of the generalizations found in the literature, where other common themes challenged the narrative that there is a standard grief response to a loss of a child regardless of age of the child at the time of death, or the cause of the death. Inherently, this study focused on a specific cause of death and a specific age range at the time of death.

I aimed to gain a better understanding of the overall lived experiences and perceptions of bereaved mothers. I explored the complex topic of maternal bereavement through the stories of the participants by collecting, reviewing, and analyzing the data and theme formulation. It is through the data collection and analyses that the bravery, longing to be heard, and commitment of the participants showed through the sharing of their loss, sorrow, and individualized experiences. It is also through all of this they shared the need for maternal grief from a drug overdose death to be advanced in the literature in order to understand and promote awareness in assisting to highlight this drug epidemic and to support other grieving mothers.

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Appendix A: Letter of Intent/Participants Needed for Research in Grief Experiences

My name is Shonetesha Quail, I am also known as Tesha Quail. I am a doctoral student at Walden University. As part of the requirements for the completion of my Ph.D. in Health Psychology, I am conducting a research project about maternal bereavement. My topic is titled "Grief Experiences of Mothers after the Death of a Child from a Drug Overdose". My interest is exploring the grief experiences of mothers who had a young adult child, between the ages of 18 and 25 years of age died from a substance use overdose. For the purpose of the project, a mother is defined as biological, adopted, or stepmother.

I have received Institutional Review Board (IRB) approval and the approval number is IRB# 05-14-20-0229291. Approximately 10 to 15 participants will be interviewed regarding their bereavement experiences of the loss. Participants must be 18 years or older and must meet the criteria for participation based upon the type of loss. In addition, the loss must have taken place at least two years ago. Participants will be requested to provide input and ensure accuracy of the transcribed written descriptions of their experiences.

If you have grief from a death of a child because of a drug overdose and would like to participate in the study please email me at or call. If you are viewing this on social media, for privacy reasons; please do not respond to this social media post. I will give you all the details about the study upon receipt of your email or telephone call. At that time, you can decide if you would like to participate in this voluntary study.

As the researcher, I will not pressure anyone to participate nor will I hold any resentment if you decide not to participate. There will not be any compensation for participating. The study is to bring awareness to maternal bereavement for the specific cause of death as listed above. Please share this flyer/post with others to promote more participation.

Please do not hesitate to contact me directly if have any questions, or if you are interested.

Thank you for your time and consideration.

Shonetesha L. Quail, LPCMH, NCC

Ph.D. Health Psychology Study
Walden University
**Telephone:**
**Study Email Address:**
**Walden University Email Address:**

Appendix B: Semi structured Interview Questions

**Research Questions**:

What are the perceptions and experiences of mothers who loss a young adult child from a drug overdose?

a. Sub question: What are the physical symptoms experienced by mothers following the death of a young adult child from a drug overdose?
b. Sub question: What are the emotional expressions experienced by mothers following the death of a young adult child from a drug overdose?

What are the coping mechanisms used by mothers following the death of a young adult child from a drug overdose?

**Physical/Emotional**

- I did not have the opportunity of meeting (child's name). Can you tell me about him/her?
  - How old?
  - Substance use over time.
  - What year did she/he die?
- How were you informed of your child's death?
  - Who was with you?
  - Where were you?
- Please tell what it was like for you to experience the loss of a child.
  - Can you tell me about your early grieving experiences?
  - Have your experiences changed over time?
  - Tell me about the process you went through in making sense of your child's death
- Did your experiences change your spiritual beliefs? If so, how?
- Did your experiences change your beliefs regarding the world in general?
- What do you recall regarding how you felt physically?
  - Early physical experiences
  - Physical experiences after 6 months
  - Physical experiences after 12 months
  - Current physical experiences
- What do you recall regarding how you felt emotionally?
  - Early emotional expressions
  - Emotional expressions after 6 months
  - Emotional expressions after 12 months
  - Current emotional expressions

**Social/Family Experiences**

- What changes have you experienced with family and friends since your loss?
  - If so, how? did others respond to you in your grief?
  - Do others relate to you differently? Coworkers?
  - Describe how coworkers helped when you returned to work.
- Tell me about your experiences and thoughts of what was the most helpful support you received from others?

**Coping**

- Please tell me your experience in returning to a sense of normalcy as a bereaved mother.
    - Describe what you did to care for your self during this time?
        - Physically (Timeframes)
        - Emotionally (Timeframes) (Professional Support)
        - If professional help was used, what was most helpful?

**Final/Overall**

Please provide any additional information you believe is important to better understand your personal experience of being a bereaved mother as it applies to a drug overdose death of a child or to any other aspects of this current study.

**Study Summary**

I will be providing you with a 1-3 page summary of the study. Would you like to receive your summary via certified US mail, or by secure email?

# Appendix C: Interview Step-by-Step Guidelines for Continuity

**Prior to the semi structured interview**

- Contact participant
- Provide Qualifying Survey and consent if not completed
- Discuss purpose of study, define concepts of maternal bereavement, lived experiences, and perceptions/attitudes
- Schedule interview, give instructions for participation
- Discuss recording procedures
- Answer any questions about the study, qualifying survey and informed consent

**At scheduled semi structured interview**

- Collect signed informed consent form if not already collected
- Reiterate study purpose, informed consent and right to withdraw without penalty
- Provide research packet to include copies of signed documents and community resources
- Obtain permission to record
- Upon completion of interview, ask if participant has other information to offer

**Post semi structured interview**

- Thank participant
- Remind a list of resources are in the packet on green paper
- Inform participant that a transcript will be sent when available, request and schedule follow-up interview for member checking purposes

# Appendix D: Community Resources

| Organization | County | Services Provided | Address | Telephone Number |
|---|---|---|---|---|
| Delaware Grief Awareness Consortium | Statewide | http://www.degac.org/grief-support-groups/ | | |
| Delaware Hospice Grief Support Programs | Kent | Free, year-round grief support groups to help adults learn about the grief process, receive support in a caring environment from those who are going through a similar experience, and ultimately feel less alone and misunderstood in your grief. Groups are facilitated by professional counselors | 911 South DuPont Highway, Dover, DE, | 1(800)838-9800 |
| The Compassionate Friends, Inc. - Bay Breeze Chapter | Kent | Organization for families (parents, grandparents, and older siblings) who have experienced the death of a child at any age. Meets second Thursday each month at 7:00 pm. | Church of Christ, 1156 S. Governors Ave., Dover, DE 19904 | Contact Liz at (302) 284-7590 |
| Delaware Hospice Grief Support Programs | Kent/Sussex | Free, year-round grief support groups to help adults learn about the grief process, receive support in a caring environment from those who are going through a similar experience, and ultimately feel less alone and misunderstood in your grief. Groups are facilitated by professional counselors | 100 Patriots Way, Milford, DE 19963 | 1(800)838-9800 |
| Delaware Hospice Grief Support Programs | Sussex | Free, year-round grief support groups to help adults learn about the grief process, receive support in a caring environment from those who are going through a similar experience, and ultimately feel less alone and misunderstood in your | 315A Old Landing Road, Millsboro, DE 19966 | 1(800)838-9800 |

| | | | | |
|---|---|---|---|---|
| | | grief. Groups are facilitated by professional counselors | | |
| **Organization** | **County** | **Services Provided** | **Address** | **Telephone Number** |
| Compassionate Care Hospice | Sussex | Offers bereavement supports services that are open to the public. Call for information regarding dates and locations. | 20165 Office Circle, Suite 2 Georgetown, DE 19947 | (302) 994-5900 / toll-free (866) 994-8137 |
| The Compassionate Friends – Lighthouse Chapter #2067 – Death of a Child Epworth Methodist Church, meetings. The Lighthouse Chapter produces a newsletter that is mailed or sent monthly to members via email. | Sussex | Compassionate Friends is a peer support group for persons grieving the death of a child of any age. Meetings are open to bereaved parents, siblings, and grandparents. There is no religious affiliation and no membership fees or dues. The Compassionate Friends is an informal support group learning how to cope with the struggles of living life without our child. Meetings offer support, friendship, and understanding with professional speakers at some | Branford Room, 19285 Holland Glade Road, Rehoboth Beach, DE 19971 | May contact Marge at (302) 930-3344 with questions. |
| Faith-Based Grief Support GriefShare | Sussex<br><br>**May have Kent County Locations** * | GriefShare is a grief recovery support program where you can find help and healing for the hurt of losing a loved one. It is a 13-session program offered in many local churches. Using the Bible to help with grieving, each meeting includes a video seminar, group discussion, and use of a personal study workbook. (depending on the facility, there may be a small charge for the workbook). The following churches offer the Grief Share program at various times throughout the year and may be contacted for | Crossroads Community Church 20684 State Forest Road Georgetown, DE 19947<br><br>Eagles Nest Fellowship 26633 Zion Church Road Milton, DE 19966<br><br>St. Johns United Methodist Church 300 N. Pine Street Seaford, DE 19973<br><br>**Other churches in the area may offer periodic classes; go to www.griefshare.org/findagroup for other locations and starting dates. | Contact Kay Bennett or Gail Betts: (302) 629-0111 ext. 105<br><br>(302) 684-3149 Linda Deaton, Grief Share Leader<br><br>Office # (302) 629-9466 |

| | | | | |
|---|---|---|---|---|
| | | information and starting dates | | |
| **Organization** | **County** | **Services Provided** | **Address** | **Telephone Number** |
| Seeds of Greatness | New Castle | GriefShare is a grief recovery support program where you can find help and healing for the hurt of losing a loved one. It is a 13-session program offered in many local churches. Using the Bible to help with grieving, each meeting includes a video seminar, group discussion, and use of a personal study workbook. (depending on the facility, there may be a small charge for the workbook). The following churches offer the Grief Share program at various times throughout the year and may be contacted for information and starting dates | 828 Frenchtown Road, New Castle DE | 302 -324-8050 |
| Canann Baptist Church | New Castle | Offers bereavement supports services that are open to the public. Call for information regarding dates and locations. | 3011 New Castle Ave, New Castle DE | 302 654-8818 |