

Caroline Lloyd

Supervisor: Prof. Conor Mc Guckin

**An exploration of female adolescent experiences of abortion and  
miscarriage from an adult retrospective bio-psycho-social perspective**

Thesis submitted for the degree of Ph.D.

School of Education

Trinity College Dublin

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**Volume 1 of 2**

## **Declaration**

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and it is entirely my own work. I agree to deposit this thesis in the University's open access institutional repository or allow the Library to do so on my behalf, subject to Irish Copyright Legislation and Trinity College Library conditions of use and acknowledgement.

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A handwritten signature in black ink, appearing to be 'C. L. O.' followed by a long horizontal flourish.

28<sup>th</sup> April, 2022

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This thesis is dedicated to:

All the females who feel disenfranchised, gaslighted, unheard, and/or  
blamed.

## **Abstract**

The current research presents an exploratory bioecological understanding of female experiences of miscarriage or abortion during secondary school-ages. A systematic review revealed that the topic area is empirically sparse, predominantly derived from the nursing discipline, and US-centric. A sequential explanatory design was conducted with continual convergence across two individual but connected studies. With a focus on qualitative methodology, the studies comprised: (a) phase one: design, implementation, and analysis of The Adult Attitude to Adolescent Perinatal Death Questionnaire (AAA) (n = 23); and (b) phase two: adult retrospective in-depth semi-structured interviews with women who had experienced an adolescent perinatal death whilst attending secondary school (n = 6). This innovative, transnational research found that, for society, there is a greater need for awareness of female victim blaming, an awareness of the continued imposition of patriarchal norms on developing females, and a need for awareness of continuing female adolescent pregnancy stigmatisation. For educators, there is a need for awareness of female adolescent pregnancy marginalisation, a need to provide education and support to adolescent girls who may become pregnant, and/or experience a perinatal death, and an urgency for appropriate, needs-based, person-centred relationship and sex education. This study also found that, for parents, there is a need for awareness of Adverse Childhood Experiences, an argument for trauma-informed parenting, and a need for greater involvement in sex education. For professionals supporting, and individuals experiencing, an adolescent miscarriage or abortion, there is a

need for awareness of the impact of the death to an individual, an advisory to allow females to choose whether they identify as a “bereaved mother” or not following these events, and there is a need for awareness of the impact of stigma, slut shaming, and bullying during secondary school on identity creation, and reconstruction, across the life course. Recommendations for educators are provided from participant narratives and proposals for future research are also discussed.

## **List of Acronyms**

AAA	Adult Self-Perception of Retrospective Perinatal Death in Adolescence Questionnaire
ABC	Aspects of Bereavement Course
ACEs	Adverse Childhood Experiences
BACP	British Association of Counselling Professionals
BELATED	The Bio-psycho-social Model of Female Experiences of Adolescent Perinatal Death
CBT	Cognitive Behavioural Therapy
CDI	Children's Depression Inventory
CRUSE	Cruse Bereavement Support
CSO	Central Statistics Office
DPM	Dual Process Model of Coping with Bereavement
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5 <sup>th</sup> Edition
EST	Ecological Systems Theory
GDPR	General Data Protection Regulations
HCBS	Harvard Child Bereavement Study
ITB	Integrative Theory of Bereavement
LR	Literature Review
LRL	Loss Response List



NI	Northern Ireland
MMPI	Minnesota Multiphasic Personality Inventory
MTB	Multidimensional Theory of Bereavement
PCBD	Persistent Complex Bereavement Disorder
PGD	Prolonged Grief Disorder
PGIS	Perinatal Grief Intensity Scale
PPCT	Process-Person-Context-Time model
PTG	Post Traumatic Growth
ROI	Republic of Ireland
RSE	Relationship and Sex Education
RTPA	Regulation of Termination of Pregnancy Act 2018
SIDS	Sudden Infant Death Syndrome
SIT	Social Identity Theory
SLT	Social Learning Theories
SMPSD	Social Media Processes and Safeguards Document
TA	Thematic Analysis
UK	United Kingdom
US	United States of America
WHO	World Health Organization
WWII	World War II

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## **Chapter One: Introduction**

*“Kate McCormick, Seduced and pregnant by her father’s friend, Unwed she died from abortion, her only choice, Abandoned in life and death by her family, With but a single rose from her mother, Buried only through the kindness of an unknown benefactor, Died February 1875, age 21, Victim of an unforgiving society, Have mercy on us.”*

*(Gravestone in Tennessee, US)*

*Evon, 2019*

### **1.0 Chapter One Overview**

This thesis explored the retrospective experiences of females who became pregnant during adolescence and subsequently experienced a perinatal death. The male experiences were excluded from this study in order to focus on the physiological, psychological, and societal variables applicable to females only. This research provides a comprehensive overview of the bio-psycho-social experiences of the study participants with a view to informing policy and practice for individuals who may provide personal or professional support to females who are experiencing, or have experienced, these events. The programme of research is conceptualised within a bioecological perspective of human experience (Bronfenbrenner, 1986). In particular, the research is understood from the participants’ bio-psycho-social narratives of the historical event within the structural components of the nested systems model (see chapter two). Furthermore, this study

understands “adolescence” as those years that study participants would have been attending post-primary/secondary education (see section 1.3.1).

This chapter details the research undertaken and sets out the underpinning rationale for its inception and implementation. The researcher is then positioned “a priori” so as to provide an understanding of the researcher’s personal and professional experiences in the area under investigation. The key concepts pertinent to work in this area are subsequently operationally defined to assuage any ambiguity and to provide clarity throughout the thesis. Finally, global statistics and pertinent variables that contribute to adolescent pregnancy, and perinatal deaths, are presented to provide a bird’s eye view of the bio-psycho-social factors involved. The final section summarises the seven chapters that comprise the body of this research thesis.

## **1.1 Introduction**

This research explored the issues that may (or may not) arise when a girl becomes pregnant during adolescence and experiences a perinatal loss (Barglow et al., 1973). Situated within Ireland, this research was conducted with a view to exploring Irish experiences of these events, however, due to a dearth of local participants, the study was expanded to encompass an international perspective.

Predominant social narratives involve grief and trauma discourse following a perinatal loss (e.g. Kersting & Wagner, 2012), however, Hutti et al. (1998) remind us that: “Differences exist in how people react to a pregnancy loss. Some men and women do not grieve, whereas others often

do grieve.” (p. 547). Additionally, each culture has a myriad of socially constructed responses to death, dying, and bereavement and within each society there are individuals who do not display outward emotional responses. Within Euro-Western cultures, for example the US, a lack of outward emotion may be interpreted as “not grieving” (Martin & Doka, 2000). Correspondingly, through exploring whether there were differences between how men and women express grief, Martin and Doka (2000) identified grieving patterns that were representative of socially constructed cultural norms. Thus, whilst grief and bereavement may sometimes be understood through categorical variables such as sex and gender, Martin and Doka determined that public expressions and depth of feelings (or lack thereof) of grief are eminently more nuanced and individual.

The predominant social media discourse that pregnancy and neonatal death losses are “taboo” or “stigmatised” subjects; i.e. that they are not talked about within our allegedly “death denying” society also originate from US cultural perspectives (Becker, 1973; Steinhäuser et al., 2000). Conversely, within the UK Walter (2017) argues that every individual has a right to choose whether to keep their experiences and feelings private; that not grieving publicly does not constitute an inability to do so, but that it is a choice that should be respected. The interested reader may wish to refer to the extensive body of research and publications on cultural, and other variations, of perspectives on death, dying, and bereavement, either historically or within contemporary society (e.g. Becker, 1973; Browne, 1907; Davies, 2017; Holloway, 2007; Kelleher, 1984; Parkes et al., 2015; Walter, 1991/2012,/2017; Woodthorpe, 2010).

Conversely, multiple scholars have refuted “death denial” perspectives, particularly within contemporary sociological discourse (e.g. DeGroot, 2014; Rosa, 2019). Holloway (2007) asserts that global images of death have spurred contemporary societies into death “obsession” and Lund (2020) identified the phenomenon of “recreational grief” as an escape from normal life to feel an existential resonance. By extension, photographs and videos of deceased embryos, foetuses, and babies are accessible and proliferating on the internet; hosted on websites, social media pages, and YouTube.

Further evidence to refute the “taboo” narratives is evident within the proliferation of websites and social media posts providing information and support on death, dying, and bereavement (Sofka et al., 2012). Figure 1 below is an example of a miscarried pregnancy posted publicly on personal social media accounts by model Chrissie Teigen and singer John Legend. These posts were also published in newspapers, on television programmes, on other social media sites, and on webpages globally.

### **Figure 1**

*Chrissie Teigen and John Legend with their Miscarried Baby*





Chrissie Teigen and John Legend have millions of followers via a multitude of online media outlets and by posting photographs such as Figure 1 they are informing many people who may not have experienced, or known anyone experience, any kind of perinatal loss that these events can have a significant impact. However, these photographs, and accompanying comments from followers all over the world, expose the juxtaposition of claiming that contemporary Western societies are socially “death denying” whilst providing evidence of “death obsession”. This study thus examined the private and the public variables with the study participants from a bioecological perspective (i.e. not just what they were thinking or feeling, but also how they were influenced by, and interacted with, their environment).

The purpose of this research is, therefore, to give a voice to women who experienced a perinatal death during adolescence, and to learn from them, thereby countering any perceived notion of social “silence”. The narratives of the study participants, as interpreted from this research, can be used to inform discussions regarding policies and practices of how best to support females during, or following, a perinatal death experience.

The Chrissie Teigen and John Legend example, discussed in the preceding paragraph, is also an example of how perinatal death is widely presented publicly as an event that occurs within consenting adult relationships, where the pregnancy is planned, and the loss is emotionally significant (Toedter, et al., 1988). Whilst this may also occur during adolescence, other variables must also be considered. For example,

adolescent pregnancy also occurs outside of secure relationships, can be unplanned, and may not be considered societally as emotionally significant (Brady et al., 2008). Further, as this study is exploring the bio-psycho-social experiences following adolescent perinatal loss, the inclusion criteria encompassed any mode of death (see chapter three). The research presented in this thesis therefore makes a contribution by examining the relatively unexplored subject of adolescent perinatal death loss with these additional variables considered.

Prior published research has examined grief intensity in adult participants utilising various psychometric instruments. Examples include The Perinatal Grief Scale which examines variables such as marital relationship and the mother's physical health (Toedter et al., 1988), the Perinatal Bereavement Grief Scale designed to distinguish perinatal grief from depression (Ritsher & Neugebauer, 2002), and The Perinatal Grief Intensity Scale (PGIS) which examines the mother's attachment to the pregnancy and impact of the loss (Hutti et al., 1998). (These examples are not exhaustive and presented as examples only, they are not intended to imply a comprehensive review of psychometric scales across academic disciplines). The PGIS was selected for this study due to its relevance and its established psychometric stability and academic longevity (Hutti & Limbo, 2019; Lasker & Toedter, 2000). This study makes a contribution to the utilisation of the PGIS in three ways; (a) by examining the perceived grief responses from a perspective across the life course; (b) by utilising the PGIS to examine adult retrospective perceptions of their adolescent

responses to perinatal loss; and (c) by investigating the grief impact following a termination, in addition to biological pregnancy losses.

Additionally, popular cultural discourse on the subject of gestational and neonatal losses incorporates the assumption that the event is a traumatic experience that follows a desired and wanted pregnancy by two consenting adults. Academic discourse also includes suggestions of traumatic outcomes following pregnancy loss by adults (e.g., Abi-Hashem, 2017; Frost & Condon, 1996; Krosch & Shakespeare-Finch, 2017). However, individual responses to perinatal death in adulthood can vary, and the whole spectrum from no impact to intense impact must be considered, in relation to adolescent experiences: “Hutti (1992) found that after early pregnancy loss responses ranged from no grief to an intense, long-lasting grief. Intense grief responses were associated with parents for whom the pregnancy and baby within were perceived as real.” (Hutti, et al., 1998, p. 549).

This research also explored the self-reported bioecological conditions that existed prior to, and at the time of, the pregnancy. Cultural differences and individual opinion will vary about efficacy of relationship and sex education (RSE) within school curriculum, and this thesis does not seek to find a generalisable consensus, however it did investigate the study participants’ view of their RSE during adolescence and whether it was a self-perceived positive, negative, or irrelevant contribution to their developmental process.

This research also explored the adult participants' perceptions of their home environment as situated within Bronfenbrenner's (1979) micro-system and whether there were any influential dyadic relationships that may have had an impact on their adolescent pregnancy experience.

This qualitative body of research provides modest contributions to the academic fields of death studies, education, medicine, psychology, and sociology from an interdisciplinary perspective, whilst not claiming to "belong" to any one scholarly discipline (Woodworth et al., 2022).

The next section provides the underpinning rationale for the research study which emerged due to a lack of knowledge, education, and training in professional discourse surrounding gestational and neonatal loss experienced by females.

## **1.2 Underpinning Rationale for the Research**

The underpinning rationale for this research emerged due to a lack of knowledge, education, or training for bereavement professionals pertaining to the issue of supporting adolescents, or adult women, who had experienced an adolescent perinatal death. The first part of this section details the researcher's positionality within the area of grief and bereavement. The second part of this section provides an overview of the limited knowledge and support available to adolescents who may be seeking information during, or following, these experiences.

### ***1.2.1 Researcher Positionality***

This section details the chronological representation of events that have led to this particular study. The historical events are recalled descriptively, and I explicitly acknowledge the fallacy of memory, and changing narratives across the lifespan with changes in my perception of these events.

My first experience of a significant bereavement was in 1988 at the age of 22 when a 26 year old friend died following unsuccessful treatment for a brain tumour. As a result of this death I became a befriender at a local hospital and would sit with terminally ill cancer patients, and their families, and chat with them. Full training was provided by the hospital and I worked with a supervisor within a boundaried environment. I experienced many more significant bereavements including perinatal deaths, family and friend deaths by suicide, and further family and friend cancer deaths, including my three year old nephew.

After many years of intermittent voluntary work, in 2011 I undertook the Aspects of Bereavement course (ABC) with Cruse Bereavement Support (Cruse) and simultaneously completed a Certificate in Counselling course. Along with supporting bereaved clients for Cruse, I joined the Client Services Committee, was a member of the training team, facilitated bereavement support groups, and volunteered on the Cruse national helpline.

Cruse Bereavement Support is a British Association of Counselling professionals (BACP) organisation and the charity works within their ethical framework. Bereavement volunteers are initially trained, and once competent, are required to attend compulsory continuing professional development (CPD) courses. Volunteers are also supervised individually, and supported by the branch, at all times. The counselling supervisors are also required to undertake an annual performance review of all the volunteers.

In 2013 I undertook further training with Roadpeace to become a Facilitator for their Resilience Building Programme (RBP) which is a Cognitive Behavioural Therapy (CBT) based programme adapted by Dr Noreen Tehrani from material developed by Dr Patrick Smith, Dr Atle Dyregrov, and Prof Bill Yule. The programme supports those bereaved after a road collision and seeks to enable those who are identified as experiencing high levels of traumatic impact to understand the traumatic element of their experience. The Traumatic Exposure Assessment Questionnaire is the name used to identify a combination of psychometric tools assembled by Roadpeace to identify suitable candidates for the programme. The psychometric tools selected comprise of; the Goldberg General Health Questionnaire (Goldberg & Hillier, 1979), Impact of Events Scale (extended) (Horowitz et al., 1979), Traumatic Grief Inventory (Boelen & Smid, 2017), and Lifestyle Questionnaire (Mayers, 2003). Ongoing training and professional supervision are also requirements to be

employed within this role. I also undertook additional training on trauma-informed practice directly with Dr Noreen Tehrani.

I also completed further training in “Complicated Grief” with Dr Susan Delaney, Dr Colin Murray Parkes, Dr Katherine Shear, and Dr David Trickey. I have also completed specific training with Cruse and Child Bereavement UK to support bereaved children and young people.

From my initial training and experience in 1988 to the present day, I have not been aware of any professional courses or other provision of bereavement support that have specifically mentioned the subject of adolescent perinatal death loss. I actively searched for resources as a lay person, i.e. through platforms such as Google and was unable to find any resources or information. My work directly supporting bereaved clients often opened up conversations of past experiences and I was aware anecdotally of a need to understand how these events contribute to current situations. Therefore it was a natural progression for me to combine my passion for supporting bereaved people from an evidential perspective, to undertake academic research within this area and make a contribution to some of the questions that were unanswered.

Since registering as a PhD student in January, 2017, I was commissioned by Jessica Kingsley Publishers to write an accessible, research based book on grief which was published in November 2017 worldwide. The book is on the reading lists for some undergraduate and postgraduate psychology courses, as well as training courses for a variety of

professionals. I have also been invited to work on an interdisciplinary project disseminating the results of the Continuing Bonds Project at the University of Bradford. I was also invited to speak at the Cruse 60<sup>th</sup> anniversary international bereavement conference as a keynote speaker on bereavement from a bio-psycho-social perspective in 2019. I have also been creating and delivering workshops, talks, and delivering training, both individually, and with other professionals. I have also been invited to, and undertaken, peer reviews of books and journal articles within the area of bereavement. I am also currently employed by a research team at the University of Edinburgh to investigate the impact of trauma training (specifically in relation to Adverse Childhood Experiences) on trauma informed practice within Police Scotland.

As a mature, experienced bereavement support worker, trained within an organisational framework where reflexivity and supervision are embedded within professional ethical practice (BACP, 2021), I was aware of the interplay between researcher and the creation of knowledge as a shared experience, and the potential for emotional impact (Valentine, 2007; Visser, 2017; Woodthorpe, 2007). Therefore, as the thesis topic is recognised as “sensitive” for research purposes, both for the participant and the researcher, a reflexive approach to emotional labour management was employed for this study (Borgstrom & Ellis, 2017; Hochschild, 2012; O’Brien, 2015).



### ***1.2.2 Adolescent Perinatal Loss Resources***

Following acceptance of the research proposal for this study in 2016, I actively searched for any resources to provide information on, or support to, adolescents who may be experiencing a perinatal loss. Prior to registration as a student in January, 2017, I only had access to resources available to the public, so a general search engine exploration was undertaken, *a priori*, to ascertain what an adolescent might find. The following sources of information were discovered:

1. The Miscarriage Association website  
([www.miscarriageassociation.org.uk](http://www.miscarriageassociation.org.uk)): The Miscarriage Association is a UK based charity that provides a short leaflet online containing information on miscarriage that addresses the specific needs of adolescents. However, the information provided is very limited. The Miscarriage Association also has a number of short films on their website featuring young women talking about their miscarriage experiences (The Miscarriage Association, 2020).
2. I also found an online forum thread on a US based website called “Babycenter”. The dialogue was specifically for, and by, adolescents who had experienced miscarriage, stillbirth, or infant loss. However, the posts are dated from 2010 to 2014, with no activity since the 7th of September, 2014 (Babycenter, 2020).
3. I also found several posts on a closed Facebook group called; “Miscarriage & Loss” by several adult women talking about

their losses during adolescence. No social media groups were found to specifically address this thesis subject.

The dearth of evidential information or professional support, and the lack of training by professional organisations on the potential impact of a perinatal death during adolescence, and any long term impact, further highlighted the need for research and evidence based information to inform policy and practice.

This section has provided the underpinning rationale for the study, summarised the researcher's positionality, and has detailed the initial search for information on the topic available to the general public. Thus, this section has provided evidence of a lack of information and/or support to assist individuals or professionals during, or following, a perinatal death experience.

### **1.3 Defining the Area**

This section explores the key terminology used throughout this thesis. The current study explored the experiences of adolescent girls who became pregnant during school age, and subsequently experienced a perinatal death, from a bio-psycho-social perspective. Humans, whether medical professionals, scholars, or society in general, are all familiar with the concepts of "grief", "bereavement", and "mourning" following the cessation of an attachment. However, the terminology associated with death losses are commonly used interchangeably, thus necessitating an explication and clarity of definitions. In doing so, the most appropriate operational definitions for the current research are set out. However, the

researcher acknowledges there is considerable overlap in their usage across academia and within society. Chapter two will further define and expand on the concepts, and definitions, introduced within this chapter.

Similarly, the terms “adolescence” and “death” have assumptive meaning to many people. Adolescence or “teenage” years are commonly assumed to encompass the secondary education stage of life; from *thirteen* to *nineteen* but developments within medical fields have expanded historical views of the delineation of adolescence and this is explored further in Section 1.3.1. Similarly, the concept of “death” was historically assumed to refer to the biological ceasing of the heart and pulse of a living human being. However, philosophical and political views surrounding when “life” begins and abortion narratives as “murder” have implications for definitions within this body of research and is explored, and defined, in Section 1.3.6.

The following subsections will define and clarify the terminology used in the current thesis and will operationally define the following terms: (a) adolescence; (b) grief; (c) bereavement; (d) mourning; (e) perinatal; (f) death; and (g) the bio-psycho-social.

### ***1.3.1 Adolescence***

Presented in this section is a brief summary of the emergence of adolescence as a separate and distinct developmental phase, and the definitional boundaries for this study.

In ancient Greece; “the chronological boundaries of the stages of life hinged upon Solon’s theory of human life as divided into ten seven year stages.” (Caramia, 2012, p. 169). The chronological age ranges for children and adolescents were respectively 0-8 years (infant) and 8-16 years (pueritia). At the age of 16 or 17 (adulescentia), a ceremony was undertaken to declare the adolescent a “teenager adult”. However, during the following centuries, as children and adolescents worked alongside adults within agrarian societies, the clear demarcation of chronological differences became theoretical in nature only (Nielsen, 1996).

In subsequent centuries, the industrialisation of Western countries, including Ireland, contributed to a reduction in demand for farm labourers and an increase in jobs that demanded some reading, writing, and mathematical skills. The development of formal education in response to labour based needs led to the decision to establish a national system of education in Ireland in 1831: “It was also a social and economic response to the widespread poverty and the quest for education evident in Ireland, with the intention that basic literacy and numeracy would improve the position of Ireland’s citizens in future generations.” (Walsh, 2016, p. 8). In 1926 the School Attendance Act was enacted in Ireland which underpins the compulsory requirement for all Irish children to attend school.

Consequently, the social changes that separated children and adolescents from adults within society revived chronological difference. The social perception of “adolescence” as a distinct and separate life stage was further progressed with the post war Euro-Western “baby boom”

period wherein the number of teenagers grew rapidly. Within the US context Nielsen (1996) explains: “Eager to cash in on the booming teenage market, businesses and the entertainment industry further contributed to our perceiving adolescence as a distinct group...convinced through advertising that it “needed” such items as special clothing, cosmetics, hair products, movies, music, and television programs.” (p. 5).

Defining “adolescence” within a contemporary context can often align with second-level education, usually beginning before twelve or *thirteen* years old, continuing until the last of the “teen” years at *eighteen* or *nineteen*. It is commonly assumed that adolescence stops once the age of twenty has been attained, however, “Longitudinal neuroimaging studies demonstrate that the adolescent brain continues to mature well into the 20s.” (Johnson et al., 2009, p. 216).

Due to evolving scientific evidence that neurological maturation continues into the early 20’s, “adolescence”, for the purpose of this study, refers to the sexual maturation of young adults from puberty onwards within the adolescent years. Due to the variances both within, and between, lay perceptions and evolving scientific findings of puberty, and adolescence, the boundaries for this study were delineated at participation in secondary level education. The inclusion criteria for this thesis therefore includes females who became pregnant whilst attending full time second-level education during the time of the perinatal death. The exclusion criteria for this study are therefore adolescents prior to puberty, i.e. those

girls who have not yet reached menarche, and adolescents who have left secondary education.

Having presented the bounded definition of adolescence for this study, the following section explores the concept of “grief” and offers a definition for this thesis.

### ***1.3.2 Grief***

Freud, in his seminal work *Mourning and Melancholia* (1917/2005), explored grief, bereavement, mourning, and “melancholia” from his psychoanalytic perspective; with “grief” viewed as the painful response to the libido’s resistance to withdrawing from the deceased person. The “failure” to detach from the deceased so that the griever could be “free and uninhibited again” was perceived to be a pathological response by Freud. Freud’s views and publications are not explored in detail within this thesis but presented as the widely accepted precedent of scientific study of the phenomenon of grief (Pearce, 2019).

Lindemann (1944) introduced the first stage theory of grief which consisted of; shock, anger, sadness, and resolution. He described grief as; “a definite syndrome with psychological and somatic symptomatology.” (p. 141). Further theorists during the 1970’s and 1980s also identified and presented “stage” grief theories from psychoanalytic perspectives (Parkes, 1972; Rando, 1984; Worden, 1982).

In 1999 Stroebe and Schut published their “Dual Process Model of Coping with Bereavement: Rationale and Description” which presented an alternate view of grief across the process of “bereavement”. This divergent

positionality from the established “stages” of grief, could be considered as the seminal establishment of the delineation of “grief” as distinct from “bereavement”.

Holloway (2007) states that; “*Grief* and *grieving* are descriptions of the individual’s psychological and emotional responses to loss...These are commonly manifested in certain outward behaviours.” (p. 66). Based upon encompassing the central tenets of grief, and the varying definitions of the responses to the death of a loved one, the researcher therefore proposes that the operational definition of “grief” for this thesis is: “the feelings, thoughts and actions we experience after the death of a significant attachment” (Lloyd, 2018).

Having defined the term “grief” for this thesis, to add clarity to the definitional variations, the next section will explore and define the term “bereavement” as distinct and separate from “grief”.

### ***1.3.3 Bereavement***

The current section operationally defines the term “bereavement” as distinct and separate from “grief” and “mourning”.

The definitions of “grief”, “bereavement”, and “mourning” continue to evolve and have been repeatedly clarified across many academic disciplines that encompass the subjects of death, dying, and bereavement. However, there is still considerable overlap and blurring. The evolution of grief theory from the psychodynamic perspective that focussed on the individual reaction to the death of a loved one, to more psycho-social

explorations of the transactional nature of grief, for example, within the Dual Process Model, have led to the interchangeability of the terms “grief” and “bereavement” within lay populations (Holloway, 2007; Stroebe & Schut, 1999).

Holloway (2007) argues that bereavement is the “...experience of loss occasioned by death...implies a social and philosophical context...widowhood, for example, is a universally defined social state.” (Holloway, 2007, p. 66). Situated within the premise of a socially constructed state, the operational definition for the term “bereavement” for this thesis is therefore; “the adjustment and re-organisation of our lives across the ecological systems subsequent to the death of a significant attachment.”

Having defined “bereavement” for this study, the following section will define the terminology of “mourning” and provide a clear operational definition for the current research study.

#### ***1.3.4 Mourning***

Historically, the psychoanalytic definition of mourning involved active “grief work” and suggested that it involved the gradual process of detaching the libido from an internal image (Freud, 2005; Lindemann, 1944). Within contemporary discourse, the two verbs “mourning” and “grieving” are used synonymously and interchangeably due to their similar meanings (Neimeyer et al., 2002).



However, contemporary theorists view mourning as the outward expression or social cues and rituals associated with the bereavement process and thus will therefore be the definition of mourning for this thesis (Davies, 2017). One example of contemporary mourning is recounted by Fletcher (2021) who details the prevalence of “R.I.P. t-shirts” within African American communities that; “function as ritualised mourning wear and are perhaps the most visible tradition in the country.” (p. 209).

### ***1.3.5 Perinatal***

The current section defines the term “perinatal” and sets out the positionality of the researcher as a critic of the term for research purposes.

The word “perinatal” is universally applied as a descriptor to describe miscarriage, stillbirth, and neonatal death losses (Broderick & Cochrane, 2013). However, the definitions for “perinatal” vary greatly across countries, organisations, and academic disciplines, with the terminology often not defined but assumed (Engle, 2004). Chapter three sets out a detailed summary of the problem of varying definitions of “perinatal” for researchers and bereavement support workers. Therefore, the definition of “perinatal” for this thesis is; “encompassing all deaths from conception to twenty eight days post birth”.

### ***1.3.6 Death***

An understanding of the definition of death, for this study, is presented within the context of an operational definition of “life”. The inclusion criteria for this research encompassed all deaths (embryonic, foetal, and

neonatal), beginning at conception and ending at twenty-eight days post-birth (see Appendix 1). The duration of human pregnancy from conception to birth consists of forty weeks on average, with the developing human life referred to as an embryo until the eighth week of pregnancy, and defined thereafter as a foetus (Nierenberg, 2017).

The inclusion of medical terminations for any reason, or none, introduces the concept of when “life” begins and what constitutes “death” (Cranford & Smith, 1987). Politically, and ideologically, definitions are continually debated within contemporary discourse and the researcher makes no assertions within the context of this thesis. Rather, the concern for this study is whether the pregnancy assumed “personhood” by the participants within this research, and if so, what the impact of any perceived losses have been. The following quote from Layne (2000) provides an example of how personhood has been constructed within contemporary narratives:

Women now may begin to actively construct the personhood of their wished-for child from the moment they do a home pregnancy test. Each cup of coffee or glass of wine abstained from, and each person informed of the impending birth adds to the ‘realness’ of the baby they are growing within. They may follow the weekly physiological development of their ‘baby’ with a home pregnancy manual and each prenatal visit contributes to and confirms the growing sense of the ‘baby’s’ realness and to their growing sense of themselves as ‘mothers’. This may be especially true of those visits where one

hears the heartbeat, sees the baby moving on the sonogram screen, or is informed of the baby's sex. (p. 322)

“Personhood” is therefore defined for this thesis as attributing human value, i.e. “life”, and the emotional attachment thereof by the woman to her embryo, foetus, or neonate. However, it is also recognised that individuals are integral within society so there may be potential disenfranchisement between the value ascribed to the pregnancy by the female and the judgement society makes about the significance of the loss (Doka, 2002; Doerr & Prescott, 1989).

As the interpretation of “life” and “personhood” can vary between individuals and cultures, the definition of “death” for this programme of research is rooted in the traditional medical position as; “The permanent cessation of functioning of the organism as a whole” (Bernat et al., 1981, p. 389).

### ***1.3.7 The Bio-Psycho-Social***

The current section operationally defines the term “bio-psycho-social” as it pertains to this research study. The biopsychosocial model was first proposed by Engel in 1977 as a framework to encompass the biomedical, behavioural, psychological, and social dimensions of illness to address his own criticisms that physicians do not take into consideration factors outside of somatic parameters. This approach has since been incorporated within other disciplines, and this study defines bio-psycho-social as: “to systematically consider biological, psychological, and social factors, and their complex interactions in understanding lifespan development” (Berger,

2014, p. 318). As an extension of the interlinked and interdependent perspective of the bio-psycho-social interactions, the Ecological Systems Theory is based on the notion that an individual does not develop in isolation, that it is vital to look at the social systems within which an individual functions and the dynamic interactions within and between them (Bronfenbrenner, 1977/1979/1992). Chapter two provides a detailed summary of the relevant adolescent developmental theories pertinent to the bio-psycho-social framework for this study.

Table 1 presents a summary of the key terminology and operational definitions for this thesis:

**Table 1**

*Key Terminology and Operational Definition*

Key Terminology	Definition
Bio-psycho-social	To systematically consider biological, psychological, and social factors, and their dynamic interactions in understanding lifespan development
Adolescence	Due to the ambiguity surrounding the definition of “adolescence”, the inclusion criteria for this thesis are females who became pregnant whilst attending full time second-level education during the time of the pregnancy and perinatal death
Death	The permanent cessation of functioning of the organism as a whole
Perinatal	A human life from conception to twenty eight days post birth

Grief	The feelings, thoughts and actions we experience after the death of a significant attachment
Bereavement	The adjustment and re-organisation of the assumptive world across the ecological systems subsequent to the death of a significant attachment
Mourning	The outward expression, i.e. social cues and rituals, associated with the bereavement process undertaken by grievers

This section has defined the key terminology and operational definitions for this thesis. The following section will review the pertinent variables and statistics relevant to adolescent pregnancy and perinatal death.

#### **1.4 Adolescent Pregnancy**

The current section reviews the pertinent variables and statistics, from a birds eye view, to provide an understanding of individual and social contributory factors to adolescent pregnancy.

The World Health Organization (WHO) stated that an estimated 21 million adolescent girls become pregnant every year between the ages of 15 and 19 (WHO, 2020). They also estimated that 12 million girls between these ages give birth, leaving a resultant estimated nine million 15 to 19 year olds who become pregnant and do not give birth. Additionally, WHO stated that an estimated 777,000 give birth under the age of 15 but they do not compile estimated pregnancy statistics for this cohort. Whilst pregnancy in adolescence confers higher medical risks, females aged younger than 15 are of particular concern because they experience higher

pregnancy related morbidity, are at higher risk of experiencing foetal deaths, stillbirth deaths, and infant mortality (e.g. Cooper et al., 1995; Malabarey et al., 2012; Menacker et al., 2004; Salihu et al., 2006; Smid et al., 2014).

WHO have also stated that adolescent pregnancy is a global problem that occurs in high-, middle-, and low-income countries, however, with the proviso that there are “enormous variations” both across geographic locations and within geographic regions (WHO, 2020). Environmental variables are therefore important contributory factors to the prevalence of adolescent pregnancy. For example, in least developed countries, where educational and/or employment opportunities might be scarcer, adolescent girls are more likely to marry at young ages and become pregnant (Singh, 1998). Globally, social contributors to adolescent pregnancy include; low socioeconomic status, inability to access contraception, lack of education, belonging to a minority ethnic group, having a mother who gave birth as a teenager, belonging to a social group with young mothers, and being raised by a single parent (e.g. Hudson & Ineichen, 1991; Moore & Rosenthal, 2007; Presser 1974; Santelli & Melnikas, 2010; Smid et al., 2014; Zelnik et al. 1981).

Within specific social environments, as presented in the preceding paragraph, familial relationships, and attachment styles, along with other relationship bonds within the nested systems, contribute to the adolescent female’s sense of identity and self -esteem (see chapter two). Unhappiness at home, or in school, and low expectations for future opportunities can also

contribute to adolescent pregnancy (Bonell et al., 2003). Additionally, very low pregnancy rates in Switzerland have been attributed to established effective RSE curriculum, alongside the expectation that adolescents will avail of free family planning services. However, even within this environment, adolescent pregnancy rates vary depending on educational level and cultural background (Boyd & Bee, 2008).

Within Western societies, where contraceptive knowledge and accessibility are high, many adolescent pregnancies are not planned (e.g. Furstenberg 1976; Santelli & Melnikas, 2010; Zelnick & Kantner, 1980). Research suggests that 82% of pregnant adolescent girls had either not considered the possibility that they might conceive, or for those that are aware of the risks, they proceed believing that pregnancy would not happen to them (Alberts et al., 2007). Further studies report that contraceptive failure is high with adolescents through either misuse or “unpreparedness” (Moore & Rosenthal, 2007). Hofferth and Hayes (1987) report three factors that contribute to effective contraceptive use during adolescence: (a) age: the older the adolescent is the more likely they are to use contraception; (b) relationship status: those involved in stable relationships are more likely to use contraception; and (c) academic achievement: those who are achieving well in secondary school are more likely to use contraception.

As noted earlier, higher foetal and female mortality is associated with adolescent pregnancy, with an absence of pre-natal care one of multiple contributory factors. Avoidance of pre-natal care can occur due to

many reasons for example lack of access to medical services or denial of the pregnancy. Conlon (2006) states: “in the event of an unexpected pregnancy a woman has two possible responses: to acknowledge or deny the pregnancy.” (p. 37). Concealed pregnancies may result in live births, or may be terminated or miscarried during gestation. (Moore & Rosenthal, 2007). Due to the nature of concealment, any perinatal death that occurs without medical attention will not be reflected in any statistical reporting thereby rendering estimates unreliable. Additionally, concealment of pregnancy during adolescence may have presented another challenging variable that may have affected recruitment of participants for this study, particularly as it has been specifically recognised within Ireland (Murphy Tighe & Lalor, 2016).

Contemporary scholars have also identified a pronounced increase in infant mortality in the UK and the Republic of Ireland (ROI) due to socioeconomic contributors; determining that females living in areas of higher deprivation are at more risk of perinatal death occurrences due to health inequalities (Thomson et al., 2021).

It is clear from this parsimonious overview of the issues that contribute to global adolescent pregnancy that there are variations across, and within, each ecological system for each individual female. The next section will therefore look at sociohistorical variables in the ROI to illustrate the centrality of environmental issues that contribute to the experiences of individual females.



### *1.4.1 Adolescent Pregnancy in the ROI: A Country Example*

Comparing adolescent pregnancy statistics from different countries is onerous due to the varying methodological approaches, or lack thereof, of the collection and/or publication of these occurrences (Sedgh et al., 2015). Therefore the ROI has been selected as a country example due to; (a) the researcher is situated within Ireland for this research; and (b) the reliability and availability of statistical information from the Irish government.

Within the ROI, the Central Statistics Office (CSO) is the government department responsible for the collection, collation, interpretation, and publication of statistics on births and deaths. Table 2 provides an extract detailing adolescent birth rates in 2018:

**Table 2**

*Births Registered to Mothers Under the Age of 20 in the ROI in 2018*

<b>Maternity Age</b>	<b>Total</b>
All ages	61,016
15 and under	22
16	57
17	138
18	246
19	517
Under 20	980

*Note.* Obtained from Vital Statistics Yearly Summary 2018, Central Statistics Office.

Table 2 reported that 980 adolescents under the age of 20 had live births, representing 1.6% of the total registered in the ROI in 2018. However, whilst the CSO statistics are compiled and published for live births to adolescent females in ROI, it should be noted the number of concealed pregnancies, miscarriages, and illegal abortions are unknown.

### **1.5 Adolescent Terminations**

In addition to the global adolescent birth rates reported by the WHO, as detailed in the previous section, the WHO estimates that over 5.6 million legal and illegal terminations occur with females aged between 15 and 19 annually (WHO, 2020). However, research suggests that younger adolescents are more likely to choose abortion than older females, and with an absence of reliable global estimates of abortions occurring with females under the age of 15, the overall number is impossible to ascertain due to country variations and lack of data (Hofferth, 1987; Hudson & Ineichen, 1991).

Various factors within, and across, the nested systems have significant impacts on societal, and individual, attitudes to abortion. These factors can include; politics, religiosity, sex education, parental views, and peer attitudes, amongst many others (e.g. Gomes, 2019/2021). Whilst abortion has been highly politicised during this century, prior to the mid to late nineteenth century, procuring an abortion did not have the social, political, or legal issues that occur today (Featherstone, 2008).

Variations occur across cultural environments on whether females are more or less likely to select abortion as a response to adolescent pregnancy. For example, research suggests that females who have unmarried adolescent mothers within their social environment are less likely to decide to terminate a pregnancy (Eisen, 1983). Conversely, adolescent females who choose to terminate pregnancies are more likely to use contraception, have high educational aspirations, and be of higher socioeconomic status (Chilman, 1980; Hayes, 1987). Abortion procedures comprise of two methods; (a) surgical, which involves an invasive procedure undertaken by a medical professional; or (b) medical, which involves taking medication, for example mifepristone (Moreau et al., 2011).

In order to provide a more specific country example, the next section will consider the sociohistorical variables that have contributed to the current climate within which Irish women are able to access legal abortion services.

### ***1.5.1 Terminations and the ROI: A Country Example***

This section presents an overview of the cultural context of pregnancy in the ROI, and the role of the Catholic Church and its influence, on societal conditions both historically and within contemporary narratives. Conlon (2006) declared: “Women’s response to and management of pregnancy in the Irish context takes place against a background whereby highly proscribed sexual morality – particularly through the control of women’s bodies and sexuality – has been central to cultural expressions of Irishness” (p. 24). She asserts that Irish motherhood, within the idyllic nuclear

family, was portrayed as representative of the integrity of the nation during the foundation of the Republic as an independent state in the 1920's, with images of women, particularly as mothers, adhering to appropriate socially determined sexual behaviour incorporated within symbolism throughout Irish society. This view is also shared by others (e.g. Gray & Ryan, 1997; Inglis, 2003).

Historically, the response by unmarried Irish females to a socially unacceptable pregnancy varied, with many resulting in concealed pregnancies followed by giving birth secretly (Conlon, 2006). The babies were then abandoned, killed, or allowed to die, with the mother being either alone, with an accomplice, or within a mother and baby home (Inglis, 2003). Guilbride (2004) examined evidence obtained from Irish court case transcripts that involved infanticide from the 1920's onwards and found that incidence of infanticide was far greater than was acknowledged within society. The socio-historic connection to concealed pregnancies can be traced back to influences evident in early Irish law which is reported to have granted husbands the right to divorce their wives on the grounds of infanticide or abortion (Kelly, 1992). The Irish online newspaper, [thejournal.ie](http://thejournal.ie), has reported; "Between 1850 and 1900 in Ireland, there were more than 4,500 suspected cases of infanticide of a child under the age of three by their mother." (Hennessy, 2015). The article was accompanied by a picture of Ann Maher, as seen in Figure 2 below, an unmarried 20 year old, who allegedly gave birth in 1898 and subsequently was convicted of manslaughter for the death of her baby son:

## Figure 2

*Photograph of Ann Maher*



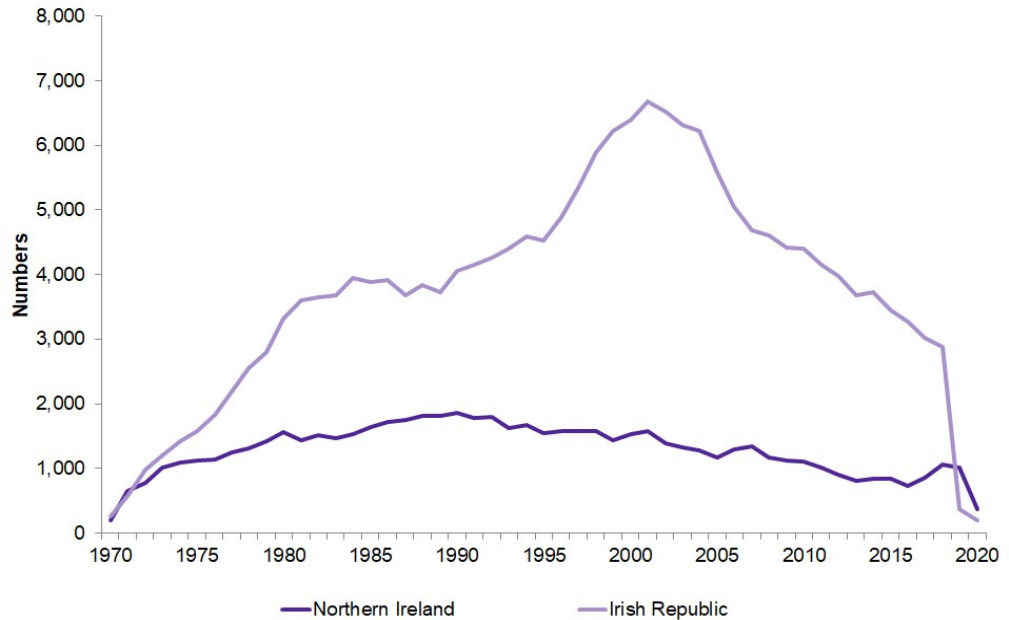
In 1906 the Magdalene homes established the first mother and baby institutions in Ireland to house unmarried pregnant females and unmarried mothers. Facilitated by nuns, the residents were required to perform physically demanding menial labour in return for their keep. Some residents resided in the homes throughout their lifespan (Dean et al, 1985). Depictions of the homes described them as cruel and harsh, with descriptors more attuned to prison environments; “The development of more calibrated services for those labelled ‘mentally defective’ was paralleled by the development of institutional services for different categories of unmarried mothers, and a number of Mother and Baby Homes were established for those known as ‘first offenders’ (i.e. women who had given birth outside of marriage for the first time)” (O’Sullivan & O’Donnell, 2007). The resident females were deemed to have contravened their socially expected roles as virtuous, or heads of nuclear households, so were firstly stripped of their social freedom, followed by a denial of their rights within these institutions. The female residents were often subjected to sexual abuse, physical abuse, and mental abuse, and many of the babies born to the unwed mothers resulted in death due to deliberate acts or deliberate neglect (e.g. BBC

News, 2021; Maloney, 2021; Michael Garrett, 2017). The cultural attitudes directed towards unmarried pregnant females, embedded historically throughout Irish society, has been described as integral to the Catholic Church's strategy to shame and control women who violated their moral rules (Inglis, 1987).

With the Catholic Church exerting significant influence on societal norms, and its' stance that life begins at conception, abortion was illegal within the ROI until the Regulation of Termination of Pregnancy Act 2018 (RTPA) (Noonan, 1967; Oireachtas, 2018). Prior to the RTPA, many Irish women travelled to other countries to procure medical services, with many obtaining legal terminations in Britain following the implementation of The Abortion Act in April 1968. Figure 3, obtained from the UK Department of Health and Social Care, illustrates the number of resident Irish women from the ROI and Northern Ireland procuring abortions in Britain from 1970 to 2020:

**Figure 3**

*Number of Abortions Obtained in Britain by Irish Residents from 1970 to 2020*



*Note.* Obtained from the Department of Health and Social Care 2020 report available online.

The provision, and procurement, of abortions was legalised in the ROI in December, 2018 following a national referendum. As can be seen pictorially in Figure 3, the UK Department of Health and Social Care reported that in 2019, 375 women resident in the ROI travelled to Britain to obtain a termination, representing a decrease of 87% compared to 2018 (Department of Health and Social Care, 2019).

However, for Irish females unable to travel to another country for medical services prior to legalisation, Delay (2018) details how Irish

women consumed; “pills, potions, and purgatives to cause abortion.” (p. 479), with failure resulting in instances of infanticide. Two high profile cases were highlighted in 1984; the first case was that of Ann Lovett who, following a concealed pregnancy, gave birth at a grotto in the grounds of a Catholic church; both mother and baby died (Luddy, 2011). The second case was that of a baby whose body was found on a beach in County Kerry, having died of multiple stab wounds (Maguire, 2001). Both cases illustrate the sociohistorical and environmental influencers on individual behaviour, and further support the rationale for utilising a bio-psycho-social design for this study.

This section has presented the global statistics, and contributory variables, to the procurement of adolescent abortions. The next section will consider the available statistics, and variables, pertinent to adolescent miscarriage experiences.

## **1.6 Adolescent Miscarriage**

The definition for “miscarriage” varies across, and within, countries and the implications for this study are detailed in chapter three. A further confounding variable that contributes to the unreliability of miscarriage statistics is that many occur without the attention of medical services. The WHO states that approximately one in four pregnancies end in miscarriage before 28 weeks’ gestation, but does not explicitly state how the estimate is calculated (Simelela, 2021). Furthering the debate on the speculative nature of ascertaining reliable adolescent miscarriage statistics, Conlon (2006)



found that almost half of the females presenting late in their pregnancies to maternity hospitals in Ireland were 19 years old or under.

Having highlighted the complexity of variables that contribute to the difficulty in estimating the occurrence of miscarriage during adolescence, and the potential difficulty thereof of recruiting participants willing to; (a) acknowledge their pregnancy and miscarriage experience during adolescence; and (b) talk openly about their pregnancy and miscarriage experience during adolescence, the next section will present information on adolescent stillbirth and adolescent neonatal death.

### **1.7 Adolescent Stillbirth and Adolescent Neonatal Death**

The WHO defines stillbirth as; “A baby who dies after 28 weeks of pregnancy, but before or during birth” (WHO, 2021). However, chapter three will present evidence that the definitions for “miscarriage” are varied and therefore influence the definitions for “stillbirth”. The WHO stated that in 2015 there were 2.6 million stillbirths globally but do not provide information on the mother’s age (WHO, 2021). Further, despite the global stillbirth study groups, and myriad publications, the researcher was unable to obtain global estimates of adolescent stillbirth rates despite suggestions that females under the age of 15 are at greater risk of these events (e.g. Althabe et al., 2015; de Bernis et al., 2016). Therefore, in the absence of global adolescent stillbirth statistics, the researcher consulted the CSO to gain an understanding of the incidence of stillbirth in the ROI as a country example (Central Statistics Office, 2019; WHO, 2021; Wilson et al., 2008).

In 2018 there were 133 stillbirths registered in ROI (a decrease from 162 registered stillbirths in 2017), with two of the registered stillbirths delivered by females under the age of 20. Table 3 details the age of the mothers who experienced stillbirths in the ROI in 2018:

**Table 3**

*Stillbirths Registered in the ROI in 2018*

**Stillbirths in 2018, classified by age of mother, sex of child and period of gestation**

Age of mother	Sex of child	Period of gestation (weeks)					
		Total	Under 28	28-31	32-35	36-39	40 and over
<b>Total</b>	<b>Males</b>	<b>66</b>	<b>15</b>	<b>14</b>	<b>16</b>	<b>14</b>	<b>7</b>
	<b>Females</b>	<b>67</b>	<b>17</b>	<b>13</b>	<b>16</b>	<b>14</b>	<b>7</b>
Under 20	Males	2	–	2	–	–	–
	Females	–	–	–	–	–	–
20-24	Males	2	–	–	2	–	–
	Females	3	1	–	1	1	–
25-29	Males	8	4	–	2	1	1
	Females	10	4	1	3	2	–
30-34	Males	22	4	3	7	6	2
	Females	20	3	6	3	4	4
35-39	Males	22	2	8	3	6	3
	Females	25	8	4	7	3	3
40 and over	Males	10	5	1	2	1	1
	Females	9	1	2	2	4	–

*Note.* (CSO, 2021).

Investigations by the researcher revealed that the CSO do not obtain exact ages of the females that give birth, so it is impossible to state whether

the two females in the ROI that experienced a stillbirth in 2018 meet the inclusion criteria for this study.

In common with a lack of adolescent stillbirth statistics, the researcher was unable to obtain global statistics on neonatal mortality rates for adolescent mothers. WHO reported 2.4 million deaths globally in 2019 of neonates aged up to 28 days post birth, stating children are at more risk of dying during this time period (WHO, 2020). Therefore, in the absence of global statistics, the researcher consulted the CSO to gain an understanding of the incidence of neonatal deaths in the ROI. Neonatal is defined by the CSO in the Infant Mortality, Stillbirths and Maternal Mortality 2018 report as infant deaths that occur on the first day of birth and within the first four weeks inclusive (Central Statistics Office, 2019). In 2018 there were 139 neonatal deaths of babies aged under 4 weeks' old in the ROI. However, the CSO published statistics do not include the age of the mothers.

This section has provided an overview of global and Irish adolescent pregnancy, abortion, miscarriage, stillbirth, and neonatal death statistics, and contributing factors, available at the time of writing.

The final section of this chapter provides an overview of the ensuing six chapters for this thesis.

## **1.8 Outline of Thesis Chapters**

Chapter one will now conclude with an overview of the current thesis which contains a total of seven chapters that constitute the body of this research.

Chapter two provides a parsimonious overview of classical child developmental theories to situate the adolescent female within the salient lifespan phase. The chapter also details the evolution of general grief and bereavement theories from a Euro-Western perspective, detailing relevant biological, psychological, and sociological views . An overview of the body of knowledge specifically addressing adolescent grief and perinatal bereavement are also presented. The chapter concludes with an elucidation of the schema for this thesis using Bronfenbrenner's (1986) bioecological nested systems as a conceptual framework. The Multidimensional Theory of Bereavement (MTB) provides a bio-psycho-social structure for examining the lived experiences of adolescent gestational death experiences.

Chapter three provides the detailed results of the literature review (LR) and critically assesses the findings. The LR identified 20 English language publications that were congruent with the inclusion criteria for the research question: "is there a bereavement impact on females across the life course following adolescent perinatal deaths?". The MTB is then positioned to present a thematic interpretation of the sparse publications detailed in the LR and highlights the areas previously unexplored within the subject area.

Chapter four details the research design and presents the methodological approach undertaken for the current study. A qualitative design was adopted by the researcher to meet the research objective; to explore the transnational experiences of adolescent perinatal deaths from an adult retrospective perspective. The detailed reasons for the conceptual framework, the methodological approach for the two studies; (a) a questionnaire (phase one); and (b) semi-structured interviews (phase two), points of convergence between the two phases, and data analyses modality are also set out in the chapter.

Chapter five presents a descriptive summary and detailed analyses of the questionnaire data obtained from the fieldwork within phase one of this study. The chapter details construction of, and implementation of, the Adult Self-Perception of Retrospective Perinatal Death in Adolescence Questionnaire (AAA) developed from the framework of the MTB (n = 23). The chapter also details the integration of the Perinatal Grief Intensity Scale (PGIS) within the questionnaire to measure the intensity of grief experienced immediately following a perinatal death and at a future date. The chapter also presents analyses of the PGIS respondent scores.

Chapter five also presents phase two of this study with the thematic analysis (TA) of the retrospective semi-structured interviews obtained from the fieldwork of Phase two (n = 6). Phase two is presented in two sections; section one details a case study example of an Irish woman's experiences of obtaining an abortion during adolescence. The second section presents the cross-case analysis procedures and analyses, utilising TA, for all six

retrospective semi-structured interviews. The chapter concludes with a presentation of the Bio-psycho-social Model of Female Experiences of Adolescent Gestational Death (BELATED).

Chapter six provides a comprehensive summary of the key findings from the phase one and phase two converged findings from a bio-psycho-social perspective.

Chapter seven presents the summarised findings of the thesis, positions this research in the context of the previous literature, summarises the strengths and limitations of this body of research, and presents opportunities for potential future research. Recommendations for policy makers, educators, and professionals are also presented directly from the fieldwork.

## Chapter Two: Theory and Evidence

*“The word puberty comes from the Latin verb pubescere, which means “to grow hairy or mossy”*

*(Nielsen, 1996, p. 27)*

### 2.0 Chapter Two Overview

Chapter one detailed the programme of research undertaken for this study by presenting; (a) the underpinning rationale for this study; (b) the positionality of the researcher “a priori”; (c) the definitions of the key concepts pertinent to work in this area; and (d) the chapter summaries for this thesis. This chapter presents a critical overview of selected relevant theoretical perspectives, in order to introduce knowledge and understanding of the bio-psycho-social experiences of females who became pregnant during adolescence, and subsequently experienced a perinatal death, from a retrospective perspective.

The current chapter further develops the contextual framework of this study by providing selected theoretical perspectives pertaining to adolescent development and selected theories of grief and bereavement. The classical theoretical perspectives were selected from a multitude of developmental theories as illustrative variables to situate the adolescent female within the appropriate lifespan phase and to conceptualise the structural components within the bio-psycho-social perspective that the historical adolescent perinatal death experiences occurred (e.g., Ainsworth, 1978; Bandura, 2001; Benedict, 1938; Bowlby, 1969; Bronfenbrenner,

1977; Darwin, 1872; Erikson, 1950; Freud, 1953; Hall, 1904; Mead, 1938; Piaget, 1932; Tajfel, 1979). This chapter is not intended to critique or favour any particular singular theory but to present evidence of multiple theoretical approaches as they have historically evolved, and may converge, to represent the complexity of variables that contribute to the biological, psychological, and sociological interactions that influence human development.

The current chapter also develops the contextual framework of this study by providing a theoretical perspective grounded in Bronfenbrenner's (1986) bioecological model as it pertains to selected theories of grief and bereavement, within a contemporary Euro-Western context.

The current chapter is presented in four individual but associated sections. The first main section of this chapter situates adolescent development within a lifespan context. Early childhood experiences are recognised across many disciplines as impactful, for example, O'Donovan et al., (2019) state: "Current thinking in health recognises the influence of early life experiences (health or otherwise) on later life outcomes." (p. 1).

The second main section of this chapter provides a parsimonious overview of selected theoretical perspectives of adolescent development as situated within the wider lifespan developmental context. The perspectives presented within this section have been selected by the researcher due to their alignment with the bio-psycho-social research question for this thesis. The seven theoretical perspectives detailed in this section present an overview of biological, psychological, and psychosocial foundations



pertaining to adolescent development and comprise of: (a) the biological perspective; (b) the psychoanalytic perspective; (c) the cognitive perspective; (d) the psychosocial perspective; (e) the social learning theory perspective; (f) the social identity theory perspective; and (g) the Ecological Systems Theory (EST) perspective.

The third main section of this chapter presents a summary of grief and bereavement theories, from a Euro-Western perspective, within a bio-psycho-social framework. This section comprises of the following; (a) summaries of generalisable grief theories from a bio-psycho-social perspective; (b) bereavement outcomes; (c) adolescent grief theories; and (d) perinatal grief research findings (e.g., Averill, 1968; Bowlby, 1969; Corr, 2019; Davies, 2017; Engel, 1961; Holloway, 2007; Lindemann, 1944; Parkes, 1972; Rando, 1984; Stroebe & Schut, 1999).

The fourth main section of this chapter presents the development of the Multidimensional Theory of Bereavement (MTB) as a framework to investigate the research question.

This chapter focuses on presenting the key theories of adolescent development, and grief and bereavement theories, to provide a canvas upon which the data collected for this study might relate to the theoretical perspectives in order to gain an understanding of adolescent experiences of perinatal death. This chapter does not seek to provide a framework for how these theories should be used, nor does it suggest they are comprehensive.

## 2.1 Adolescence Within Lifespan Development

The current section provides an outline of the context within which adolescent developmental theories will be considered. Adolescent development is situated within the broader perspective of lifespan development, which has been described as; “the way our psychological characteristics change and develop throughout life, from conception to old age.” (Cooper & Roth, 2007, p. 3). Within a lifespan developmental context, adolescent maturation is the process of transition from childhood to adulthood and is considered a significant period within human development (Berger, 2014; Boyd & Bee, 2008; Galván, 2017). The transition is signified biologically by the secretion of hormones triggered by the pituitary gland which stimulate the growth of testes in boys and ovaries in girls (Boyd & Bee, 2008). All humans produce body chemicals, known as hormones, which regulate biological functions (Norman & Litwack, 1997). The function of hormones is to; “...act as chemical messengers to body organs, stimulating certain life processes and retarding others. Growth, reproduction, control of metabolic processes, sexual attributes, and even mental conditions and personality traits are dependent on hormones.” (‘Hormone’, 2017).

Following the production of hormones that stimulate reproductive development, adolescent girls ordinarily experience their first menstruation which is known as “menarche” (Canelón & Boland, 2020). The advent of menarche is correlated with body fat percentage; girls with higher body fat experience earlier onset of menses (Frisch, 1987; Kaplowitz, 2008). The current average global age for the onset of menarche is 12 years old,

however the average age is declining which has been attributed to various factors including air quality (due to climate change), and food availability, which impact on female health (Canelón & Boland, 2020). Whilst within this context puberty may be perceived as a biological transition only, there are also psychological and psychosocial demands of pubescence that are integral to the transformative process (Kastenbaum, 1986). Contemporary perspectives of biological maturation have increasingly evolved from neuroscientists, who estimate that adolescence may begin as early as nine years old and brain maturation may complete in the mid 20's (Galván, 2017; Johnson et al., 2009; Silvers, 2019). It is asserted that the prefrontal cortex of the brain, which is the area used in complex decision-making, is not fully mature until humans reach approximately 25 years old, therefore expanding the definition of adolescence beyond “teen” years (American College of Pediatricians, 2016). However, for this study, the inclusion criteria excluded females that were not attending secondary school.

Historically within richer nations, and currently within less developed countries, the adolescent developmental stage involved a short unitary phase between childhood and the conferring of adult status (Weisfield, 1997). However, in contemporary industrialised nations most young people are dependent on their parents for a much longer time period in order to complete many years of education in preparation for participation in economic life (Arnett, 1998). Therefore, the period of adolescent development within Euro-Western environments may span ten years, or more, before the assumption of adult roles and responsibilities (Hamburg, 1985).

The adolescent developmental phase may be understood as encompassing three fluid, and interlinking, stages (Berger, 2014; Boyd & Bee, 2008; Petersen & Hamburg, 1986). Within each adolescent developmental theory the maturational phases vary (selected theories are presented in more detail in section 2.2 of this chapter), however, a summary may be considered within the following three definitions:

- (a) Early adolescence. This phase may begin as early as 9/10 years old and may end at, or around, 15 years of age. This is generally considered a period of rapid bio-psycho-social change that encompasses the beginning phase of puberty; the start of separation from parents as the individual begins establishing an independent identity (Hamburg, 1985);
- (b) Middle adolescence. This phase may begin at, or around, 15 years of age and end at, or around, 17 years of age. At this stage biological pubertal changes may largely be completed and the individual may be developing romantic relationships (Berger, 2014); and
- (c) Late adolescence. This phase may begin at, or around, 18 years of age and end at, or around, early to mid-20's. This phase is when the individual is conferred full adult responsibilities and has completed all of the physical pubertal changes (Silvers, 2019).

This section has introduced the concept of adolescent development from a bio-psycho-social perspective within the context of lifespan development. The biological aspects of adolescent development incorporate changes that encompass puberty, the psychological factors involve adjusting to adult responsibilities, and the social aspects of adolescence involve the conference of cultural determinants of adulthood. The following section will explore the relevant developmental theories of

adolescence encompassing the biological, psychological, and social perspectives in more depth.

## **2.2 Adolescent Developmental Theories**

Whilst there are a multitude of theories of development both within different life stages, and across the lifespan, the following adolescent theories have been selected due to their relevance for this study and collectively offer a framework within which to develop a basic understanding of this life stage. A summary of the theories explored can be viewed in Appendix 2.

### ***2.2.1 Biological Theories***

Biological theories provide explanations of how children develop into adults as a result of human biological species adaption and individual physical maturation (Gottesman & Hanson, 2005). Adolescent biological development is triggered by puberty, the process that begins with the secretion of hormones by the pituitary gland to commence all of the changes, both seen and unseen, that are required for reproductive maturity (Boyd & Bee, 2008). The biological perspective underscores the universal determinants of adolescent development that are not affected by other factors, such as social context (Steinberg & Morris, 2001).

The biological study of human lifespan development emerged during the late nineteenth century with Charles Darwin as an early scholar (Sloan, 2019). As a biologist, Darwin suggested that developmental behaviours are successful biological evolutionary adaptations (Lerner &

Steinberg, 2013). Heavily influenced by Darwin, G. Stanley Hall's (1904) seminal book concentrated entirely on adolescent development as a distinct and separate developmental phase (Arnett, 2006). Hall was the first scholar to extensively examine the biological changes that occur during puberty, describing adolescence as a period of "storm" and "stress".

Whilst Hall, and early researchers, focussed on the observable changes that were stimulated by hormonal changes, over a century later the advances of scientific innovations in genetics, and neuroscience, have provided new lenses to view biological development (Venter et al., 2001; Panksepp, 2004). Contemporary neuroscience scholars are contributing to the literature on adolescent development through studies of brain activity, with some suggesting that adolescence is a particularly vulnerable developmental stage for the onset of psychiatric disorders (e.g. Galván, 2017; Silvers et al., 2017). However, the interconnectedness of biological development within the environmental context are widely acknowledged within neuroscience. For example, McCrory (2021) attributes a multitude of psychosocial factors, within an ecological framework, to explain how these contribute to neurological development.

### ***2.2.2 Psychological Theories***

The following sections will detail the psychoanalytic, psychosocial, cognitive, and social learning theory perspectives of child and adolescent development.

### 2.2.2.1 Psychoanalytic Perspectives

Freud's (1953) psychoanalytic perspective placed importance on events during childhood that affect understanding of human development throughout the lifespan. He introduced three theories; (a) Theory of the Mind: that the unconscious mind influences conscious thought and that most of our mental processes are outside of our awareness; (b) Theory of the Self: that the id is the self that is born, the instinctual driver of the pleasure principle i.e. sexual gratification (particularly relevant for adolescent development), the ego which learns what is acceptable to do and how to wait for our needs to be met when necessary, and the superego which develops and adapts to socially accepted norms; and (c) The Psychosexual Stages: the oral, anal, and phallic stages attributed to infant development that can contribute to adult manifestations of mental illness if not passed through "successfully", and the genital stage where the adolescent, and young adult, is preoccupied with sex and reproduction.

Freud's daughter, Anna, advanced the psychoanalytic construct of adolescent development. She stated that the psychological impact following adolescent changes, triggered by biological determinants, include "unruly sexual and aggressive energies" (Crane, 2010, p. 252). She proffered that the adolescent is expected to depend on the ego to think logically to moderate these "unruly" and "aggressive" (id) energies and deploy defence mechanisms to help prevent unpleasant emotions such as anxiety in response to the pubertal changes (Freud, 1936). With regards to psychosocial development, Freud believed that pubertal energies should be moderated by society, with the superego moderating individual behaviour

according to the prevailing moral code. However, conflicts between the id (instinct/biology), ego (reality/psychological), and superego (morality/sociological) should be expected during adolescent adjustment between childhood and adulthood (Freud, 1953). Anna Freud also contributed to adolescent developmental theory with the concept of “individuation”, explained as the thoughts, feelings, decisions, identities etc. as independent from parents (Nielsen, 1996).

Several criticisms have been levelled at the psychoanalytic perspective which include the following; (a) the theories are unfalsifiable; (b) the theories are based on case studies which are subjective; (c) that the theories simplify cognitive processes; and (d) that free will isn't considered, thereby rendering the theories too deterministic (Nielsen, 1996; Wright, 1998). Some of these criticisms have been addressed in successive evolutions of developmental theories, for example by Erikson (1950), who incorporated social factors and added additional developmental stages.

Having reviewed the foundation of psychoanalytical theory, and its contribution to understanding adolescent development, the next section will explore the seminal work of Bowlby (1969), which directly relates to the attachment that infants form with their caregivers and how that impacts on relationships across the lifespan. The ways in which an individual responds to a death will be partly dependent on the relationship and attachment that was established prior to the death and this includes any attachments that may have been formed during the gestational period.



### **2.2.2.2 Attachment Theory**

The previous section presented a brief overview of the psychoanalytic perspective on human development, and, as detailed, Freud (2005) believed that the ego deploys defence mechanisms which at an unconscious level help defend against unpleasant emotions such as anxiety to make us feel better. Therefore Freud would consider infant expressions of distress as undeveloped defence mechanisms. However, Bowlby (1969) departed from this view, he theorised that specific infant behaviour, such as yearning for the mother, were evolutionary and instinctual rather than ego driven. He believed that infants need to stay close to the mother to ensure their survival to reproductive age, and he hypothesised that this relationship was the template for all future relationships, this is known as the internal working model. He theorised that there are four phases of attachment throughout childhood development that comprise of; (a) from birth to three months where infants attach to proximally close adults indiscriminately; (b) from three to six months where infants focus on familiar proximal adults; (c) from six months to 2 years (later extended to five years) where intense attachment and proximity seeking are heightened; and (d) from three years old to the end of childhood where attachments expand to partnership behaviour. Bowlby's studies on attachment contribute to understandings of child and adolescent development as his findings: "supported the concept that emotional deprivation and frequent separations were a major contribution to delinquency and psychiatric disorders." (O'Brien, 2015).

As presented in the previous section, the psychoanalytic perspective recognised adolescents seek to establish an individual identity, distinct from

their parents, during this developmental phase (Nielsen, 1996). Attachment theory recognises the increase in independent behaviour during adolescence but adds that earlier attachments to the primary caretakers are still predominant as adolescents' seek proximity to them during adverse events (Bowlby, 1969; Crain, 2010). Therefore, the concept of attachment may be used to describe relationships that are ongoing and involve emotional bonds that are enduring and meaningful (Schaffer, 1996).

Concurrently, Ainsworth and Bell (1970) published their experimental findings, known as the "strange situation". They conducted experiments that observed children's behaviour following separation from the mother, visitation by a stranger, and then the child reuniting with the mother. Ainsworth (1978) published the findings from her experiments, identifying three types of attachment styles:

- (a) Insecure -Avoidant Infants. This attachment style develops when a child has parents who are neglecting their needs, therefore forcing them to become independent. During the strange situation the avoidant children simply ignored the mother;
- (b) Insecure -Anxious/Ambivalent Infants. This attachment style develops when a child has parents who are unreliable to their needs so they become "clingy". During the strange situation the anxious ambivalent children would be preoccupied with the mother; and
- (c) Securely attached Infants. Children of mothers who appeared responsive to their needs exhibited secure attachment styles; neither ignoring nor being preoccupied with the mother.

Attachment theory, and associated attachment styles, provide a framework to understand how children learn from the models of behaviour exhibited to them within their immediate social environment (Ainsworth, 1978; Bowlby, 1979). Further studies in adult attachment behaviour suggest that attachment styles within romantic relationships were related to childhood experiences and confirmed that attachment styles continue throughout the lifespan (Hazan and Shaver, 1987). Moreover, an additional attachment style was later identified by Main and Hess (1990) which they named “disorganised”. A disorganised attachment style is considered the response to traumatic experiences during childhood, which manifest in the development of anxiety and fear based coping mechanisms, for example controlling behaviour (Green & Goldwyn, 2002).

Of particular relevance for the current research, attachment styles may be an important indicator of potential grief responses to a perinatal death. It could be hypothesised that females with an avoidant attachment style may not develop an attachment to the pregnancy and therefore not experience grief following the death. Adolescents with an ambivalent attachment style may develop a strong attachment to the pregnancy and experience an overwhelming or prolonged grief response, and females with a secure attachment style may experience an attachment to the pregnancy resulting in a grief response that adjusts normally over time (Scheidt et al., 2012). Additionally, individual attachment styles can contribute to positive or negative responses to events: “...securely attached individuals integrate cognitive and affective resources to enable adaptive and flexible responses

to emotions, whilst insecurely attached individuals employ maladaptive strategies” (Goodall, 2014; p. 209).

Having provided an overview of attachment theory, and the contribution this makes to understanding adolescent development, the next section will provide a summary of cognitive stage theories and how development is influenced by events within the environment.

### **2.2.2.3 Cognitive Stage Theories**

Piaget’s (1932) theory of cognitive development introduced the concept of how children make sense of their surrounding environment. Piaget determined a staged theory that utilises a biological linear progression to explain how, as a child matures, their ability to solve problems, to reason, to accommodate new knowledge, and to interact with other people develops accordingly. Piaget’s developmental stages comprise of;

1. The sensorimotor stage - from birth to 2 years old. Within this first stage, infants acquire knowledge through manipulating objects and through sensory experiences. They learn that their actions can cause reactions within their environment.
2. The preoperational stage - from ages 2 to 7 years old. Within this second stage, children develop language skills and become more adept at interacting with other people within their environment.
3. The concrete operational stage - from 7 to 11 years old. Within this third stage, children develop cognitive understanding of how other people may view a situation.

4. The formal operational stage - from age 12 and onwards. Within this fourth stage, adolescents develop the capacity to expand their moral, philosophical, ethical, social, and political understandings, and their ability to reason matures.

Whilst this study is focused on events during the formal operational stage, events prior to, and post the fourth stage, may contribute to understanding the individual experience of each female who experienced an adolescent perinatal death.

Piaget recognised children progress through the stages at different times, at different rates, so he therefore attached minimal importance to the ages associated with them. He did, however, maintain that all children will progress through the stages in the same order; starting from earlier stages where infants develop from the acquisition of learning skills, through to a competent understanding of, and interaction with, the social environment, the ability to think logically and solve adult problems (Piaget, 2003).

As Piaget's (1932) theory of cognitive development identifies a universal stage process of cognitive development over time, the model has been identified as an appropriate framework for examining how children and adolescents understand experiences, particularly death and bereavement, irrespective of the environment in which they grow up in (Corr & Corr, 2004). Piaget's fourth stage (formal operational stage) encompasses adolescence and involves the evolution of scientific reasoning, abstract thought, and the ability to solve complex problems from early adolescence through to adulthood. Therefore, cognitive functioning, or lack

thereof, prior to the adolescent pregnancy, and the immediate reactions to the perinatal death, may be broadly attributed to the maturational achievement of each individual at the time of the event (Piaget,1932). For example, as detailed in Section 2.1, puberty can be initiated in children as young as 9 years old and typically children entering the formal operations stage would be establishing the ability to think beyond the capability of the previous concrete operational stage. Therefore, young adolescents may become pregnant due to an inability to fully comprehend the risks, and consequences, associated with sexual activity.

Additionally, research undertaken by Alberts, Elkind and Ginsberg (2007) determined an “invincibility fable” which occurs when adolescents believe that they will not be affected by something that would ordinarily affect an average person negatively. Correspondingly, a pregnancy may not signify personhood, and subsequent parenthood, to a young adolescent, resulting in little or no grief response to the perinatal death immediately following the event. Conversely, late adolescents have achieved, or are nearing completion of Piaget’s fourth stage of cognitive development and have an increased ability to think abstractly and employ deductive reasoning. Therefore we would expect a late adolescent to fully understand the risks of pregnancy resulting from sexual behaviour, the maturational potential to ascribe personhood to the developing pregnancy, and the potential for a parental bereavement response to a perinatal death. Additionally, within the middle adolescence phase, pregnancy occurrence, and potential grief responses to a perinatal death, would be correlated with the maturational attainment of the individual at that time.

#### **2.2.2.4 Psychosocial Theories.**

The previous section summarised Piaget's (1932) four stages of childhood development, which focussed on the cognitive development of the child and adolescent. Erikson (1950) expanded the staged developmental approach to incorporate the whole lifespan determining a prescribed order through eight stages of psychosocial development from childhood through to end of life. In *Childhood and Society* he summarises that the stages, and their sequence, are predetermined but that the growing person's readiness to interact with society is driven by their personality. Erikson lists the "Eight Ages of Man" as life-course stages which require "successful completion" of each "conflict". Erikson's fifth stage is of particular relevance to the research question for this study. In common with the psychoanalytic perspective, and cognitive stage theoretical perspective, establishing a sense of independence and identity during adolescence is the central psychosocial "conflict" during this phase. As children become more independent and start developing their identity in preparation for impending adulthood, adolescence is a critical bridge between the two. The positive resolution of Erikson's fifth stage is determined by identity achievement and the adoption of prevailing cultural values. Some adolescents adopt the values expected by their parents and some young people develop identities common to their peer group that differ from parental expectations (Erikson, 1950).

Erikson explicitly acknowledged the interaction between the developing psychological needs of the person and the social needs of their environment, with completion of each stage of development involving

resolution of *individual* psychosocial crises. For this thesis, Erikson's stage five, "identity v role confusion" is relevant for the perinatal death experiences, but the previous four stages, and their positive or negative crises response, contribute as building blocks to this developmental stage and the events under investigation. The three further adult stages are also relevant, as the focus of this study has been on adult perceptions of retrospective experiences and the impact on the lifespan to date.

One criticism of Erikson's psychosocial staged theory is that it is descriptive, not explanative, to which he acknowledged and responded: "the list represents a total conception within which there is much room for a discussion of terminology and methodology." (Erikson, 1977, p. 247). Marcia (1966) attempted to address this criticism by describing four identity statuses during adolescence; identity confusion, foreclosure, moratorium, and identity achievement.

Marcia's first identity status is described as identity confusion/diffusion and occurs when children enter the identity formation stage, at early adolescence, where they are exposed to experiences, and people, who present them with identity possibilities. Secondly, identity foreclosure is the term used to describe adolescents who have formed an identity without exploring their options. Some adolescents are heavily influenced by specific social dictates, including parental pressure, and may continue through adulthood with foreclosed identity. Conversely, some individuals may explore their options during later adolescence or adulthood. Thirdly, identity moratorium is the descriptor for adolescents



exploring potential identity roles, and differing beliefs, and is considered the precursor to identity achievement. The fourth identity status is identity achievement which describes the identity state where an individual explored varying options and has made an identity commitment.

Similarly to Piaget's (1932) universality perspective of development over time, Erikson's (1950) model has also been identified as an appropriate framework for examining how children and adolescents respond to death, particularly during a stage characterised by role confusion and identity creation (Oltjenbruns, 2001). Erikson's fifth stage incorporates a psychosocial perspective that encompasses adolescent cognitive development and the formulation of individual identity as a response to social experiences. Wheeler & Sefton (2015) stated that pregnancy during adolescence is often unplanned and therefore presents a situational and developmental crisis as they consider their social identity within their peer group (Black et al., 2015). We may hypothesise that adolescent females feel separated from the non-pregnant cohort, and may feel vulnerable, at a time when they are separating from parental influence and prioritising peer relationships. Additionally, pregnancy creates dependency, and whilst the adolescent is seeking independence, we may hypothesise that this creates a psychosocial crisis within an environment where they may feel disconnected from their support system. Further, the event of a perinatal death following the pregnancy crisis may exacerbate the psychosocial crisis and lead to a negative response and failure to complete this stage, or identity achievement adequately (Erikson, 1950; Marcia, 1966).

Furthermore, as highlighted in chapter one, the prevailing cultural norm in ROI is of the female as the adult head of a nuclear, married family and pregnancy during adolescence rejects this cultural norm, thus posing a potential challenge to successful identity achievement as perceived by society. However, Côtè (2006) suggests that most adolescents do not complete identity achievement until early adulthood thus further underlining the need for this study to examine events across the lifespan.

Whilst Freud (1936), Piaget (1932), Erikson (1950), Bowlby (1969), Ainsworth (1978), and many other scholars, have contributed significantly to our understanding of adolescent development, from various psychological perspectives, the next section will consider the social context and its influence on the individual.

### ***2.2.3 Social Psychological Theories***

As the third frame of reference for the bio-psycho-social perspective of this study, this section will present a brief summary of two examples of relevant social psychological theories that contribute to our understanding of adolescent development. Social psychology seeks to understand how the social environment influences individuals, and the transactional interactions, within in it. The behaviours of people within the surrounding environment, particularly the immediate family during early human development, as highlighted earlier in this chapter, can significantly impact on the developing individual (Berger, 2014; Nielsen, 1996).

### 2.2.3.1 Social Learning Theories

Social Learning Theories (SLT) provide an understanding of how social influences within the environment contribute to childhood development.

Anthropologist Ruth Benedict (1938) stated: “Although it is a fact of nature that the child becomes a man, the way in which this transition is effected varies from one society to another, and no one of these particular cultural bridges should be regarded as the “natural” path to maturity.” (p. 161).

Benedict, and colleague Margaret Mead, adopted a theoretical framework that suggested the way children are socialised significantly influences the way they think and behave (Benedict, 1938; Mead, 1974).

The biological and psychological perspectives presented earlier in this chapter focus centrally on individual development and then consider the environmental factors as additional elements to consider; from the “inside” out (Berzoff et al., 2021). In contrast, social theorists situate the influences of social factors on the developing individual; from the “outside” in (Nielsen, 1996). One example of social influence is that of socioeconomic status, which can significantly impact on family structures and behaviours, and can be a contributing factor to variables such as school attendance rates, adolescent pregnancy rates, and law abidance (Havighurst, 1973; Hollingshead, 1949; Layte et al., 2015; Smyth & Banks, 2012). Social theorists argue that “...much of what historically had been blamed on “being an adolescent” or “raging hormones” was related to environmental factors such as poverty.” (Nielsen, 1996, p. 9).

Albert Bandura suggested the social environment that children develop within can heavily influence their beliefs and thought processes and posited that by the time young people reach adolescence they have constructed their own unique perspective on what they have learnt through social interactions and observations (Bandura, 1977; 1989). One illustrative example of this process can be gleaned from Margaret Mead (2003) who explained how Eskimo boys are actively encouraged to hunt and taught how to build houses in the snow, whilst girls are not. However, she observed that girls acquired the same skills as the boys through observing the boys conducting these activities. Moreover, the differentiation of socialisation based on perceived gender roles can influence what is considered appropriate behaviour within different cultural environments (Taylor, 2020).

A succinct summary of a social learning positionality is encapsulated within the following quote; “[its] doubtful that children learn much on their own, out of an intrinsic interest in moderately novel events...If we want children to learn, we must motivate and assist them...After a while...children do become self-motivated learners....they learn to meet their internal achievement standards.” (Bandura, 1986, pgs. 340, 480-488).

### **2.2.3.2 Social Identity Theory**

Social Identity Theory (SIT) provides an understanding of how an individual determines their identity within a group setting. Tajfel (1979) proposed that social groups, for example, the social class which people

identify with are an important source of identity. Further, he stated; “social categorizations of various kinds may have profound effects on some interpersonal responses.” (p. 188), which is particularly relevant as social cohorts are divided into “us” and “them” through a process of categorisation. When social groups are divided, prejudice results from an awareness that there is a perceived lesser “out-group” (i.e. the other group), and positive self-esteem is derived from feeling a belonging to the perceived desirable “in-group” (Turner et al., 1979). Dovetailing into social learning theory, social identity theory highlights the importance of considering external variables, and group dynamics, in conjunction with the biological and psychological theories that contribute to understanding adolescent development.

This section has considered selected theoretical perspectives of child and adolescent development from a bio-psycho-social framework. The parsimonious overview of *biological* processes presented a brief summary of the role of hormonal and brain developmental changes within adolescence. A selected presentation of relevant *psychological* theories contribute to understanding; (a) the psychoanalytic view of individualism, unconscious and conscious thought, and psychosexual development; (b) the attachment theory perspective of evolutionary patterns of behaviour and attachment styles; (c) the cognitive stage theoretical perspective that views childhood development through four stages through to adolescence; and (d) the psychosocial perspective viewed as eight developmental stages known as the “eight ages of man”. The final *social* perspective provided two selected psycho-social theories to contribute to a broader understanding of

the role of societal factors on childhood maturation; (a) the SLT perspective which views the environmental factors as significant contributors to the developing human; and (b) the SIT perspective that highlights the role of identity creation within social settings and its importance for individuation.

This section has highlighted the importance of classical theoretical perspectives related to child and adolescent development and the potential impacts of events during this time. As is evident from this selective, and concise, overview of the various perspectives, the developing human is concurrently biologically developing, cognitively developing, and socially developing. Therefore the following section will present Bronfenbrenner's Ecological Systems Theory (1986) which provides a framework within which to consider the bio-psycho-social variables collectively, within the context of adolescent development.

#### ***2.2.4 Ecological Systems Theory***

In 1977, Urie Bronfenbrenner criticised the lack of ecological context within prior research on human development by stating: "A broader approach to research in human development is proposed that focuses on the progressive accommodation, throughout the life span, between the growing human organism and the changing environments in which it actually lives and grows." (p. 513).

An ecological understanding of individual development therefore requires an understanding of the influence of culture, subculture, and sociohistorical factors on interpersonal processes across the lifespan. The 1977 seminal paper is the culmination of Bronfenbrenner's earlier work in

the 1960s when he developed his critical stance on the inclusion of environmental factors as dynamic variables when comparing child development in the US and the Soviet Union (Bronfenbrenner, 1962).

Bronfenbrenner also argued that psychologists had investigated specific behaviours within constructed, artificial environments, and whilst acknowledging the contributions of various methodological approaches, he proposed an ecological framework to further understand human behaviour within a naturalistic environment. He also criticised sociological models, for example SLT, for presenting human development as a passive construct, proposing his ecological framework as a dynamic and reciprocal model (Bronfenbrenner, 1977). His positionality, therefore, emphasises the fact that the human cannot be isolated from the transactional variables within, and across, the social environment, and continuously throughout the lifespan.

The Bio-Ecological Systems Theory, was developed further by Bronfenbrenner (1979) as presented in Appendix 3. Bronfenbrenner presents a framework for understanding how the genetic code of individuals (the biological) transfers into observable behaviour (the psychological) within the environment (the sociological) and how these systems, and the interactions within and across them, are not static. As Merçon-Vargas et al. (2020) elucidate:

For Bronfenbrenner (1977), the ecology of human development is the study of progressive and mutual accommodations taking place across the life span between individuals and their changing

immediate environments; relations taking place within and between the immediate settings, as well as the larger formal and informal social contexts (in which these settings are embedded), have an impact on this accommodation process. (p. 3)

The developing person is located within four “nested” environmental systems, with each multisystemic level spanning out from the proximally close system to the proximally distant system. Bronfenbrenner delineates four ecological systems in the original 1979 model:

1. The Individual. Whilst the development of each individual is unique, there are general biological features such as neural, endocrine, and psychophysiological variables that can contribute to a variety of characteristics, such as impulsivity and temperament, that influence adolescent behaviour (Eley et al., 1999; Olson et al., 1998).
2. The Microsystem. The closest system to the individual and, as such, exerts the earliest influence on the developing child. Within this system face to face contact is central, whether in person or remotely, and includes interactions with for example family, peers, and teachers. Within the microsystem, conflict between parents and adolescents is common due to the developmental changes occurring which can include concerns about behaviour, attitude, and petty arguments (Moed et al., 2015). As mentioned in the previous section, the developing adolescent is attending to pubertal changes and constructing a distinct identity in preparedness for adult roles and



responsibilities. This study is therefore hypothesising that interactions between the developing adolescent and their immediate family, peers, medical professionals, and school staff will be affected due to the pregnancy status of the female.

3. The Mesosystem. The system nested adjacent and outside of the microsystem, the mesosystem consists of interactions between the microsystems. These interactions consist of for example interrelationships between families and schools. This study seeks to ascertain if there are any interactions between the microsystems, i.e. the school and the parents when an adolescent becomes pregnant whilst attending school and subsequently experiences a perinatal death.
4. The Exosystem. The nested system situated directly outside of the mesosystem consists of experiences within a social setting that exert indirect influence on the individual. One example of an exosystem influence might be neighbourhood attitudes towards adolescent pregnancy. This study seeks to examine any exosystem influences that may affect adolescent females who experience a perinatal death whilst attending secondary school and whether they contribute positively, negatively, or neutrally to the process either at the time of the event or across the lifespan.
5. The Macrosystem. Situated outside of the exosystem, the macrosystem provides the broad ideological influences, or social cultural influences that affect the developing individual. The

influences on child and adolescent development can include variables such as technological changes. This study seeks to provide narratives from participants on the influence of cultural, and subcultural, factors that contributed to their perinatal death experiences during adolescence.

6. A further fifth system, the chronosystem, was a later addition, demonstrating earlier assertions of the responsive construct of the theory (Bronfenbrenner, 1986). The chronosystem, as the furthest system from the individual, incorporates the ongoing reciprocal interactions across the lifespan. One example may be the impact of Adverse Childhood Experiences (ACEs) and their influence on the individual and their behaviours over the lifespan. For example, Trickey and Black (2000) suggest that even minor trauma during childhood, and adolescence, can lead to negative psychological manifestations that include emotional, behavioural and cognitive, both immediately, and impacting adulthood. Conversely, McLafferty et al., (2021) suggested that adults who experienced familial adversity during childhood indicated a resilience that may be associated with protective factors developed in response to adversity.

Bronfenbrenner's (1986) bio-psycho-social model therefore provides a relevant framework to examine adolescent experiences of perinatal death and potential life course responses.

Whilst the delineation of separate, but connected, nested ecological systems parsed out the variety of environmental influencers on human development, from a person-centred interrelated perspective, Bronfenbrenner continued to develop his model to illustrate how the various multidirectional effects of ultimate, proximal, and distal factors influence development and behaviour (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2006; Flay et al., 2009). From the 1990's onwards his central focus was on the Process-Person-Context-Time model (PPCT) which specified proximal processes as the central "primary mechanisms" in human development (Bronfenbrenner & Morris, 1998). Described as interactions between humans and other humans, objects, or symbols within close proximity, the processes must be fairly regular, must become increasingly complex, must not be unidirectional, and must occur over periods of time (Merçon-Vargas et al., 2020). It is through engaging in, for example, child-child activities that individuals make sense of the world around them and processes may either interfere with, or encourage, positive development (Bandura, 1977; Mead, 1974; Tajfel, 1979).

Bronfenbrenner positioned the individual at the centre of the ecological models and further divided the characteristics into three types in the PPCT model; demand, resource, and force (Bronfenbrenner & Morris, 1998). Demand characteristics largely influence initial interactions between individuals and other humans as they involve skin colour, age, gender, and other physical attributes that may contribute to assumptive expectations. Resource characteristics, derived from implicit resources,

may also influence initial interactions as they are derived from sources such as educational attainment (based on resource opportunities), physical health (based on access to quality nutrition, exercise opportunities, quality housing etc.), and other social and financial resources. Force characteristics encompass individual variations of behaviour such as persistence, resilience, motivation, and temperament. Thus Bronfenbrenner highlighted that whilst demand and resource characteristics may be similar between two individuals, force characteristics can determine different developmental trajectories; with one individual excelling in some areas for example team sports, whilst the other individual may not even participate (Merçon-Vargas et al., 2020).

The third concept of the PPCT model is the context, i.e. the environment which comprises the various nested systems: the microsystem, the mesosystem, the exosystem, the macrosystem, and the chronosystem (as detailed above). The ecological perspective emphasises the interrelationships between individuals and the contexts within which they develop. Bronfenbrenner recognised that; “for any particular value system to have any influence on a developing person it has to be experienced within one or more of the microsystems in which that person is situated.” (Tudge et al., 2009, p. 201). The final concept of the PPCT model is time, as human development evolves over a timespan. Divided between two concepts; “micro-time” delineates the time involved during a specific event, and “macro-time” is the term used to describe developmental processes during specific historical timelines. For example, macro-time for this study includes female participants from the ages of 19 years old onwards, who

became pregnant when abortion was illegal, and being unmarried and pregnant was considered socially unacceptable; and women who became pregnant in recent years when abortion is legally sanctioned and single parenthood is socially acceptable.

This study sought to explore the impact of adolescent perinatal deaths on females and is therefore based on the Bronfenbrenner and Ceci (1993) premise that the individual does not experience this event in isolation:

The ecology of human development is the study of the progressive, mutual accommodation throughout the life course, between an active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by the relations between these settings and by the larger contexts in which the settings are embedded. (p. 107)

This thesis therefore builds upon the theoretical imperatives of ecological theories of development to illustrate the complexities of confounding variables but it does not seek to impose a specific formulaic construct for example PPCT (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006; Mc Guckin & Minton, 2014; O'Brien, 2015; Tudge et al., 2009). Some aspects of the PPCT model may prove relevant, and may be reflected in the findings of this thesis, but the researcher explicitly acknowledges that the application of the PPCT model was not embedded within the research design (Tudge et al., 2009).

This section has presented a parsimonious summary of relevant adolescent developmental theories and highlighted the suitability of Bronfenbrenner's bio-psycho-social model as the framework for the research design for this study (Bronfenbrenner, 1986).

Having presented a parsimonious summary of relevant adolescent developmental theories, and rationale for selection of the Ecological Systems Theory (EST) for the research design of this study, the next section will explore the theoretical foundations of grief and bereavement theories in order to identify the potential responses that a female may have following a perinatal death loss.

### **2.3 Grief and Bereavement Theories**

The previous chapter summarised the available statistics, and pertinent variables, relevant to adolescent perinatal deaths. Various academic disciplines have contributed theoretical perspectives on death, dying, grief, and bereavement, which include: psychology, sociology, anthropology, theology, medical, philosophy, and others. Due to the variety of disciplinary contributions, and cultural perspectives, this section provides an overview of the evolution of grief and bereavement theories within a bio-psycho-social framework. The researcher explicitly acknowledges Euro-Western bias within this thesis as a reflection of researcher positionality and would like to stress that the theories presented are selected elements that contribute to a limited understanding of the complexity of the bereavement experience. Twenty years ago Stroebe et al. (2001) stated in the *Handbook of Bereavement Research* that bereavement scholars

recognise complex phenomena through various bio-psycho-social lenses; this section is intended to provide a historical context for the evolution of grief and bereavement knowledge as a dynamic phenomena. The following section will therefore present an overview of grief and bereavement theories within this framework.

### ***2.3.1 Biological Grief Theories***

This perspective views grief as a universal biological response that is not unique to individuals or exclusive to humans (Shear & Shair, 2005).

Studies of animal behaviour have highlighted the human ability to anticipate death, and process the meaning of life across time and space, but some scholars believe that human emotional experiences should not be considered more profound compared to other animals (Darwin, 1872; King, 2016). The biological, universal perspective of grief was succinctly articulated by Averill (1968) who stated; “Grief comprises a stereotyped set of psychological and physiological reactions of biological origin. It is hypothesized that the adaptive function of grief is to ensure group cohesiveness in species where a social form of existence is necessary for survival.” (p. 721).

Lindemann (1944) was also a proponent of biological universality and during WWII identified some grief responses to war casualties as; “a definite syndrome with psychological and somatic symptomatology.” (p. 188). His view that grief was a psychological sickness that could manifest into physical symptoms was echoed by Engel (1961) who also suggested a significant bereavement was equivalent to an impactful physical injury or

disease. Lindemann (1944) also provided the first linear process model based on the premise that grief is biological, universal, and causal. With variables that can be uniformly “measured”, he identified; shock, anger, sadness, and resolution as evolutionary stages of the responses to loss as they happen “to” you. Additional stage and phase grief theories emerged with similar response trajectories (e.g. Averill, 1968; Bowlby, 1969; Parkes, 1972; Rando, 1984). It is important to note that the staged/phased theories of grief were not intended to be interpreted as linear and several scholars, including Dr Colin Murray Parkes OBE, highlighted this fact at the time of publication, and J. William Worden has revised and updated his “Tasks of Mourning” as new publications have revealed updated knowledge (Parkes, 1972; Worden, 2009).

Despite the prevalence and popularity of the staged/phased approach to grief, criticisms include; (a) the models are all representative of Euro-Western cultural perspectives examining typically white, middle class participants, thereby excluding cultural or individual variations; (b) the models do not address the interactional and communicative nature of the bereavement experience within the social environment; and (c) the grief experience does not fit neatly into universal boxes (Corr, 2019; Davies, 2017; Holloway, 2007; Stroebe & Schut, 1999).

The early biological perspectives of grief also categorised human experiences as “normal” or “abnormal” which laid the foundations for later studies that resulted in the definitions of Prolonged Grief Disorder (PGD) and Persistent Complex Bereavement Disorder (PCBD) (APA, 2013; ICD-



11, 2018). The concepts of “abnormal” grief, and the various definitions, are presented in section 2.3.4 of this chapter.

Having provided an introduction to the biological perspective of grief, the next section will present pertinent grief theories from a hermeneutic perspective which recognises the individuality of human thoughts, feelings, and experiences in response to loss.

### ***2.3.2 Psychological Grief Theories***

This section explores grief theories from a psychological perspective which considers individual interpretations and understandings of human experiences (Hall, 2014). In contrast to the biological perspective that views grief responses as ubiquitous, psychological theories recognise the unique thoughts, feelings, and behaviour exhibited by each individual in response to each death and their interpretation of the experience.

The psychoanalytic perspective has been prominent within the evolution of grief and bereavement theories. Originating with Freud’s seminal work in 1917 on “mourning” and “melancholia”, this perspective continues to exercise influence within contemporary discourse (Freud, 2005). Whilst the stage and phase theories are rooted in the biological, deterministic perspective of death response, the psychoanalytic lens presents a more nuanced individualistic interpretation that varies with each individual. Rooted in the premise that a griever needs to actively mourn the loss and then gradually relinquish the attachment, some lay people have interpreted Freud’s work as “getting over” the death. However, an

alternative view is that Freud was drawing attention to the resulting “melancholia” that ensues long after the death (Holloway, 2007).

Within a chronological context, the advancement of knowledge on grief involved largely stage, phase, and task (i.e. deterministic) models (Averill, 1968; Bowlby, 1969; Lindemann, 1944; Parkes, 1972; Rando, 1984; Sanders, 1999; Worden, 2009), however, Parkes (1972) made a significant contribution by asserting that grievers use a “filtering” system to let through, or filter out, unwanted information; that the process of grieving is an overall process of realisation in which the individual comes to terms with the reality of the loss. Whilst still related to the earlier grief “work” models where bereavement was a process of “working through” a series of stages/phases/tasks until “acceptance” is achieved, Parkes’ contribution highlighted the individualistic component of grief.

Academic research subsequently undertaken to examine individualistic grieving differences lends further insight into phenomenological variations. One example is provided by the findings of Martin and Doka (2000) who identified specific variables pertinent to individual grievers and how they influence the expression, and adaptive patterns, employed. They found that there are different grieving types broadly summarised into two patterns; “Instrumental Pattern” and “Intuitive Pattern”. The two patterns of grieving, and multifarious variations across, and within them, describe the individual differences of grievers as they adapt to a death loss. The two patterns may be understood as; (a) intuitive grievers employ adaptive strategies that incorporate repetitive storytelling,

emotional expression, and conveyance of intensity of emotions; and (b) instrumental grievers employ adaptive strategies that include problem-solving, mastery of oneself, and reluctance to convey emotionality. Further empirical data also identifies variations in individual experiences that transcend universal, stage/phase deterministic bereavement patterns. For example, the Dual Process Model of Coping with Bereavement (DPM) highlights the oscillation for grievers between the stressors of loss orientation (i.e. attending to the death loss), the stressors of restoration orientation (i.e. attending to the secondary losses), and the space of cognitive retreat in between the two orientations (Stroebe & Schut, 1999). Advances in professional support available to grievers have also been made within the psychological disciplines. For example, Prof Neimeyer and colleagues have provided significant empirical contributions on meaning making, and meaning reconstruction, following death as central to normative adjustment (Gillies et al., 2014; Milman et al., 2019; Neimeyer et al., 2002).

The identification of variables of distinctive grieving patterns, and individualistic adaptation through meaning making, are examples of contemporary empirical findings that address criticisms of the universal, often stage/phase based theories of grief and bereavement. However, critics, such as Pearce (2019) argue that the psychological theoretical perspectives of grief have portrayed the experience as intrinsically individualistic and predominantly emotional without consideration of other variables, particularly social contributors. The next section will therefore introduce examples of social contributors to grief and bereavement theories.

### ***2.3.3 Psycho-Social Theories of Grief and Bereavement***

Confirmatory studies suggesting grief and bereavement are psycho-social stressors have been published within academic discourse (e.g. Parkes & Prigerson, 2010), suggesting that whilst grief may be viewed as a universal biological reaction to a death, with individuals experiencing bereavement in individual psychological ways, the socially derived attachment forms the relationship that may be considered as the trigger for the grief reaction.

Within the realm of psycho-social approaches to bereavement was the introduction of the environmental concept of the “shattered assumptive world” (Janoff-Bulman, 2010; Parkes, 1988). This view proposes that individuals live their lives with unquestioned assumptions about themselves; conceptualised as their *internal* world. The unquestioned assumptions held by individuals about the environment surrounding them is conceptualised as the *external* world. Within this paradigm bereavement is regarded as a threat to both the internal and the external worlds, and the individual is forced to cope with assimilating their experiences within a changing schema known as a “Psycho-Social Transition” (Parkes, 1971; Parkes & Prigerson, 2010). Psycho-social transitions involve many variables; both internally and externally, and occur within the process of adjusting to, and relinquishing old assumptions, in order to establish new schema in response to the “new normal”. The psycho-social adjustment to a post death “new normal” is partly attributed to social interactions, social rituals, and establishing a new social identity.

A further addition to understanding the attachment between the griever and the deceased, through a psycho-social lens, is the concept of continuing bonds (Klass, 2006; Klass et al., 2014; Klass & Steffen, 2017). A new paradigm that challenged the prevailing linear staged, universal discourse that grief was a response that needed “resolution”, continuing bonds theory proposes that there is a continuing, albeit altered, relationship that endures (Boelen et al., 2006).

Further, within society there are generalisable rules for, and expectations of, grievers that govern variables including behaviour, cognition, spirituality, and emotional responses (Becker et al., 2020; Birrell et al., 2020; Davies, 2017; Parkes et al., 2015; Woodthorpe, 2017). The impact on grievers from social variables can significantly affect the individual bereavement experience. For example, when relationships, or other variables such as grief responses, are not socially validated, acknowledged, or are dismissed, the individual may experience “disenfranchised” grief (Doka, 2002). Societal mediators are therefore recognisable factors that influence human activity so that individuals learn how to behave and perform within different environments. Further, Davies’s (2020) concept of the “dividual” suggests that individuals are not *separate* from society but that they *embody* environmental influences. Therefore the positionality of this study is that the biological, the psychological, and the sociological theories of grief and bereavement all contribute collectively to contemporary understandings of individual experiences, and that individuals embody environmental influences.

Woodthorpe and Rumble (2016) have also criticised the lack of sociological discourse on relational interaction, and the impact of experiences of death, dying, and bereavement, particularly within families. Further, with low life expectancy, increased homicides, and suicides prevalent in societies steeped in poverty it has been argued there is sparse literature on the examination of bereavement experiences from a sociological perspective (Mulrine, 2020; Pickett & Wilkinson, 2010). Whilst scholars are attempting to address these research gaps, how these issues intersect with care responsibilities at end-of-life and/or bereavement have previously received very little attention (Mulrine, 2020). Thus, this thesis examined the experiences of adolescent perinatal death loss from a bio-psycho-social perspective to situate individual narratives within social situations and cultural environments (Flay et al., 2009).

This section has provided a parsimonious summary of the development of grief and bereavement theories from the biological, psychological, and social perspectives, collectively. The next section explores the potential bereavement outcomes that may occur for individual grievers.

#### ***2.3.4 Bereavement Outcomes***

Empirical studies of bereavement experiences have suggested that there may be three possible outcomes following the adjustment to the death of a significant attachment (Bonanno & Malgaroli, 2020; Calhoun et al., 2010; Sanders, 1999; Stroebe & Schut, 1999). The three potential bereavement outcomes are explored in this section and are presented as; “complicated”

grief, “post traumatic growth”, and “normative” adjustment (APA, 2013; ICD-11, 2018; Lloyd, 2018; Tedeschi & Calhoun, 1995).

Within the cultural environment of the US, one descriptor of intense and prolonged grief has emerged as a manifestation considered pathological. The descriptors are variously termed but describe a positionality where a bereaved person is determined to have not adjusted “appropriately” to their death loss (APA, 2013; ICD-11, 2018). The pathological condition has variously been ascribed the terms “complicated grief”, “Prolonged Grief Disorder” (PGD), “Persistent Complex Bereavement Disorder” (PCBD), and many others. These labels, and various definitions, suggest; “the depth of some bereaved people's distress can mean they experience very great difficulty in progressing through the natural healing process.” (Shear, 2010, p. 10). Conversely, academics in countries outside of the US are critical of the inclusion of grief as a pathological condition in the DSM-5, rendering the diagnosis of PGD, and any variations of “complicated” grief, as contentious (e.g. Schroeder et al., 2013). Pearce (2018) details objections to the medicalisation of grief on the grounds that death and bereavement are normal life events; “complicated forms of grief provide pathology for the ‘psy’ disciplines to focus on and justify interventions” (p. 45). However, regardless of positionality of the medicalisation of grief, estimates of bereaved people presumed to have experienced intense, prolonged experiences range from 2% to 20% (Delaney, 2015). Within this cohort, grievers of unexpected, untimely, or violent deaths are over-represented within the estimates (Delaney, 2015; Hall, 2014).

Whilst there is a proliferation of research investigating negative bereavement outcomes, with popular and academic discourse reinforcing these narratives, systematic investigations of the potential for psychological growth as a bereavement outcome have received less attention (Tedeschi et al., 1998). For example, first published in 1946, Viktor E. Frankl (2004) conveyed the idea that positivity and optimism can occur following great suffering as he recounted his personal experiences during the holocaust. He later added a chapter entitled “The Case for a Tragic Optimism” suggesting that following death, and other “miserable” events that there is a; “human capacity to creatively turn life’s negative aspects into something positive or constructive.” (p. 139). Later scholars, most notably, Tedeschi and Calhoun (2004) refined, and defined, the concept of post traumatic growth (PTG) as: “the experience of positive change that occurs as a result of the struggle with highly challenging life crises. It is manifested in a variety of ways, including an increased appreciation for life in general, more meaningful interpersonal relationships, an increased sense of personal strength, changed priorities, and a richer existential and spiritual life.” (p. 1).

Whilst bereavement outcomes may therefore be considered on a sliding scale from PGD through to PTG, research suggests that most individuals will adjust to the loss of a significant attachment in a “normative”, adaptive way that is appropriate to that person (Bonanno et al., 2002). For example, Davies (2017) surveyed bereaved people’s adjustment times following death, stating that the majority 45% of participants returned to “normal” within days of a bereavement. A further 23% of bereaved people returned to “normal” within weeks, 18% of



bereaved people returned to “normal” within months, and a minority 15% of bereaved people adjusted to their loss within years, due to variables such as child death. These findings support Delaney’s (2015) and Hall’s (2014) assertions that less than 20% of bereaved people experience prolonged grief reactions, and for those that do, there are confounding variables such as traumatic response. Moreover, Adolfsson’s (2011) meta-analysis suggested that approximately 10% of females experienced grief reactions following a perinatal loss that could potentially be determined as PGD responses.

Grief and bereavement studies, in general, have historically focussed on adult phenomena, therefore the following section presents an overview of theoretical findings of adolescent grief and bereavement responses to death.

### ***2.3.5 Adolescent Grief***

The prevalence of global child and adolescent bereavement, as a result of immediate family or close friend death, is uncertain due to reporting, methodological, and data source variations (Burns et al., 2020; Osterweis et al., 1984). One UK study found that 77.6% of their respondents aged between 11 and 16 years old had experienced the death of a first, or second, degree relative or close friend (Harrison & Harrington, 2001). Whereas the Irish Childhood Bereavement Network report much lower estimates with 2.2% of children experiencing the death of a parent, 1.1% experiencing the death of a sibling, and 6% the loss of a close friend (‘New Online Resource for Teachers Launched by Senator Marie Louise O’ Donnell’, 2015).

Whilst there is substantial research on adolescent development from varying perspectives, there is comparatively less corresponding literature on adolescent bereavement. Dyregrov (2008) addresses the lack of connectivity stating: “we do not yet know enough about the interplay between trauma processing and the different developmental tasks of childhood.” (p. 75).

Criticisms of emerging literature on adolescent grief were raised by Fleming and Adolph (1986) who cited “methodological problems”, a perceived lack of consistency of the definition of “adolescence”, and the resultant inability to compare findings as problems within early studies. They also stated that studies of adolescent grief prior to the 1980s were retrospective in design, utilised convenience samples from psychotherapists, and were restricted to only investigating experiences up to seven years post death. Having identified these methodological issues, Fleming and Adolph constructed a theoretical framework of adolescent grief to provide a foundational platform for understanding adolescent developmental stages, and their connection to death and grief responses (Corr & McNeil, 1986).

The Fleming and Adolph *model of grieving for adolescents* (1986) is grounded in their definitions of three adolescent developmental phases and the tasks associated with each maturational phase. The developmental phases comprise; (a) Phase I; from ages 11 to 14 when early adolescents learn how to manage the emotional separation process from their parents. This is when young people start learning how to manage when to rely on

their parents and when to maintain independence; (b) Phase II; from age 14 to 17 when young people continue to master the task of balancing the tension between personal autonomy and continued dependence on the parents; and (c) Phase III; from age 17 to 21 involves later adolescents balancing the independence they've gained against the demands of their first intimate relationships. The definitions for the three adolescent developmental phases, and associated responses to death and grief, were designed to provide a framework for consistency within future research.

Fleming and Adolph (1986) also identify what they term the; "*five core issues* around which bereaved adolescents attempt to accomplish some resolution of the ambivalence engendered by phase conflicts." (p. 105) which include; predictability of events, self-image, belonging, fairness/justice, and mastery/control. They also identified three "Reactions" by grieving adolescents; "Cognitive", "Behavioral", and "Affective". The three reactions and the five core issues are combined into three matrices, one for each adolescent phase, to highlight the differences in maturation. This model identifies that death and bereavement engender a particular intensity to developmental issues which can lead to potential complications within the processes.

In summarising the intricate *model of grieving for adolescents*, it is suggested that bereavement affects many aspects of identity formation, school experiences, family life, peer relationships, and overall mental and physical health, within the bio-psycho-social environment (Corr & McNeil, 1986; Fleming and Adolph, 1986). Early research therefore suggests that

the death of a significant attachment, and adjustments throughout the bereavement process, can therefore potentially impair “normal” adolescent development (Balk, 1991).

A decade following Fleming and Adolph’s seminal work, the longitudinal Harvard Child Bereavement Study (HCBS) reported that bereaved adolescents were more anxious and fearful compared to non-bereaved peers (Silverman & Worden, 1993; Worden, 1996). The authors of the report suggested that the unpredictability of death triggers these responses, validating the earlier hypothesis suggested by Fleming & Adolph (1986). Recent contributions from neuroscientists suggest that grief is more intensely experienced by adolescents during this developmental phase due to brain sensitisation and emotion regulatory development (Siegel, 2014; Silvers et al., 2017).

Building on the structure of attending to specific developmental tasks within each maturational phase of adolescence, some scholars have suggested that as each adolescent developmental stage is reached, increased cognitive perception presents some individuals with a re-grief phenomena (Oltjenbruns, 2001). Re-grieving is a concept whereby the death is re-interpreted, new meanings may be ascribed to the event, and/or new questions related to the death, or bereavement experience, may emerge (Miller, 1995). Oltjenbruns (2001) further elucidates: “Within this milieu of maturing developmental capacities and shifting developmental tasks, an individual who experiences a significant loss during childhood will often “regrieve” the loss at a later time from a different and more mature vantage

point.” (p. 169-170). Additionally, as adolescence is a sociologically critical developmental phase, bio-psycho-social variables may contribute to different bereavement experiences than in childhood or in adulthood. For example, research by Ribbens McCarthy and Jessop (2005) suggests that peer relationships may contribute to a sense of difference or being excluded from the “in-group” (Tajfel, 1979), and in some circumstances, being bullied as a result of their changed circumstances. Further, academics have recognised that experiences of death of significant attachments can cause further difficulties in coping with loss across the lifespan (Fang & Comery, 2021).

Having presented a summary of the key findings within adolescent grief and bereavement theories, the following section will investigate perinatal grief to provide additional theoretical context for the research question.

### ***2.3.6 Perinatal Grief***

The studies examining adolescent grief and bereavement have predominantly been conducted with participants who have experienced parental, sibling, or peer deaths (e.g. Balk, 1983; Silverman and Worden, 1993; Weller et al., 1991). This section will therefore present an overview of perinatal grief, with an explicit acknowledgement that research in this area is focussed primarily on adult experiences.

Medical historian Withycombe (2018) reports finding joyful narratives instead of grief stories when conducting research into miscarriage experiences during the 19<sup>th</sup> Century. The historical narratives revealed that

women expressed thankfulness at the biological cessation of pregnancies due to various conditions which included perilous financial circumstances, or living in frontier conditions in the US. Thus Withycombe suggests miscarriages were a source of contraception prior to modern methods of birth control. As society has evolved, and birth control has advanced in accessibility and efficacy, often referred to medically as “spontaneous abortions”, the miscarriage experience has remained socially perceived as the “lesser” of the three types of perinatal death experiences (Friedman & Gath, 1989; Leppert & Pahlka, 1984). This is predominantly because stillbirths and neonatal deaths provide “evidence” of the potential human within the hierarchy of grief; a tangible “baby” is deemed socially “worthy” of recognition and impact (Doka, 2002; Lloyd, 2018).

However, contemporary narratives on miscarriage, following the widespread use of home pregnancy tests and ultrasound imaging, have reflected the evolving discourse of our social and medical relationship to the foetus: “The language used to talk about what a pregnancy actually is and who it involves, reveals deeply held beliefs about pregnancy, abortion, and life itself. To use the term “baby” to speak about the embryo or fetus is to begin, at least, to assign personhood to it. Conversely, to use the term “embryo” or “fetus” is to buy into the medicalization of pregnancy, and to deny personhood. To identify a pregnant woman as “mother” is, again, to reveal something of beliefs about the pregnancy and her status within it.” (O’Donnell, 2019, p. 147).

Cultural attitudes continue to change towards embryos and fetuses, for example, several states in the US have enacted laws that recognise fertilised eggs, embryos, and fetuses as individual persons distinct and separate from the pregnant female, furthering the concept of grieving for a lost “person” (Bynum, 2018). Within this context, the potential for grief reactions following terminations is therefore also increasingly recognised; “There is a popular consensus in the medical profession and the laity that spontaneous and induced abortions have few psychologic sequelae. A review of the literature reveals that this is not true” (McAll & Wilson, 1987, p. 817). Contemporary discourse therefore allows for socially recognised, and supported, self -disclosure of “bereaved parent” status following perinatal deaths (Brier, 2008; Frost & Condon, 1996; Lovell, 1983).

Whilst it is noted that not all pregnancies are planned, and not all miscarriages provoke a grief reaction, within the context of attachment and perceived personhood, if research suggests that attachment, and therefore grief, can occur and have a significant impact on some females from the moment of conception, the term “perinatal” has implications for research purposes as definitions traditionally start at, or around, twenty weeks’ gestation (Barfield & Newborn, 2011; Broderick & Cochrane, 2013). For example, the WHO specify the perinatal period begins at the 20<sup>th</sup> week of gestation and ends at the point of one month post birth (WHO, 2021). However, some empirical publications specify the beginning of the perinatal period at 12 weeks following conception and others specify the end of the period up to four weeks post birth (Hill et al., 2008). The variability of definitions, and the exclusion of some perinatal deaths,

complicates comparative analysis of published data. Based on the arguments set out in detail in chapter three, this thesis recognises the potential attachment, and potential loss impact, from the moment of conception to twenty eight days post birth.

Section 2.3 of this chapter explored the various Euro-Western perspectives of grief and bereavement models, and theories, from a bio-psycho-social perspective. As grief has been determined for this thesis to be the feelings, thoughts, and actions following the death of a significant attachment, it may be concluded that gestational losses, where personhood has been ascribed, can provoke a grief response, regardless of the age of gestation or mode of death (Lloyd, 2018).

Within countries such as Japan, Thailand, and China all deaths from conception to neonatal are publicly recognised, irrespective of whether they are induced or uninduced (Florida, 1991). In Japan a Buddhist ceremony is performed for the *Mizuko* (水子) to facilitate the passing of the soul and comfort the bereaved “parent” (Smith, 1988). However, whilst the emotional responses to biological deaths (i.e. miscarriage, stillbirth, and neonatal deaths) have been widely researched and acknowledged in Euro-Western and colonial cultures, empirical data investigating grief responses to abortion have largely been ignored (Lee, 2003).

This thesis also recognises that ascription of personhood, and the potential for resultant grief responses, are not universally conferred following any type of perinatal death (including abortion). Slade (1994)



reported that studies suggest between one half to four fifths of women may not experience a debilitating response to a miscarriage.

However, it is notable that the literature on perinatal death, and grief response, is predominantly focussed on adult planned pregnancies, which is also reflected in the predominant narratives within contemporary social discourse. Brady et al. (2008) argue that; “although termination and miscarriage are generally perceived as distinct and different issues, the issues become more blurred where ‘younger women’ are concerned...[viewed] as a positive solution to the ‘problem’ of teenage pregnancy and young motherhood.” (p. 187).

#### **2.4 Developing a New Bereavement Theoretical Structure**

As an extension of the grief and bereavement theoretical summary provided in this chapter, a new framework for understanding bereavement experiences was developed. The Multidimensional Theory of Bereavement (MTB) (Appendix 5) was constructed to expand existing knowledge on grief and bereavement by situating them within a bio-ecological structure (Bronfenbrenner, 1979/1986; Corcoran, 1999). The MTB theory and accompanying model are designed to be flexible and adaptable to incorporate new research, new understandings, and to be modified for use in multiple ways.

The review of Euro-Western grief and bereavement theories, and models, within this chapter has identified several commonalities which include:

1. They are predominantly focussed on the individual perspective.
2. They commonly originate from the event of the death.
3. They primarily focus on the emotional reactions of the griever.

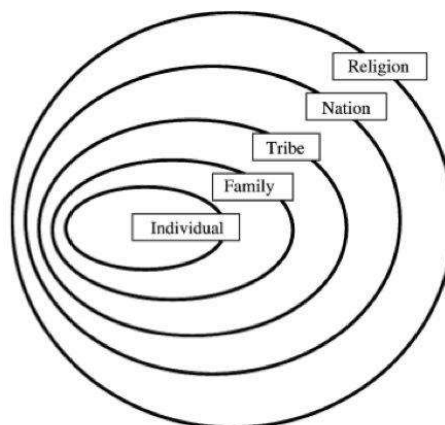
The MTB theory contributes to the field of death studies by elaborating on existing, research-based findings, and seeks to reframe and expand the evidential models within a bio-ecological context (Bronfenbrenner, 1986; Mc Guckin & Minton, 2014; Tudge et al., 2009). The MTB has been utilised as a framework for this thesis to better understand adolescent perinatal death experiences, and builds upon the theoretical imperatives of ecological theories of development to illustrate the complexities of confounding variables, but it does not seek to impose a specific formulaic construct, for example the Process-Person-Context-Time (PPCT) model (e.g., Bronfenbrenner & Morris, 2006; Tudge et al., 2009). Some aspects of the PPCT model may prove relevant, and may be reflected in the findings of this thesis, but the researcher explicitly acknowledges that the application of the PPCT model was not embedded within the research design.

Further, this model expands to include Davies' (2017) postulation that; “persons ... as dividually as individually conceived. They contain a generalized sociality within.” (p. 54). More specifically: although we are individualistic, we do not exist in one dimensional isolation, developing humans assimilate pervasive cultural views and norms (Davies, 2020; Mosko, 2010).

As can be seen in Figure 4, incorporating bereavement experiences within an ecological context was first presented by Klass in 2006. He placed the construction and continuation of bonds to the deceased within a series of “nested narratives”. These consist of the Individual, Family, Tribe, Nation, and Religion, with each “ring” expanding out from the Individual.

#### Figure 4

##### *Klass’ Nested Narratives*



**FIGURE 2** Individuals and families construct and maintain their bonds with the dead within a series of nested narratives.

*Note.* From *Continuing Conversation about Continuing Bonds*, Klass, 2006, p. 855

Klass contended that the nested narratives can be extended to the whole death, dying, and bereavement experiences through understanding attachment theory, he stated:

The most useful way to understand the individual's relationship to family, community, political, and cultural narratives is by extending attachment theory. Each level of social membership or identity is an attachment: family, tribe, nation, religion (Klass, 2006, p. 12)

Similarly, the MTB framework (see Appendix 5) positions grief and bereavement within a bio-ecological system. However, the MTB is also designed to expand and encompass further bereavement theories and bereavement outcomes (Calhoun et al., 2010; Davies, 2017; Shear & Shair, 2005). Therefore, the MTB recognises the nature of the transactional elements, rendering the “nature” versus “nurture” debate extraneous as they are both interwoven within the various environments and universally integrated (Mitchell, 2007).

The MTB also positions the bereaved individual at the core of the “cone” which represents the multiple levels of the surrounding environment, with bi-directional influences within, and among, systems which comprise of the following:

1. The Individual. Grief and the bereavement experience involve influencers of biology and behaviour that the griever may not be able to control, may be able to control, or may be able to influence (Flay et al., 2009). One example being that the emotional and social needs of a developing adolescent individual should be recognised within secondary schools so that females can have control and choice over accessing services and support to provide the best

protective factors against poor social outcomes and/or poor health outcomes following a perinatal death (Washburn et al., 2011).

2. The Microsystem. Humans have evolved over time to form attachments with those we are proximally close to, and the loss of an attachment may result in a grief reaction (Bowlby, 1969). For example, when instrumental and intuitive grievers reside in the same home, there can be misunderstandings and/or conflict (Martin & Doka, 2000). Contemporary society now incorporates other proximally close methods of communicating, for example via apps on smartphones, accordingly, Bronfenbrenner's microsystem has been updated to include a "Techno-subsystem" (Johnson & Puplampu, 2008). Johnson and Puplampu suggest that face to face communications are now routinely conducted via technological modes such as portable devices, smartphones, and computers, therefore geographical proximity is no longer a requirement for relational attachment. Moreover, dead remains exist within new technologies as artefacts that can be interacted with on a daily basis, thus they: "also run the risk that we lose precisely the dimension of lostness that should characterise our relationship to the dead" (Stokes, 2015, p. 237).
3. The Mesosystem. The next bioecological system involves social recognition, provision of information, and availability of support. For example, research by Doka (2002) and colleagues suggest that if grief is not socially recognised it may be considered disenfranchised, which may have an adverse impact on the

bereaved. For example, adolescent girls who experience perinatal loss who are not “recognised” as grievers may report poorer bereavement outcomes. Within contemporary narratives, adverse events are increasingly being shared over social media and the internet, which raises issues of control, the sharing of news and online grieving (Bassett, 2022; Sofka et al., 2012). Whilst most bereavement related interactions within online platforms appear to be positive, trolling, lack of empathy, and the spreading of inaccurate information both around the “story” of the deceased and those involved with them is also prevalent (Kasket, 2019). As detailed in chapter one, the researcher found sparse online information and/or support for female adolescents who experienced a perinatal death, thereby raising the question of whether this cohort may be disenfranchised (Doka, 2008).

4. The Exosystem. The following bioecological system involves policies, for example bereavement policies and resultant practice, can influence and impact on grievers. Specifically for this study, school bereavement policies that recognise and support adolescent females following perinatal death losses, including allowing time off school, could contribute to reducing mental or physical negative outcomes (Brady et al., 2008; Rodgers & DuBois, 2018).
5. The Macrosystem. The next bioecological system includes the cultural environment which influences how we view death, dying, and bereavement and how we socially construct normative narratives (Davies, 2017; Valentine, 2008; Woodthorpe, 2017). As

detailed in chapter one, the recognition of, and support provided to, adolescent girls who experience any type of perinatal death is broadly lacking within Euro-Western social environments.

6. The Chronosystem. The next bioecological system incorporates the sociohistorical variables that contribute to normative contemporary social ideals. Chapter one detailed the sociohistorical perspective of females as virtuous heads of Irish families and that an unmarried pregnancy within this environment disrupts the social contract, resulting in “punishment” of girls (Maloney, 2021; Michael Garrett, 2017). As detailed, the historical prohibition of legal abortion services resulted in some of the most vulnerable members of society confined to brutality and enslavement in mother and baby institutions (de Londras, 2020; O’Sullivan & O’Donnell, 2007).
7. A further proposed addition to Bronfenbrenner’s ecological systems theory was the digisystem (Walker, 2015). The digisystem incorporates all of the preceding nested systems, and is identified in conjunction with the chronosystem due to its modernity. The technologies that pervade, and have integrated within societal activities, were absent when Bronfenbrenner published the amended 1986 bio-ecological systems model. Within the digisystem is the demarcation of “thanatechnology”, defined as; “all types of communication technology that can be used in the provision of death education, grief counselling, and thanatology research.” (Sofka et al., 2012, p. 3). Thanatechnology also allows the bereaved to find publications, peer support, and information from across the

globe on death, dying, and bereavement; it also allows individuals to gain societal recognition for their grief (Bassett, 2018). Historically, Euro-Western humans would grieve within communities, however, grieving online has become increasingly common, as evidenced in chapter one by Chrissie Teigen and John Legend.

To illustrate the flexibility of the MTB, the framework allows for the integration of further death studies contributions, such as, Penfold-Mounce's (2018) narratives of posthumous lives through the utilisation of technology. Moreover, it incorporates Bassett's (2022) contribution to the advancement of thanatechnology through modification of the Dual Process Model of Coping with Bereavement (Stroebe & Schut, 1999).

One aspect of grieving that encompasses all social, historical, and cultural systems is the concept of a "hierarchy of grief" (Lloyd, 2018). Butler (2004) describes hierarchies of grief as the grievability of a human; that some lives are more grievable than others. The researcher concurs that hierarchies exist across the bereavement communities with individuals ascribing "value" to relationships based on their own experiences or social values. For example, within the "babyloss" community, a higher grieving status is afforded to parents who experience a stillbirth than those who experience a miscarriage, and thus understanding and support appears to be more prevalent for those experiencing a stillbirth than those who experience a miscarriage, regardless of the grief impact (Barglow et al., 1973). This socially determined conceptual value ascription may contribute to



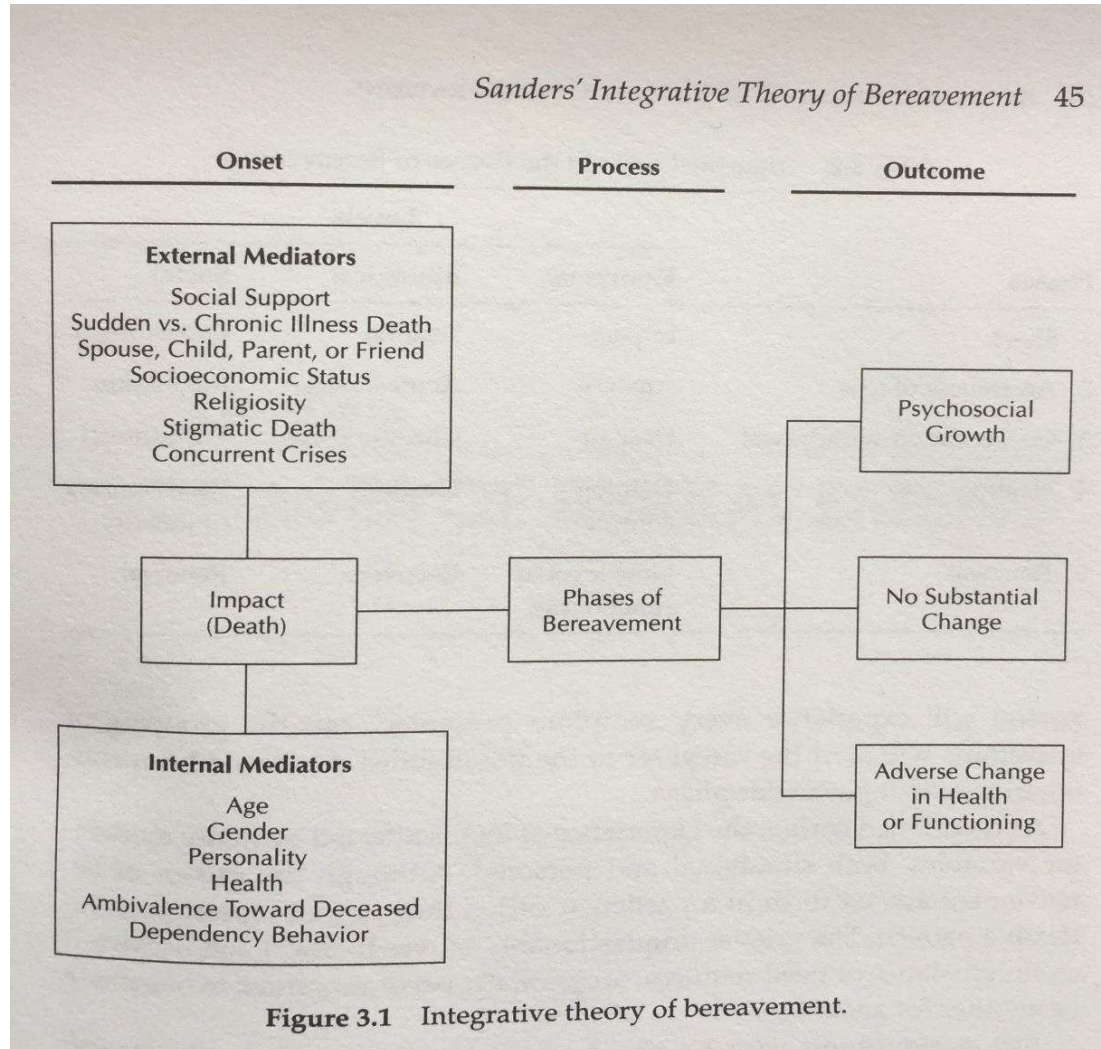
disenfranchisement and marginalisation, and further exemplifies the argument for recognition of impact in the topic area, regardless of age of female or type of perinatal death.

As presented in Appendix 5, the MTB views the “cone” as three separate, but interlocking, bio-ecological systems; the individual within their ecological environment prior to the death, an additional cone to encompass the death and bereavement experiences, and the third cone added to represent the three variations of outcomes detailed in section 2.3.4. The “cones” are presented as dynamic, interactive, and expansive.

The researcher explicitly states that there are notable similarities between the MTB and Sanders’ (1999) Integrative Theory of Bereavement (ITB). Sanders’ model identifies the internal and external mediators of individuals within their ecological environment pre death, utilises a phase model of bereavement post death, and classifies post death outcomes in three ways as seen in Figure 5 on the next page:

**Figure 5**

*Sanders' Integrative Theory of Bereavement (1999)*



*Note.* From *Grief: The Mourning After: Dealing With Adult Bereavement*, Sanders, 1999, p. 45

Both models recognise that attachments are formed, and determined, by the transactional nature of relationships across, and within, the ecological systems across the lifespan (Ainsworth & Bowlby, 1991; Bronfenbrenner 1986; Hazan & Shaver, 1990). They both understand the bereavement process from a bio-psycho-social perspective, and that the

relationship and the experiences pre, during, and post bereavement, must be situated within the wider context; individually, socially and environmentally (Bronfenbrenner, 1979; Sanders, 1999). However, the MTB incorporates contemporary bereavement theories and is positioned to be flexible and inclusive of further contributions to the development of understanding bereavement experiences from a bioecological perspective.

The definition of synergy may be considered the combining of elements in order to create something that is greater than the sum of the individual constituents and this is what the MTB seeks to represent.

## **2.5 Chapter Conclusion**

This chapter has reviewed the relevant theoretical perspectives in order to introduce knowledge and understanding of the bio-psycho-social experiences of females who became pregnant during adolescence and subsequently experienced a perinatal death.

This chapter has presented a parsimonious overview of relevant theories of adolescent development to situate the maturing female within the development timeline at the time of the pregnancy and the associated death. The biological theories provide information on puberty, and the resultant physiological changes, including adolescent neurological development. Within the maturational changes, the advent of menarche enables girls to become fertile and potentially pregnant. However, not all females of school age are willing or able to carry a pregnancy to term, with all its inherent risks, so abortions are one potential option; both legally and illegally.

In turn, the biological changes impact on the psychological development of the individual, highlighting the importance of identity creation, independence from parental control, and the assumption of adult responsibilities. The psychological variables that contribute to pregnancy at this developmental stage include contraceptive ignorance, contraceptive failure, and concealed pregnancy, among others.

Social psychological theories contribute to understandings of social influences on the individual such as peer relationships and socioeconomic conditions, and how these help or hinder adolescent development. Sociological factors also contribute to young girls being more susceptible to immature pregnancy; for example, early marriage, lack of educational opportunities, and mothers or peers who were also young parents. Further ecological influences contribute to perinatal deaths as a result of lack of ante-natal care, pressure to terminate, or to kill newborns as a result of societal pressure or stigma.

This chapter also presented a brief summary of grief and bereavement theories from a bio-psycho-social perspective. However, as identified, the theories summarised are limited to a predominantly Euro-Western perspective. Studies of adult perinatal death responses suggest that 10% of females experienced grief reactions that could be considered prolonged and intense. Conversely, some studies suggest that between one half to four fifths of women may not experience a debilitating response to a miscarriage suggesting that not all pregnancies are ascribed personhood. However, studies of adolescent grief do not ordinarily include perinatal

death and studies of perinatal grief do not ordinarily include adolescent experiences.

Finally, the MTB was presented as a bio-psycho-social framework for consolidating the various grief and bereavement theories and to create a synergistic approach to the topic area.

The next chapter provides the results from the literature review (LR), conducted to investigate existing scholarship concerning female adolescent perinatal death experiences.

## Chapter Three: Literature Review

*“Precarious life, life that is forgotten and marginalized, is not grievable. In the same way that grievability is not granted to every life or to every dead person, the grief of the survivors is not equally recognized either.”*

*(Bayatrizi et al., 2021, p. 512)*

### 3.0 Chapter Overview

The aim of this chapter is to present a critical overview of the relevant published literature pertaining to the experiences of females who became pregnant during adolescence and subsequently experienced a perinatal death. Whilst the previous chapter presented a developmental map of classical adolescent developmental theories, and grief and bereavement theories, the current chapter narrows the scope from the previous chapter to provide an analytical review of the empirical, and non-empirical, publications that encompass the inclusion criteria, as determined *a priori*, for this thesis.

The current chapter is presented in four individual but associated sections. The first main section of this chapter identifies the terminological and definitional issues with the inclusion criteria for this study. This section identifies the ambiguous and unambiguous definitions within the perinatal literature and underscores the problematic nature of non-parity of data.

The second main section of this chapter presents the methodological approach of the Literature Review (LR) for this study. This section also

presents clarification, and justification of, the necessity for an all-encompassing definition for the inclusion criteria of all perinatal deaths for this thesis.

The third main section of this chapter presents a critical overview of the empirical and non-empirical literature findings for this study.

The fourth main section of this chapter presents a summary of the literature review (LR) themes within a bio-psycho-social perspective. This section also identifies the gaps in research within the topic area and presents the resultant research objectives.

### **3.1 Terminological and Definitional Issues**

Whilst searching the literature within the research topic area, it was necessary to define the research terms to filter out non-relevant data. The research question was determined to be: “is there a bereavement impact on females across the life course following adolescent perinatal deaths?”. The primary terminology for any gestational or neonatal death is collectively referred to as “perinatal”, which posed many challenges for this study due to definitional inconsistency (e.g., Adolfsson, 2011; Barfield & Newborn, 2011; Hutti et al., 2013; Jones & Murphy, 2021). Therefore it was necessary to evaluate the definitional variations, and determine whether the inconsistencies were impactful to the LR.

#### ***3.1.1 Defining the Area***

All deaths (embryonic, foetal, and neonatal) for this study fall along a timeline, beginning at conception and ending at twenty-eight days post-

birth, to include all gestational and neonatal deaths (Barfield & Newborn, 2011; Broderick & Cochrane, 2013). The duration of human pregnancy from conception to birth consists of forty weeks on average (Nierenberg, 2017). The developing baby is referred to as an embryo until the eighth week of pregnancy, and from then until birth the developing baby is defined as a foetus (Nierenberg, 2017).

There are two distinct, but linked, periods that cover this timeline; firstly, the term “gestation” encompasses the entire development of the baby and is defined as “The process of carrying or being carried in the womb between conception and birth.” (Swannell, 1995, p. 115). The second period is the neonatal, defined as: “Relating to the period immediately succeeding birth and continuing through the first 28 days of life.” (Stedman, 2005, p. 44).

The death of an embryo or foetus from conception to post 28 days after birth has been categorised by the researcher as either induced or uninduced. Uninduced deaths are spontaneous, induced deaths result from intervention whether legal or illegal. The developmental stage of the baby determines the definition of death and varies from country to country. A summary of both uninduced and induced deaths are presented in Appendix 1.

### ***3.1.2 Uninduced Deaths***

Spontaneous deaths can be categorised in the following three ways depending on the gestational age of the developing baby:



1. Miscarriage: may be defined as “the loss of a pregnancy before 24 completed weeks.” (Broderick & Cochrane, 2013, p. 9).

Miscarriage is considered “early” prior to 12 weeks’ gestation, miscarriages after 12 weeks’ gestation onwards are considered “late” (Broderick & Cochrane, 2013). Whilst the definition of miscarriage remains consistent as “the loss of a pregnancy...” (Neugebauer et al., 1992, p. 1333) the determinant of gestational age ranges can vary between 20 weeks and 28 weeks depending on the country and the source of information (Kolte et al., 2015).

Stillbirth: can be defined as “a baby born with no signs of life at or after 28 weeks’ gestation.” (World Health Organization, 2017).

Stillbirth can occur intrauterine (prior to labour) or intrapartum (during labour) (Broderick & Cochrane, 2013).

2. As the age of viability for a baby has been reduced with increased medical advances, the difference between “late miscarriage” and “stillborn” can be ambiguous (Broderick & Cochrane, 2013). As a result, women find that the term miscarriage minimises their loss when the baby dies after 20 weeks’ gestation (Broderick & Cochrane, 2013).

Definitional ambiguity regarding gestational stages between miscarriage and stillbirth contributes to difficulty comparing statistics (Kolte et al., 2015). For example, in Ireland one definition of miscarriage is confined to the weight of the embryo or foetus as less than 500 grams rather than a prescribed week limit (Millett & Byrne-Lynch, 2000).

3. Neonatal Death: is unambiguously defined as the death of a baby “occurring within the first 28 days of life.” (Broderick & Cochrane, 2013, p. 26).

Miscarriage, stillbirth and neonatal deaths are collectively referred to as “perinatal” deaths. However, Appendix 1 illustrates that definitional variations exist, and that miscarriage prior to twenty weeks’ gestation is often excluded.

Appendix 1 also presents the second category detailing gestational and neonatal deaths that are induced through considered actions.

### ***3.1.3 Induced Deaths***

Each country has laws governing the legality of induced deaths (Berer, 2017). These may be conducted in a medical capacity if the law permits or may occur in an illegal manner.

Two categories of induced deaths of an embryo or foetus were identified in countries where the law permits:

1. Abortion: defined by the University of Maryland Medical Center as “the use of medicine to end a pregnancy.” (Storck, 2012). Countries vary on the maximum gestational age of the foetus for a legal abortion; “The clear norm among countries that permit elective abortion is to limit abortion to before 20 weeks gestation, and elective abortion is more commonly limited to 12 weeks (the first trimester).” (Baglini, 2014).

2. Therapeutic termination: occurs after the diagnosis of a foetal abnormality and is performed within a medical environment (Newton & Murphy, 2015).

Whilst abortions and therapeutic terminations can be undertaken by professionals within medical facilities, induced deaths can also occur illegally both via an external person or at the hand of a parent, with or without medical consultation or intervention. The deliberate killing of a foetus that has not completed full term gestation but can live independently outside of the womb is against the law in many countries, including Ireland (Baglini, 2014).

Illustrated in Appendix 1 are the four categories of induced death performed with or without external assistance:

1. Illegal Abortion: The same definition and procedure as legal abortions but carried out in countries or states that do not legally allow the procedure (Figà-Talamanca et al., 1986).
2. Child Destruction: defined as “An act causing a viable unborn child to die during the course of pregnancy or birth if the pregnancy has lasted at least 24 weeks. If carried out with the intention of causing death, and if it is proved that the act was not carried out in good faith in order to preserve the mother’s life.” (Kim, 2015).
3. Neonaticide: defined as “the killing of a child [by a parent] on the day of birth.” (Bourget, Grace, & Whitehurst, 2007, p. 74).

4. Infanticide: defined as “the killing of a child under the age of 12 months by a mother who has not fully recovered from the effects of pregnancy.” (Bourget, Grace, & Whitehurst, 2007, p. 75).

The Infanticide Act, 1949 in Ireland uses an extended variation of this definition.

### ***3.1.4 Ambiguous Definitions***

Whilst there is clarity with the categories of induced and uninduced deaths as detailed, some definitions of terminology can vary considerably depending on country or organisation. Ambiguous definitions of gestational and neonatal deaths include; miscarriage, stillbirth, feticide, and perinatal. For example, one definition of the perinatal development stage encompasses the gestational ages between 20 weeks in utero until 28 days’ post birth (Barfield, 2011). Whereas another definition of perinatal is a gestational age of 22 weeks development until 7 days’ post birth (World Health Organization, 2017).

During the extensive database searches, the terms “feticide” and “perinatal” yielded the most variety in definitions:

1. Feticide. The Medical Dictionary for the Health Professions and Nursing (2012) define the term “feticide” [foeticide] as: “destruction of the fetus”. The term is used to refer to different scenarios: legal medical procedures (Broderick & Cochrane, 2013), illegal sex selection abortions (Seth, 2007), and is used as another definition of “child destruction” to define fetal homicide in countries where there are laws prohibiting the unlawful killing of a viable foetus

(Haubursin, 2015). This term is therefore used judiciously, and with exact definition, within the thesis to avoid any misinterpretation.

2. Perinatal: this is widely used to refer to varying gestational periods:
  - Gestational age of 20 weeks until 7 days' post birth (Barfield, 2011).
  - Gestational age of 20 weeks until 28 days' post birth (Barfield, 2011).
  - Gestational age of 22 weeks until 7 days' post birth (World Health Organization, 2017).
  - Gestational age of 22 weeks until 28 days' post birth. Nguyen and Wilcox (2005) state this is the definition for international perinatal mortality statistics.
  - Gestational age of 28 weeks until 7 days' post birth (Barfield, 2011).

### ***3.1.5 Unambiguous Definitions***

Unambiguous terminology defines the specific type of death without variations, these include neonatal death, abortion, therapeutic termination, child destruction, neonaticide, and infanticide. Broderick & Cochrane (2013) define neonatal death as the death of a baby “occurring within the first 28 days of life.” (p. 26). The World Health Organization (2006) defines neonatal death as “large numbers of children die soon after birth: many of them in the first four weeks of life (neonatal deaths)” (p. 2). Medical, academic, and general information (e.g. internet sites) define neonatal as four weeks or twenty-eight days without variation (Shiel, 2018; Stedman, 2005).

Unambiguous terminology provides consistency and enables clear understanding, interpretation, and comparison of data, regardless of the source of information. Definitional parity also enables dissemination of information to be easily understood by any audience, thus reducing, or eliminating confusion. Another advantage of unambiguous terminology is reliability; research is easily replicated with clear, consistent parameters.

Definitional variation is problematic because it prevents consistency, understanding, and comparison of data and research findings. The lack of definitional parity means that, unless explicitly stated, the audience may have formed incorrect assumptions of the information presented.

A second complication of definitional variations, particularly between miscarriage and stillbirth, is that the cut off point for a miscarriage varies between countries, and with the definitional variance determined by a minute, this can influence the medical care, social enfranchisement, bereavement experience, legal implications, and public commemorative opportunities (e.g., Romanoff, 1998; Smith et al., 2020).

### ***3.1.6 Conclusion on Terminological and Definitional Issues***

Appendix 1 provides a summary of various types of deaths along the gestational and neonatal timeline, beginning at conception and ending at twenty-eight days post-birth. All terminology and definitions are either classified as ambiguous or unambiguous and all deaths can be classified as either induced or uninduced. All foetal, embryonic, and neonatal deaths were included in the research question.

### **3.2 The Creation of an Operational Definition**

Whilst investigating the literature, there did not appear to be any evidence of terminology to encompass all unambiguous and ambiguous deaths (i.e., along the timeline of embryonic, foetal and neonatal deaths) for this research. Further investigation was required to identify if there was an existing term that was not included in the literature reviewed.

#### ***3.2.1 Interrogating the Search Engines***

Technical information websites were consulted for recommendations of search engines that were the most widely used to ensure efficient searches were undertaken (National Research Council, 2005). The internet sites sampled provide either ranked by usage (numbered) lists and/or recommendations (crossed) of popular search engines. There is no information on the websites to explain how the rankings are comprised, but when compared they are broadly similar in conclusions.

From the sample chosen, the following search engines were identified as the five most popular in 2016. This was determined by averaging the popularity rankings from the internet lists and averaged. Google and Bing were universally determined to be the top two search engines used. The other three sites: AOL, Baidu, and Yahoo! were consistently in the top six and averaged as the next three popular sites.

Each of the search engines identified were interrogated with a predetermined list of search words relevant to the terminology covering all baby deaths. The terms employed within the searches were; “miscarriage”,

“stillbirth”, “neonatal death”, “perinatal death”, “abortion”, “therapeutic termination”, “child destruction”, “neonaticide” and “infanticide”.

Several searches were undertaken within each of the five search engines identified:

1. Each search term was used individually.
2. The search terms were varied with different combinations. For example, miscarriage, stillbirth and neonatal were one combination.
3. All search terms were used collectively.

To illustrate the number of search items found, or ‘hits’, the following Google search statistics are shown as an example of the magnitude of information available on the internet (correct as at 14/12/2017):

1. “miscarriage”	19,500,000
2. “stillbirth”	13,200,000
3. “neonatal death”	5,650,000
4. “perinatal death”	2,990,000
5. “abortion”	23,600,000
6. “therapeutic termination”	5,260,000
7. “child destruction”	42,600,000
8. “neonaticide”	22,700
9. “infanticide”	3,460,000

The search results with the most relevant data pertaining to the search term/s were analysed for evidence of a word that encompassed gestational and neonatal deaths from the time of conception to post 28 days. It was found that the term “perinatal” is used liberally to combine some of these



terms, and mostly without any definition. Without a definition, it is impossible to ascertain what the inclusion and exclusion criteria is for the data or information presented.

### ***3.2.2 Interrogating the Databases***

In consultation with the subject librarian for education and psychology at Trinity College Dublin, further searches of the databases available to the library were undertaken using the same predetermined list of terms. The searches were performed within specialist academic and medical journals (e.g., Scopus, PubMed, Sage) and no existing term was found. Consistent with the search engine results, it was found that the word “perinatal” is used extensively within any collective context, with varying definitions, or none.

### ***3.2.3 Clarifying the Terminology***

Language, and its meaning, have care and societal implications, particularly with regards to the definitional variations. As Davies (2020) succinctly explains: “The way it is classified feeds into the way the woman relates to it, to him or to her, and also determines how others, including the medical profession, relate to the woman.” (p. 67)

To address this problem the term “gestnatal” was defined as: “The length of time from conception and continuing through to the first 28 days of life.” The term “gestnatal” was used to construct the research instruments at inception of this study. However, on reflection, the researcher has determined the term “perinatal” could be clearly defined as inclusive from conception to 28 days post birth, without need for new

terminology. Therefore the research instruments, as detailed within the appendices, include the word “gestnatal”, wherein the thesis uses the term perinatal.

### **3.3 Literature Review Results**

Following clarification of the terminology for inclusion within the database searches for this study, the current section provides the results of the literature review (LR). As detailed in the previous section, the databases were interrogated extensively and with a dearth of literature within the research area, it was determined that the researcher was unable to conduct a Systematic Literature Review (SLR). By expanding the search, 20 published texts were identified that included journal articles, book chapters, and one booklet. The 20 publications are presented in chronological order from 1973 to 2016, followed by a critical thematic overview (see Appendix 4).

#### ***3.3.1 The Impact of Adolescent Perinatal Death Experiences***

Chapter two presented a classical overview of pertinent adolescent developmental theories, and a summary of grief and bereavement theories, from a Euro-western bioecological perspective.

#### ***3.3.2 LR Empirical Results***

The objective of this study was to explore the experiences of adolescents during, and following, a perinatal death loss from a retrospective adult perspective. Therefore, it was essential to explore the literature that exists within the parameters of the inclusion and exclusion criteria. The criteria

for inclusion of this study comprised of; must be female, must be attending secondary school, must have experienced a perinatal death, must be grief and/or bereavement focussed, and publications must be in the English language. Publications that did not meet all of the criteria set out *a priori* were excluded.

Following extensive searches of the databases, 20 accordant published results were identified that satisfied the inclusion and exclusion criteria for this study; journal articles (n = 14), book chapters (n = 4), booklet (n = 1), and an online article for a government department (n = 1). A full list can be viewed in Appendix 4 (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Fenstermacher, 2014; Hatcher, 1973; Horowitz, 1978; Joralemon, 1986; Nykiel, 1996; Nykiel, 2002; Perez-Reyes & Falk, 1973; Schodt, 1982; Sefton, 2002; Sefton, 2007; Shaefer, 1992; Soto, 2010; Tonelli, 2006; Welch & Bergen, 2000; Wheeler & Austin, 2000; Wheeler & Austin, 2001; Wheeler & Sefton, 2015).

As chapter two ascertained, contemporary death studies scholarship has evolved significantly over the past thirty years. However, the LR results suggest an absence of studies investigating adolescent perinatal losses.

### **3.3.2.1 LR Findings: Barglow et al., 1973**

Identified as the first of the LR publications that met the inclusion criteria for this thesis, Barglow et al. (1973) evaluated 31 adolescent participants who had experienced a miscarriage, neonatal death, or infant loss, within an outpatient community service programme in the US.

As a seminal publication, the Barglow et al. book chapter provides an introductory text to the medical interpretative view of African American, adolescent (13 to 19 years old), experiences of perinatal death loss. Whilst the inclusion criteria for this programme of research delineates at twenty eight days post birth, Barglow and colleagues present case studies that suggest that mourning reactions were not dependent on the age of the embryo, foetus, or baby. The authors provide supporting narratives to suggest the findings presented in chapter two that, similar to adult griever of perinatal death, adolescents can also form attachments and ascribe personhood to the gestational development of a human life (e.g. Appuhamilage, 2017; Conklin & Morgan, 1996; O'Donnell, 2019).

There were four stated purposes for their study that included; (a) determining “successful mourning” criteria; (b) ascertaining a definition for “pathological mourning”; (c) identifying what could interfere with “successful” mourning; and (d) the development of therapeutic guidelines for bereaved adolescents following a perinatal death. Their methodological approach employed two phases which included; (a) thirty one participants being “evaluated psychiatrically” via their medical, social work, academic, and nursing records; and (b) twenty patient interviews utilising a semi-structured format.

Aligning their views with Lindemann’s (1944) staged model, Barglow et al. (1973) determined the criteria for “successful mourning” was met by ten participants based on their criteria of evidencing a “progressive typical sequence of emotional reactions to the loss.” (p. 287). They

ascertained that the “stages” of grief should successfully end within a few months. Additionally, the researchers determined “successful” mourning occurs if the adolescent is capable of identifying and engaging with people who can provide emotional support.

Fourteen participants were considered to be in the “unsuccessful” mourning category based on Lindemann’s (1944) criteria which included suicidal ideation, “antisocial” acts (not defined), promiscuity, repeat pregnancy, “intense rage reactions” or leaving school prematurely. Additionally, Barglow and colleagues state they were unable to make a judgement on five of the participants.

Barglow et al. also discovered that short term denial of the death within this cohort seemed to be universal, that guilt was common but often transitory, and that twelve of the participants became pregnant again within one year of the loss. These findings were consistent with later studies (Horowitz, 1978; Welch & Bergen, 2000; Fenstermacher, 2014).

The patients who Barglow and colleagues alleged suffered the two “most severe emotional disturbances” had a history of “severe pre pregnancy psychiatric problems”. The researchers identified additional specific pre-pregnancy factors such as “school problems, intolerance to life’s everyday pressures, or minor psychic symptoms.” as contributing to maladaptive grief responses and attribute these to ego weakness common in all adolescents. These findings suggest that existing factors pre-pregnancy should be considered as contributory variables to post perinatal death response.

Barglow et al. also considered circumstances within the bioecological environment and impact on the adolescent, specifically referring to the role of the grandmother, the stigma of pregnancy whilst unmarried, and the influence of poverty. They suggested that these variables taken in isolation contribute to a normative crisis, but taken together; “constitute a crushing stress of traumatic proportions.” (p. 297). These considerations acknowledge the importance of an integrative ecological perspective, taking into account the social dynamics and cultural environment in which the adolescent females are interacting.

There were several major limitations to this study: (a) the study is not replicable; (b) the female participants were of the same race and socioeconomic status, selected from the same geographic location, the restricted demographic therefore provides insufficient basis for generalisable results; (c) the chapter is context specific to time and place; “adaptive mourning” was identified by the researchers as returning to “normal” life within a few months; and (d) most of the participants for this study were evaluated as suffering from “major psychiatric symptoms”.

The study limitations highlight gaps in the literature for more inclusive data, with a broader geographic and socioeconomic scope, within contemporary discourse.

Whilst the study provided findings on hitherto unacknowledged adolescent perinatal death loss and impact on females, the focus was limited to black girls only. When situated within the historical cultural context of the civil rights movement at that time, this may limit extrapolation of

findings to the multicultural demographic within the US. African Americans had been subject to a history of unimaginable abuse and a lack of constitutional and legal rights that Caucasian residents acquired automatically, these may have contributed to the “major psychiatric symptoms” identified by the researchers that may not be present within other U.S. demographics (Bordere, 2019; Fletcher, 2013; Laurie & Neimeyer, 2008; Osel, 2008).

Bordere (2019) provides an African American centric example of a specific type of grief termed “suffocated”; defined as the experience of normal grief reactions being penalised. She suggests that the diaspora are misinterpreted due to the Euro-centric lens within which grief and normative reactions are viewed. This perspective sheds a different interpretive focus on Barglow et al.’s determinants of normative and pathological grief responses. Bordere states African American adolescents are streamed into special education classes because following a loss their behaviour is misinterpreted as an issue to be penalised.

Whilst presenting a valuable historical insight into the experiences of adolescent African American females in the 1960s, in light of contemporary bereavement theories and knowledge, Barglow et al.’s findings can now be considered outdated.

### **3.3.2.2 LR Findings: Hatcher, 1973**

The researcher determined Hatcher (1973) as the earliest published article identified that addresses adolescent grief following elective terminations. Hatcher evaluated 13 participants psychologically within a large university

hospital. The participants were aged between 15 and 26, unmarried, middle-class, and requested an elective termination. The author does not state the ethnicity of the participants. Whilst it is acknowledged that the inclusion criteria for this study excludes adolescents who are over the age of 19, it was felt that as there was a dearth of results within the topic area, and as the first study identified that addressed grief following abortion, it warranted inclusion in the LR.

Prior to the 1973 Roe V Wade ruling that legalised termination procedures in the US, abortions were illegal and subject to approval for “therapeutic” and “nonmedical” reasons by the hospital’s abortion board. Hatcher conducted pre termination structured interviews with 13 adolescents who were seeking approval for an abortion within the hospital. Follow up interviews post termination only included six of the initial 13 participants due to varying reasons.

In conjunction with the interviews, Hatcher (1973) also administered a modified Draw-a-Person test, Six thematic Apperception cards, and Two Early Memories, both pre termination and again post termination. All of the psychometric tests were adapted to relate to pregnancy and motherhood.

In order to gain an understanding of adolescent developmental stages, Hatcher (1973) developed a scale incorporating the girl’s view of herself, behavioural measures, and relationships with others to determine if they were either correlated with the early, middle, or late adolescent



development category. The stages are not discrete, and she notes that development is on a continuum that incorporate items from other stages.

Hatcher's (1973) findings were that the developmental stage of the girl may influence many variables related to the pregnancy, termination, and loss response. She defined early adolescence between the ages of 12 to 15, middle adolescence as ages 15 to 18, and late adolescence as ages 18 to 21.

Whilst the contribution of this journal article adds valuable insight into the various stages of adolescent development and its potential effect on pregnancy and loss, the main limitation to this research is that only six participants were fully involved in the study, making it difficult to draw generalisable conclusions appropriate for a population the size of the US.

#### **3.3.2.3 LR Findings: Perez-Reyes & Falk, 1973**

This is the third journal article identified from 1973 that met the inclusion criteria for this research. This study examined girls aged between 13 and 16 years old with the aim of identifying the reasons for the pregnancy, the reasons for the decision to terminate the pregnancy, and the emotional impact. Sixty one percent of the participants in this study were Caucasian and 39% were black, with family structures distributed across a wide range of socioeconomic, and educational, backgrounds.

The methodology employed by Perez-Reyes and Falk (1973) included a pre-termination structured interview conducted with 71 girls who were seeking an elective abortion. The parents of the adolescent

participants were also interviewed separately. In addition to the interview, the girls all completed the Minnesota Multiphasic Personality Inventory (MMPI). Follow up investigations by the researchers found that of the 71 females, 10 did not subsequently have an abortion, and 20 girls either could not be located or refused to further participate in the study. The resultant 41 adolescents participated in a post termination interview, completed a questionnaire, and undertook the MMPI six months following the elective termination.

Perez-Reyes and Falk (1973) suggest there were potentially three reasons for the adolescent pregnancy; (a) the very young inexperienced “passive” girl who submits to intercourse under the pressure of the older male partner; (b) the girl who is engaged in sexual experimentation before having full knowledge of the possible consequences; or (c) the adolescent who has had a history of emotional problems, who practices intercourse as part of a pattern of behaviour to fulfil unsatisfied emotional needs. These three reasons are congruent with Hatcher’s (1973) findings of developmental phase behavioural differences. Of particular relevance to this study was the following finding:

One outstanding fact about the group was their expressed interest in proceeding with their education, and even the cases from low socioeconomic levels had aspirations of continuing their training beyond high school. (p. 123)

The authors report that the predominant emotions felt by the adolescent female participants following the abortions were guilt and depression. Additional behavioural responses experienced by the participants were narrated as; worrying, crying, anger, and anxiety. The intensity of feelings experienced by adolescent females within this study was largely confined to the immediate postoperative period in the hospital, or during the first week at home following the procedure. Perez-Reyes and Falk (1973) also report that 83% of participants were “very glad to neutral”, with 10% “Fairly Unhappy”, and a minority 3% “Very Unhappy”, explaining:

The patients who expressed regret...were girls who had been criticised by their mothers, sisters, or relatives and/or their friends who had become pregnant and had had their babies. They were mostly black and had had several illegitimate children born in their families. (p. 123)

One consideration for contemporary interpretation of this study is the absence of modern medication, and outpatient treatment, which were not available to these participants. Narratives within the article suggest that the invasiveness of early abortion medical procedures within hospitals had a significant impact on participant responses as they were reported as invasive and painful. An additional limitation to this study, from a contemporary perspective, is the possibility of socially desirable participant response: in the US abortions were legalised following Roe V Wade in 1973, however, prevailing sociohistorical and religious cultural norms

influenced societal narratives of “illegitimate” pregnancies which stigmatised adolescent females who undertook an elective termination (DiMaggio et al., 1996; Noonan, 1967; Shellenberg et al., 2011).

#### **3.3.2.4 LR Findings: Horowitz, 1978**

Horowitz (1978) sought to build on the findings published by Barglow et al. (1973) by utilising their definitions of “adaptive” or “non-adaptive” mourning as guidelines for her qualitative enquiries of 22 young women who had experienced a miscarriage or abortion.

The participants for this study were attendees of the two “special schools for pregnant teenagers” operated by the Chicago Board of Education, with a 90% black population from larger, lower income families with high unemployment rates. The demographic concentration for this study was consistent with the participants of the Barglow et al.’s (1973) study where the girls were also attendees of a service for unwed pregnant girls, also black and “most were poor”. However, in contrast to Barglow et al.’s (1973) findings, the girls in Horowitz’s (1978) study had experienced a previous perinatal death loss.

Horowitz (1978), utilising Barlow et al.’s (1973) definition for adaptive mourning, stating that less than one quarter ( $n = 4$ ) of the participants for her study completed the required sequence for adaptive mourning. For these four females adaptation was deemed satisfactory when their emotions had “subsided” following “expression” of grief. Ten of the participants were categorised as exhibiting “maladaptive” grief because they did not display evidence of mourning, and/or there was a repeat

pregnancy after the death. A further two participants were considered to have “extreme non-adaptive reactions”; with an example provided of losing the capacity to carry out normal activities and spending time alone. It is unclear if the grief reactions are attributed to the perinatal loss, a subsequent pregnancy loss, the combination of loss responses, or a multitude of other potential factors.

In contrast to Perez-Reyes and Falk (1973) and Hatcher (1973) who both report that their participants reacted emotionally, and had a sense of loss following their abortions, Horowitz (1978) states that in her study “sadness is not mentioned by any woman” (page 557).

Barglow et al. (1973) defined “pathological mourning” as someone with “inappropriate rage, guilt and depression”. Therefore, one of the limitations of this study, and of the original Barglow et al. (1973) study, are that the guidelines set out on what is “maladaptive” grief are now outdated and superseded within the US-centric literature on the definition of PGD (Bandini, 2015; Bonanno & Malgaroli, 2020; Shear & Shair, 2005).

A further limitation of these findings is that the participants had previously experienced a perinatal death loss and there is no consideration of a cumulative grief response. Twenty two participants in this study had experienced recent close relative deaths potentially “complicating” responses to the current perinatal loss, in addition to the previous perinatal loss (Feldstein & Gemma, 1995; Kaye, 2015).

### **3.3.2.5 LR Findings: Barnickol, Fuller, and Shinnars, 1986**

Barnickol et al. published a book chapter in 1986 entitled “Helping Bereaved Adolescent Parents”. Whilst not a study, the authors sought to provide their opinions on the adolescent experiences of neonatal death or Sudden Infant Death Syndrome (SIDS) death losses based on their clinical experience.

The predominant contribution the Barnickol et al. (1986) chapter makes to the literature is their assertion that society reacts in one of three ways in response to an adolescent neonatal or SIDS death loss. These are described as; (a) minimising the impact of the death by for example suggesting the female can get pregnant in the future; (b) minimising the impact of the ascription of personhood, and resultant grief impact; and (c) that society does not recognise that the female may want support in coping with the infant loss. The authors claim the societal responses to adolescent neonatal, and infant, death losses are due to the convergence of the two “taboos” of death and sex.

### **3.3.2.6 LR Findings: Welch & Bergen, 2000**

Welch and Bergen’s (2000) study examined six female experiences of adolescent stillbirths (n = 4) and neonatal deaths (n = 2). The six participants for this study were white females aged between 15 and 17 years old, and their socioeconomic status was not declared. The participants were initially interviewed at the time of the loss, then re-interviewed at two, four, six and twelve months postpartum to identify themes with the context of identity, family, peers, and bereavement support.

Welch and Bergen (2000) observed several commonalities within the participant experiences; (a) the girls felt their bodies had “failed”; (b) the grieving patterns mirrored those of adults; (c) half of the grandparents were informed of the death prior to the mother; (d) their peers attempted to support them through “partying”; and (e) although two of the six participants were provided with access to bereavement support groups, they did not attend. All participants stated that they were not provided with any bereavement information.

Of particular relevance to this study, Welch and Bergen (2000) also explored the social aspects of the adolescent experiences following a perinatal death (Lovell, 1983; Newman & Newman, 1976). The synthesis of individual, family, peer, and social responses furthers the knowledge in this research area to encompass the dynamic interactions within the bioecological system (Bronfenbrenner, 1979).

One limitation of this study is that one of the authors was the birth doula to all of the participants, and due to the intimate nature of the birth doula/birth mother relationship, there is the potential for response bias and/or interpretive bias (Kaptchuk, 2003; Nederhof, 1985; Mazor et al., 2002; Stroebe et al., 2003).

### **3.3.2.7 LR Findings: Wheeler & Austin, 2000**

Wheeler and Austin state in their 2000 publication there was little known about how adolescent miscarriage and abortion affect women “over time”. The authors pronounce that there were only three published studies on this area; Barglow et al. (1973), Horowitz (1978), and Smith, Weinman and

Malinak (1984). The Smith et al. (1984) journal article is excluded from this LR because the authors present the medical risks of adolescent pregnancy and promote adolescent use of birth control; both outside of the inclusion criteria for this study.

Wheeler and Austin published their 2000 journal article to provide information on the development of their “Loss Response List” (LRL) which is a self-report questionnaire for adolescent girls who have experienced a perinatal death. Originally developed by Wheeler in 1997, the LRL comprises of an 83 item self-report questionnaire featuring four grief response themes; physical, emotional, social & cognitive. Whilst not strictly addressing the research topic directly, this journal article is included because it encompasses the inclusion criteria of investigating the bereavement experiences of adolescents who experience a perinatal death.

Wheeler and Austin recruited 40 participants for their pilot study, aged between 13 and 19, from low socioeconomic backgrounds, who were either currently pregnant (n=17) and had not experienced a loss, or had been pregnant, and subsequently experienced a perinatal loss (n=23). The reason the authors state for selecting the two groups was to control for non-death losses described as “everyday life” events, for example; “losing a favorite piece of jewelry, anticipated grades, or break-up with a boyfriend.” (p. 25).

A further study was conducted with 164 participants to test the LRL again. This study expanded the participant experiences to (a) never pregnant; (b) pregnant; (c) pregnancy loss within the past year; and (d)



pregnancy loss in the past two years and currently pregnant. The Children's Depression Inventory (CDI) was also administered to this cohort to test construct validity for the LRL by using depression as the dependant variable (Wheeler & Austin, 2000).

Results from the Wheeler and Austin (2000) study suggest that the pregnancy loss group had higher depression scores than the never pregnant group, and that the pregnancy loss, and the previous loss and now pregnant group, had significantly higher physical grief scores than the never pregnant and the pregnant groups. The findings conclude that adolescents who have experienced pregnancy loss, regardless of a subsequent pregnancy or not, are susceptible to higher depression and grief scores. However, there were also higher scores on the grief scales of the LRL for adolescents who had experienced a significant loss in the prior two years. This disclosure raises the issue of other variables that could contribute to increased grief and/or depression scores.

One limitation of this study is apparent within their review of the previous adolescent perinatal loss literature. Wheeler and Austin assert that Horowitz (1978) reported the adolescent participants in her study "demonstrated few grief responses", whereas the published paper is clear that this statement applies to only 10 of the 22 participants. Wheeler and Austin also omit the fact that Barglow et al. (1973) identified prior psychiatric problems as a possible contributor to "complicated mourning" when they summarise this study's findings; an important contribution to be considered for the LRL.

Despite extensive searches, there is little evidence of further use of the LRL. However, Wheeler and Austin's contribution was to expand research in the topic area into an exploration of the physical and social aspects of grieving, alongside the emotional response to an adolescent perinatal death.

### **3.3.2.8 LR Findings: Wheeler & Austin, 2001/2002**

Following Wheeler and Austin's (2000) development of the LRL, the authors undertook further investigations to determine the impact of early pregnant loss during adolescence.

Utilising the same participant group, the methodology employed by Wheeler and Austin for this study was quite extensive; they employed the LRL as in previous studies, and added; The Children's Depression Inventory (CDI), Rosenberg's (1965) Self-Esteem Scale, the Family APGAR (Smilkstein, 1978) to measure family member's satisfaction with family functioning, and an adaptation of BCOS (Bakas' Caregiving Outcome Scale) (Bakas, 1995) to measure perceptions of life changes.

The researchers found that self-esteem and family relationship measures were similar across the four pregnancy status groups; never pregnant, pregnant, early pregnancy loss group, and early pregnancy loss and subsequent pregnancy group. However, as previously published in Wheeler and Austin (2000), depression & grief scores were higher in the early pregnancy loss group compared to the other three groups.

One potential limitation of administering five different psychometric tests to adolescent participants could be resultant social desirability responses or respondent fatigue (Mazor et al., 2002 & Nederhof, 1985; O'Reilly-Shah, 2017). Additionally, as detailed in chapter two, bereavement experiences all have unique bioecological aspects to them, conducting multiple quantitative tests will yield generalisable homogenous results, without the depth of qualitative narrative (Neimeyer & Hogan, 2001; Stroebe et al., 2001). A third limitation of this study is that whilst higher symptoms of depression have been identified within the perinatal loss adolescent group, the authors are unclear if these findings are linked to the perinatal death, previous bereavements, or any other contributory variables (Ritsher & Neugebauer, 2002).

This study focuses on “depression” which is adding to the body of knowledge regarding the potential impact of grief, however this is now superseded by the distinctions between “depression”, as separate from “Prolonged Grief Disorder”, and “normal” grief, in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Sefton states the purpose for the follow up 2002 study was to explore the psychosocial effects of early miscarriage (before 16 weeks gestation) with 14 Latina adolescents aged between 13 and 19 years old.

Sefton chose a small scale qualitative approach, utilising Naturalistic Inquiry, to understand the participants' interpretation of their experiences (Denzin, 1971; Lincoln & Guba, 1985). She conducted the interviews between two and five years after the miscarriage ( $m = 3.4$  years)

and as such is the only study identified for the LR that investigated adolescent perinatal bereavement experiences retrospectively.

Following the Naturalistic Inquiry analyses, Sefton (2002) identified four themes;

- (a) Confirming Wheeler and Austin's (2000/2001) findings, Sefton also found a greater risk of depression in adolescents following a perinatal death. She also found there was a greater risk of a "replacement" pregnancy; also identified by Welch and Bergen (2000). Sefton (2002) also found evidence of different phases of grief, which was earlier identified by Barglow et al. (1973) and Horowitz (1978), and also reported in Fenstermacher's later (2014) PhD research findings.
- (b) Sefton reports that at the time of the miscarriage all 14 of the adolescent girls planned to complete high school but at the time of the interviews only eight had actually graduated.
- (c) Sefton also found that a quick resumption of sexual activity was linked to participant perceptions that their mother was unsupportive.
- (d) Sefton details the most prominent relationships with the participants were those with their mothers and boyfriends. Only 10 of the girls told their mothers and boyfriends they were pregnant.

In general, the findings showed that social support and positive interpersonal relationships had a beneficial effect on the emotional health of

the participants which led to better educational outcomes and lower repeat pregnancy rates.

Sefton states that she chose the topic “based on the value that a pregnancy is a life and its loss can precipitate a strong emotional response.” Such a strong bias prior to planning and conducting the research may influence the responses via the selection of questions asked and is therefore a limitation for this study. As evidenced in previous chapters, not all females ascribe personhood to a pregnancy (Hatcher, 1973; Horowitz, 1978). Another potential limiting factor is that the participants were all Latino and the researcher is Anglo American, this may have affected the rapport building and/or communication during the interviews.

However, the major strength of this publication is that it is the first study that raises the issue of educational impact and stresses the importance of social supports following these events.

### **3.3.2.9 LR Findings: Sefton, 2007**

Sefton (2007) re-interviewed the same 14 female participants from her 2002 study that investigated the experiences of early miscarriage by Latina adolescents. She subsequently re-interpreted the data utilising Sanders’ (1999) Integrative Theory of Bereavement (ITB).

The first stage of the ITB identifies variables present prior to death which are not explored within the Sefton (2007) study. The second stage of the ITB follows a staged approach to grief that incorporates; (a) Shock; (b) Awareness of Loss; (c) Conservation-Withdrawal; (d) Healing; and (e)

Renewal. It is this staged approach that Sefton utilises to interpret the narratives from the re-interviews to determine if the participants had “resolved” their grief in a healthy manner. She states that the participants all demonstrated some evidence of a staged sequence of bereavement that conforms with Sanders’ (1999) framework.

The third stage of the ITB determines three bereavement outcomes: (a) Psychosocial Growth; (b) No Substantial Change; and (c) Adverse Change – Prolonged Grief. Whilst Sefton assessed eight participants as grieving in a “healthy manner”; consistent with psychosocial growth, she assessed two participants as unaffected by the miscarriage, and she determined the remaining six participants were adversely affected. These results are somewhat misleading because the numbers add up to 16 but the number of stated participants were 14.

#### **3.3.2.10 LR Findings: Fenstermacher, 2014**

Fenstermacher (2014) conducted interviews with eight unmarried, black women between the ages of 16 and 21, who had experienced a perinatal death which she defined as; miscarriage, stillbirth or neonatal loss within the first 28 days of life. She conducted three interviews; the first interview was undertaken immediately after the death, the second interview was conducted six to nine weeks post death, and a third interview was undertaken twelve weeks post death.

Utilising Grounded Theory (Corbin & Strauss, 2008), Fenstermacher identified the following staged process experienced by black adolescents following a perinatal loss:

1. Surprised by unintended pregnancy
2. Accepting the pregnancy
3. Suffering through the loss
4. Emotional turmoil
5. Reaching out for support
6. Preserving the memory
7. Searching for meaning
8. Gaining new perspective on life

One of the limitations to this study is that all participants were referred to the study via the bereavement counselling service as a convenience sample. There are two potential limitations to this recruitment method for this subject area: (a) adolescents referred from one hospital department to another may provide socially desirable, or false positive, responses to the interview questions (Nederhof, 1985); and (b) overrepresentation of similar narratives have been identified as a disadvantage of purposive sampling (Lyons & Coyle, 2021).

Another potential limitation to this research is that the researcher is white and the participants are black. As mentioned previously in this chapter, the US has historical cultural and power differentials between the two demographics that may have influenced participant responses (Bordere, 2019).

An additional concern with this study is the identification of a sequential phased linear process as prescriptive (Corr, 2019; Hall, 2014). As discussed in chapter two, “stage”, “phase”, or “process” models of grief

were identified historically as common to bereaved people (e.g., Lindemann, 1944; Kubler-Ross, 1969; Worden, 1983; Rando, 1984). However, multiple scholars have refuted the universal applicability of stage/phase/process models of grief, and contemporary Euro-Western models and theories provide substantial bio-psycho-social perspectives to counteract unidirectional narratives (e.g., Birrell et al., 2020; Corr, 2019; Davies, 2017; Hall, 2014; Holloway, 2007; Stroebe & Schut, 1999; Woodthorpe, 2017). However, the thematic findings do provide support for Gillies & Neimeyer's Model of Meaning Reconstruction (2006), which is represented in stage seven.

### **3.4 LR Non-empirical Findings**

This section presents a summary of the non-empirical LR findings related to the impact of adolescent perinatal bereavement. The database searches yielded five journal articles, three book chapters, one website article and one booklet. The results are summarised in chronological order in Table 4 on the next page:



**Table 4***Summary of Non-Empirical Publications*

Author, Year and Title	Focus
Schodt, C. M. (1982). Grief in Adolescent Mothers After an Infant Death. <i>Image</i> , 14(1), 20-25.	This nursing article explored general grief theory. Schodt mentions Barlow et al. (1973), and identifies the need for research in this area, but has not undertaken any research herself.
Barnickol, C. A., Fuller, H., & Shinnors, B. (1986). Helping bereaved adolescent parents. <i>Adolescence and death</i> , 132-147.	This is a book chapter by nurses who have clinical experience of working with adolescents following a neonatal and SIDS death. Barnickol, Fuller and Shinnors reference Schodt (1982) but not any previous or empirical publications. Barnickol et al. make generalisable statements but provide no statistical evidence or references for their statements. However, they do state that grandparents are often making funeral or medical decisions, which supports Welch & Bergen's (2000) findings of role ambiguity.
Joralemon, B. (1986). Terminating an Adolescent Pregnancy: Choice and Loss. <i>Adolescence and death</i> , 132-147.	This is a book chapter by a nurse providing advice on pregnancy during adolescence, the abortion experience, and the bereavement experience. Joralemon presents her opinions based on her work experience and there are no references to other publications.
Bright, P.D. (1987). Adolescent Pregnancy and Loss. <i>Maternal Child Nursing Journal</i> , 16(1), 1-12.	This is a nursing journal article that mainly discusses adult losses and uses one adolescent case study to illustrate her clinical experience.
Shaefer, S. J. (1992). Adolescent pregnancy loss. A school-based program. <i>The Journal of school nursing: the official publication of the National Association of School Nurses</i> , 8(2), 6-8.	This is an article in a nursing journal discussing adolescent pregnancy as a "problem". In common with the other empirical articles presented in this table, she also makes generalised statements based on her work experience.
Nykiel, C. (1996). Working with the Bereaved Adolescent Mother: Challenges, Lessons, and Guidelines. <i>WISSPers</i> , 3(1).	This is an article published on a website by a nurse. Whilst pastoral in tone, she makes generalised statements about "deep grief" following all abortions and states "facts" without references.
Nykiel, C. (2002). <i>After the Loss of Your Baby: For Teen Mothers</i> . Omaha, NE: Centering Corporation.	This is a booklet produced by the nurse that authored the website article detailed above. The booklet was published to provide information to bereaved adolescents after a perinatal or infant death. It details the phases of grief and provides advice that Nykiel determined could be helpful to bereaved young people.
Tonelli, M. (2006). Perinatal loss and Adolescents. <i>Journal of Pediatric Adolescent Gynaecology</i> , 19, 247-248.	This is a very short article written by a nurse who makes varying suggestions on how to support bereaved adolescents based on the Nykiel, 2002 booklet.

<p>Soto, M. (2010). Anticipatory Guidance: A Hospital-Based Intervention for Adolescents with Perinatal Loss. <i>Child and Adolescent Social Work Journal</i>, 28(1), 49-62.</p>	<p>This is a journal article written for social workers working in hospitals offering advice on how to support adolescents following a perinatal death. She suggests assessing the meaning of the loss. She suggests from her experience that there are three types of adolescent in this cohort: 1. The griever 2. The ambivalent and 3. The one that doesn't acknowledge the loss. She also quotes Horowitz, 1978 and Wheeler &amp; Austin, 2001 in stating that adolescents are susceptible to repeat pregnancies.</p>
<p>Wheeler, S., &amp; Sefton, M. (2015). Early pregnancy loss during adolescence. <i>Perinatal and Pediatric Bereavement in Nursing and Other Health Professions</i>. New York, NY: Springer Publishing Company, 137-57.</p>	<p>This is a chapter of a book that broadly talks about their research as described earlier in this Chapter.</p>

### 3.5 Rationale for Literature Review Themes

This section details the rationale for the categorisation of the LR publications identified that meet the inclusion criteria for this study (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Fenstermacher, 2014; Hatcher, 1973; Horowitz, 1978; Joralemon, 1986; Nykiel, 1996; Nykiel, 2002; Perez-Reyes & Falk, 1973; Schodt, 1982; Sefton, 2002; Sefton, 2007; Shaefer, 1992; Soto, 2010; Tonelli, 2006; Welch & Bergen, 2000; Wheeler & Austin, 2000; Wheeler & Austin, 2001; Wheeler & Sefton, 2016).

Due to the modest number of relevant publications identified following the database searches, identification of recurrent themes was challenging. The researcher therefore determined that consistency within the thesis should be apparent and undertook to synthesise the findings within the bio-psycho-social context. Categorisation of the LR therefore entailed identifying themes within the publications that aligned with the bioecological framework (Bronfenbrenner, 1979).

### ***3.5.1 Theme One: Individual***

This section highlights the central focus of the bioecological system: the individual (Bronfenbrenner, 1979; Mc Guckin & Minton, 2014; Tudge et al., 2009). Firstly, the individual biological elements; age of participants, ethnicity of participants, and type of perinatal or infant death within the 20 publications for the LR are detailed. Secondly, the individual behavioural themes from the LR were identified as: adolescent contraceptive use, adolescent mental health, adolescent identity, repeat pregnancies, adolescent attitude to education, and bereavement responses to the death.

#### **3.5.1.1 Individual Biological**

The 20 salient publications derived from the database findings included studies that investigated the adolescent responses to a perinatal death loss that spanned adolescence from 12 years old to 21 years old. Whilst adolescents not attending secondary school are excluded from this study, the dearth of LR findings necessitated examining all studies identified because they incorporated participants relevant for this study.

In addition to the age of the participants, the ethnicity of the participants, and the type of perinatal death experienced by the participants were also detailed in some of the publications, but not all. Nine of the journal articles identified within the LR stated the ethnicity of the participants as follows; (a) two studies investigated African American participant experiences (Barglow et al., 1973; Fenstermacher, 2014); (b) one study investigated black (40%) and white (60%) participant experiences; (c) three articles report on Latina experiences (Sefton, 2002;

Sefton, 2007; Soto, 2010); (d) one journal article states participants are “nearly all black” (Horowitz, 1979); (e) one study declares a “multiracial” sample (Wheeler & Austin, 2000); and (f) one study reports a 60% white participant sample but does not declare the ethnic group/s of the further 40% (Wheeler & Austin, 2001).

Vague terms such as “infant death” and “baby loss” made it impossible to ascertain if the study met the inclusion criteria for the LR but were included as the publications also included perinatal death. The 20 publications detailed the type of death as: (a) one book chapter defined the deaths as miscarriage, stillbirth, and infant death up to 2 months post birth (Barglow et al., 1973); (b) one book chapter and two journal articles investigated elective terminations (Hatcher, 1973; Joralemon 1986; Perez-Reyes & Falk, 1973); (c) one journal article defined the deaths as abortion, miscarriage, or “other infant or fetal loss” (Horowitz, 1978); (d) one journal article defined the deaths as “infant death” (Schodt, 1982); (e) one book chapter defined the deaths as “neonatal and SIDS” (Barnickol et al., 1986); (f) one journal article stated "pregnancy loss' is defined as abortion, miscarriage, stillbirth, and neonatal death (Bright, 1987); (g) one journal article defined the deaths as "pregnancy loss or baby death” (Schaefer, 1992); (h) one blogpost defined the scope of the article as encompassing infant death, stillbirth, miscarriage, ectopic pregnancy, abortion deaths, and adoption as a loss event (Nykiel, 1996); (i) one journal article investigated the experiences post stillbirth and neonatal death (Welch & Bergen, 2000); (j) one journal article used the term “perinatal” without providing a definition (Wheeler & Austin, 2000); (k) one journal article investigated

miscarriages and abortions (Wheeler & Austin, 2001); (l) one booklet encompassed information proffered on ectopic pregnancy loss, miscarriage, stillbirth, neonatal death, infant death, and Sudden Infant Death Syndrome (SIDS) (Nykiel, 2002); (m) one study investigated the experiences of miscarriages of 4-14 weeks' gestation (Sefton, 2002; Sefton, 2007; Wheeler & Sefton, 2016); (n) one paper stated a perinatal loss is defined as an induced abortion, or a foetal loss, and that the author had also included miscarriage experiences (Soto, 2010); (o) Fenstermacher (2014) defined "perinatal" as miscarriage, stillbirth, or neonatal; and (p) Tonelli (2006) did not define their use of the term "perinatal".

### **3.5.1.2 Individual Behavioural**

The publications identified from the database searches were authored by medical professionals (n = 16) or published by professionals investigating experiences within a medical environment (n = 4). The central focus of all 20 centered on the behavioural responses, predominantly grief, exhibited by the adolescent participants at the time, or immediately following, the perinatal death.

There was some evidence of additional individual behavioural themes from the LR which were identified as: adolescent contraceptive use, adolescent mental health, adolescent identity, repeat pregnancies, and adolescent attitude to education (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Fenstermacher, 2014; Hatcher, 1973; Sefton, 2002; Shaefer, 1992; Welch & Bergen, 2000; Wheeler & Austin, 2000).

### *3.5.1.2.1 Adolescent Contraceptive Use*

A consistent theme across this thesis are the context-dependent connections illustrating how the social environment has a relational impact on individual behaviour (Bronfenbrenner, 1979). One example of these dynamic interactions, within the microsystem, considers female adolescent contraceptive use, and risky sexual behaviour, and how they have been associated with factors related to family environments, peer networks, partner influence, contraceptive accessibility, and age of individual (e.g. Hatcher, 1973; Manlove et al., 2008; Whitley & Schofield, 1985; Li et al., 2020).

As chapter one detailed, within Western societies, where contraception is accessible to most individuals, many adolescent pregnancies are not planned or prevented (e.g. Furstenberg, 1976; Santelli & Melnikas, 2010; Zelnick & Kantner, 1980). Research suggests that 82% of pregnant adolescent girls had either not considered the possibility that they might conceive or, for those that are aware of the risks, they proceed believing that pregnancy would not happen to them (Alberts et al., 2007). Additional studies report that contraceptive failure is high with adolescents through either misuse or “unpreparedness”, with older adolescents reportedly more likely to use contraception (Aquilino & Bragadottir, 2000; Marcia, 1966; Moore & Rosenthal, 2007; Whitley & Schofield, 1985).

Within the LR, Hatcher (1973) determined that the use of contraceptives by adolescent girls was largely influenced by the stage of development. She stated that early adolescents fail to use contraception due

to a lack of planning and denial of responsibility. Hatcher furthered her argument by stating that mid adolescents have the relevant information and understanding of contraceptive responsibility but blame others for their lack of use. Finally, late adolescents, according to Hatcher, are aware that the pregnancy is their responsibility. Welch & Bergen (2000), however, attribute lack of contraceptive use only to poor decision making.

This study therefore sought to confirm/refute Hatcher's (1973) hypothesis that contraceptive use is age determined. Additionally, this study sought to also ascertain if participants spoke to their parents about relationships and sex, where the participants obtained their most important source of RSE information was derived, and, where relevant, the reasons why the participants did not use contraception, i.e. was the pregnancy planned (e.g. Manlove et al., 2008; Whitley & Schofield, 1985; Li et al., 2020).

#### ***3.5.1.2.2 Adolescent Mental Health***

Many studies have been published detailing the influence of events during childhood development and their impact on adolescent mental health (e.g. Abdinasir, n.d.; Galván, 2017; Lynam et al., 2018; McCrory, 2021; Silvers et al., 2012; Trickey & Black, 2000; Trickey et al., 2012).

Barglow et al. (1973) specifically sought to investigate the psychiatric health of adolescents following miscarriage, stillbirth, and infant death. The authors reported that most of the adolescents included within their investigation had a history of "severe" psychiatric problems which included; "intolerance to life's everyday pressures" (p. 293). This study

was conducted within a US medical facility for unwed pregnant girls in the 1970s wherein the framework for “maladaptation” following the death loss was the inability to “successfully” complete the stages of bereavement within a few months. The researchers reported “pathological” mental health issues that included psychosis, “acting out”, depression, anxiety, guilt, leaving school prematurely, and promiscuity. Moreover, they also state that adult women have no significant psychiatric difficulties following stillbirth, arguing that teenagers must have; “prepregnancy ego weakness” (p. 293). Barglow and colleagues also identified prior psychiatric problems as a possible contributor to “complicated mourning”; an important variable that was considered within this study.

Situating this chapter within the appropriate sociohistorical context is an important determinant of assessing the Barglow et al. (1973) chapter for its usefulness to the current study. The researcher would argue that grief, and mental health, information has significantly advanced since the publication of their findings almost fifty years ago. Moreover, the author positionality of selecting psychiatric patients for examination from a psychiatric perspective might have introduced selection, and investigative, bias (Nederhof, 1985).

Wheeler & Austin (2001) report from their study of 164 adolescent females that the early pregnancy loss group (before 20 weeks’ gestation) indicated higher depressive scores than the never pregnant group, the pregnant group, and the early pregnancy loss and subsequent pregnancy group. They further expand; “Adolescents who had more physical,



emotional, social, and cognitive grief responses were more depressed” (p. 157). Thereby raising the question of whether the adolescents were grieving normatively or if the researchers were imposing the medical, American cultural interpretation of pathological grieving as “depression”. As chapter two detailed, one example of contributors to depression, and poor mental health, during adolescence are the impact of Adverse Childhood Experiences (ACEs). Trickey and Black (2000) suggest that even minor trauma during childhood, and adolescence, can lead to negative psychological manifestations that include emotional, behavioural, and cognitive, both immediately and across the lifespan. Further, Fry & Elliott (2017) state that a fifth of women worldwide have reported being victims of child sexual abuse (with an unknown quantity unreported) and that this violence is associated with reproductive and mental health issues.

Following the lack evidence of research from the LR into mental health issues prior to perinatal death loss during adolescence, this study sought to explore the perception of mental health prior to the pregnancy, as retrospectively determined by the adult participants, to seek a baseline of knowledge on whether there may be underlying vulnerabilities that contribute to post loss response. Following the antiquated findings from Barlow et al. (1973) this study also sought to examine the loss responses utilising the Perinatal Grief Intensity Scale (PGIS). The results provide an indication of the prevalence of Prolonged Grief Disorder (PGD), normative adjustment and Post Traumatic Growth (PTG), and if there may be any correlation between prior mental health and grief response (Boelen & Prigerson, 2012; Calhoun et al., 2010; Hutti et al., 1998).

### *3.5.1.2.3 Adolescent Identity*

Chapter two presented a parsimonious classical summary of salient theories pertinent to adolescent development, detailing the connection between biological changes and psychological development within individuals. These interlinked maturational developments contribute to identity creation, independence from parental control, and the assumption of adult responsibilities (e.g. Bandura, 2001; Erikson, 1950; Marcia, 1966; Newman & Newman, 1976; Piaget, 1932).

As identity formation, and identity recreation, has been highlighted as a central task of adolescence, the advent of pregnancy, and subsequent perinatal loss, may affect this process. Bright (1987) directly addressed this statement by stating that adolescent pregnancy may interfere with identity creation during this developmental phase.

The assignment of personhood to a pregnancy and potential self-identification as “bereaved mother”, was discussed in chapter two. Euro-Western social discourse has increasingly referred to women who have experienced a perinatal death as “bereaved” mothers (e.g. Cullen et al., 2017; Layne, 1990; Miscarriage Mummies, n.d.; Mostrenko, 2020).

The LR review findings also identified that authors of the publications assigned “mother” status to the participants. Whilst Sefton (2002) and Fenstermacher (2014) suggest adolescents identify as bereaved parents immediately following a perinatal loss, Hatcher’s (1973) findings were more nuanced and motherhood identity was dependent on the adolescent’s age at the time of the event. She stated that early adolescents

call the pregnancy “it” and is: “too tied to her own mother to conceive of herself in that role” (p. 63). Hatcher also suggested that middle adolescents fantasise about motherhood but that they struggle to visualise themselves as parents. Conversely, Hatcher (1973) stated that late adolescents ascribe parenthood to the pregnancy, have genuine maternal feelings towards it, eagerly anticipate becoming a mother, and have more realistic views on what motherhood entails. Welch and Bergen (2000) state that identity creation, particularly regarding “mother” status, is obfuscated by medical professionals who inform the grandparents of the perinatal death before the mother.

This study therefore sought to confirm/refute Hatcher’s (1973) assertion that personhood, and related identity as bereaved parent, are related to the adolescent stage at the time of the death. As all authors referred to the adolescents as mothers, or parents, this study also sought to ascertain how, and if, identity status related to the perinatal death i.e. “bereaved mother” was constructed or reconstructed over the lifespan by the women themselves. Additionally, the researcher notes there is no indication in any LR publication of whether the females had been consulted before parental identity had been conferred by the authors following an adolescent perinatal death.

#### ***3.5.1.2.4 Adolescent Repeat Pregnancies***

A recurring theme within the LR findings was the suggestion that females who experienced a biological perinatal death became pregnant again during adolescence (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987;

Horowitz, 1978; Schodt, 1982; Sefton, 2002; Welch & Bergen, 2000; Wheeler & Austin, 2001). Early studies such as Barglow et al. (1973) suggest that “exaggerated self-destructive acting out” was a “criterion of inadequate mourning” (p. 290) within which repeat pregnancies were included. The authors proposed that adolescent females become pregnant following a perinatal death to avoid accepting the reality of the death and to reclaim their identity as “mother”. Narratives of replacement pregnancies to avoid “letting go” of the biological death mirror bereavement theories of acceptance and “moving on” of the same historical era (Barglow et al., 1973; Bright, 1987; Horowitz, 1978; Freud, 1917; Lindemann, 1944; Schodt, 1982).

Later studies, such as Wheeler and Austin (2001), suggest that the early pregnancy loss group has higher grief and depressive scores than other adolescent control groups, including the early pregnancy loss and subsequent pregnant group. These findings might support earlier suggestions that repeat pregnancies are attempts to circumvent the grieving process.

This study therefore sought to confirm/refute Barglow et al.’s (1973) assertions that repeat pregnancies were a response to the inability to grieve for the perinatal loss, and later assertions that repeat pregnancies were attempts at avoiding the normative, adaptive, bereavement process (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Horowitz, 1978; Schodt, 1982; Sefton, 2002; Welch & Bergen, 2000; Wheeler & Austin, 2001).

### ***3.5.1.2.5 Adolescent Attitude to Education***

Studies on adolescent grief, and related school experiences, have previously focused on parental, sibling, or peer death (e.g. Balk, 1983; Gray, 1987; Hogan et al., 1994; Lynam et al., 2018; McGovern & Tracey, 2010; O'Brien, 2015). Chapter two details how adolescent bereavement affects many aspects of identity formation, school experiences, family life, peer relationships, and overall mental and physical health (Corr & McNeil, 1986; Fleming and Adolph, 1986). The existing literature suggests that the death of a significant attachment during childhood and adolescence, and adjustments throughout the bereavement process, can therefore potentially impair “normal” adolescent development (Balk, 1991; Corr & McNeil, 1986; Dyregrov, 2008; Fleming & Adolph, 1986). Further, research suggests that following a death during adolescence, concentration levels can be impaired and intrusive thoughts can preoccupy pupils in school (Balk, 1983; Hogan et al., 1994). Bereavement experiences during adolescence may therefore contribute to poor school performance and lower school attendance (e.g. Balk, 1983; Gray, 1987; Hogan & Desantis, 1994; Lynam et al., 2018; McGovern & Tracey, 2010; O'Brien, 2015).

Within the LR, only one publication identified poor school performance as a risk factor following a perinatal death during adolescence (Shaefer, 1992). However, a limitation to Schaefer's journal article is that it provides her personal opinion on how to “intervene” in the adolescent's bereavement process in order to “support” the girl. There is no evidence provided of collaborative or investigative enquiry with the adolescent female participants to support the negative school outcome narrative.

Additionally, Shaefer suggests that adolescents who do not deliver a viable human may believe that their career options are limited due to the “unsuccessful” event. Conversely, Sefton (2002) refutes the “unsuccessful” narrative stating that all the participants of her study planned to finish High School.

Perez-Reyes and Falk (1973) interviewed the parents of participants who had experienced an adolescent abortion. The parents stated there was an improvement in the girls maturity following the experience, that they were more considerate, that they were studying more, had increased grades, and that they were making more friends.

Due to the disparities in reported findings, this study therefore sought to explore the perception of educational attitude prior to the pregnancy, as retrospectively determined by the adult participants, to seek a baseline of knowledge of whether there may be underlying vulnerabilities that contribute to poor post loss educational response or if post event growth is prevalent. This study also sought to confirm/refute Shaefer’s (1992) suggestion that the adolescent who is unsuccessful at producing a viable infant may believe she now has no career options. This study also sought to ascertain educational attainment post adolescent perinatal loss following Sefton (2002)’s assertion that participants report their intention to complete secondary education, and further, to provide a foundational knowledge of the potential for post traumatic growth (Büchi et al., 2007; Krosch & Shakespeare-Finch, 2017; Tedeschi et al., 1998).

### ***3.5.1.2.6 Adolescent Bereavement Response***

The universal theme that encompassed 19 of the 20 LR publications was the determinant of a grief response immediately following an adolescent perinatal death. Within the texts, medical professionals, and professionals investigating experiences within a medical environment, predominantly focus on biological, and psychological, grief responses for example fear, depression, guilt, ambivalence, confusion, denial (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Fenstermacher, 2014; Horowitz, 1978; Joralemon, 1986; Nykiel, 1996; Nykiel, 2002; Perez-Reyes & Falk, 1973; Schodt, 1982; Sefton, 2002; Sefton, 2007; Shaefer, 1992; Soto, 2010; Tonelli, 2006; Welch & Bergen, 2000; Wheeler & Austin, 2000; Wheeler & Austin, 2001; Wheeler & Sefton, 2021).

However, as grief and bereavement theories have evolved over time, there is little evidence that the LR findings have broadly similarly evolved. Appendix 6 illustrates the development of significant Euro-Western grief theories and the correlating LR publications' citations. For example, Fenstermacher's (2014) article disseminating her PhD findings, from interviews with eight black adolescent females who experienced miscarriages, includes her model that incorporates; "Preserving the Memory and Maintaining Relationship" but does not mention or reference Klass's (2006) seminal paper on continuing bonds. Further, her paper, written from a medical perspective, provides a staged process model that is reminiscent of historical theoretical perspectives (e.g. Lindemann, 1944; Bowlby, 1961; Parkes, 1972). A second example is provided by Wheeler and Sefton's

(2016) chapter on adolescent perinatal bereavement that only references two general bereavement theories (Doka, 1989; Sanders, 1989).

The construct for Horowitz's (1978) study investigating adolescent females who experienced abortions (n = 20) and miscarriages (n = 21) was devised from the Barglow et al. (1973) structural design. Based on the same rigid, prescriptive, mourning criteria, Horowitz (1978) found less than one quarter seemed to complete a sequence of adaptive mourning responses, reflecting Barglow et al.'s earlier findings. However, notably, 20 of the participants had also experienced other significant close relative deaths prior to the event. Additionally, all of Horowitz's (1978) participants had experienced a previous miscarriage or abortion.

More recently, Fenstermacher (2014) reports that all eight African American participants for her study experienced a staged process. These findings are accompanied by a proviso that despite the linear presentation, both within the text, and within the model, that the stages may not occur on a linear timeline. The author has, however, failed in the journal article to acknowledge the potential for interpretive error. For example, Kübler-Ross (1969) in her book *On Death and Dying* explicitly stated that her observations of the process individuals experience following a terminal diagnosis are not linear. Nonetheless, since its publication over 50 years ago both academics and lay people have continually presented Kübler-Ross's work as pre-determined steps that suggest pathological response if they aren't experienced or followed in order (Corr, 2019; Hall, 2014). The



potential for Fenstermacher's (2014) model to be interpreted as a staged, linear, process is therefore high when considered within antecedents.

Expansion from the purely biological, psycho-social bereavement narratives appeared within the LR in 1986, with Barnickol et al. explicitly acknowledging adolescent behaviour following a perinatal death loss. The authors state: "Emotional injury at this point in development may last a lifetime unless there is skillful intervention, since self-destructive behavior such as drug usage, alcohol abuse, and acting out is quite common as a mode of resolving grief among teenagers" (p. 141). However, as O'Brien (2015) counters, debates have arisen pertaining to the unproven assumptions regarding negative behaviour following child and adolescent bereavement and cites Harrington and Harrison (1999) as evidencing unproven negative impact myths.

Expanding earlier knowledge, Wheeler and Austin (2001), in their article examining 164 adolescents who had experienced an abortion or miscarriage, state that healthcare clinics should be aware that girls with physical complaints may actually be exhibiting symptoms of grief related to an earlier pregnancy death. Thus explicitly acknowledging the mind body connection hitherto missing in the Euro-Western biological grief narratives (Kabat-Zinn, 1990).

Further contributing to the psycho-social integrative narrative, Sefton's (2002) re-interviews of 14 women, two to five years post miscarriage, revealed themes encompassing the emotional, cognitive, behavioural, and interpersonal, thus confirming that general bereavement

narratives are also applicable to those experiencing perinatal grief (e.g. Doka, 1989; Martin & Doka, 2000; Prigerson & Jacobs, 1997; Stroebe & Schut, 1999). Sefton suggests that participant emotional responses to the death were varied in both duration and intensity, with the majority considering the miscarriage an attachment loss. Consistent with general bereavement outcomes across a spectrum (see chapter two), she also reports that the majority of women had experienced a normative grief adjustment over the year following the perinatal death, with a few participants showing signs of depression or PGD. Sefton's psycho-social findings therefore support earlier normative grief adjustment narratives provided by Wheeler (1997) and Wheeler & Austin (2001) thus furthering the argument for an integrative approach to understanding adolescent perinatal bereavement experiences. Moreover, Sefton utilised Sanders' (1999) Integrative Theory of Bereavement (ITB), a theory that incorporates existing variables pre-death, the bereavement experience as a sequential, non-linear, process, and also measures outcomes on a scale (see Figure 5). Using the criterion provided by Sanders, Sefton determined that of the 14 participants in her study, eight women were assessed as having resolved their grief in a healthy manner and subsequently experienced psychosocial growth, with the resultant six women exhibiting some attributes of adverse change.

This study therefore sought to integrate contemporary Euro-Western bereavement theories, from a bio-psycho-social positionality, within the research design to better understand the adolescent experiences from adult retrospective perspectives (see Appendix 5). Secondly, this study also sought to confirm/refute Sefton's (2002) findings that bereavement

outcomes following an adolescent perinatal death either manifest as PGD or PTG.

Nineteen of the publications found during the LR assume, or suggest, grief is omnipresent following an adolescent perinatal death loss, however, adult perinatal evidential research suggests that grief is positively correlated with perception of personhood, and socially mediated narratives (e.g. Conklin & Morgan, 1996; Layne, 2000; Withycombe, 2018). Therefore this study utilised the PGIS, for the first time, to ascertain if grief could be measured retrospectively within in an adult cohort, to determine bereavement outcomes following an adolescent perinatal death, and to partially mitigate socially desirable response bias and researcher bias (Hutti et al., 1998).

Furthermore, the LR publications do not consider contemporary Euro-Western general bereavement and grief models as applied to adolescent perinatal death, so this study sought to ascertain impact within contemporary discourse (e.g. Birrell et al., 2020; Corr, 2019; Davies, 2017; Hall, 2014; Klass & Steffen, 2017; Lynam et al., 2018; Milman et al., 2019; Stroebe & Schut, 2010).

### ***3.5.2 Theme Two: Microsystem Themes***

This section explores the microsystem themes within the nested system closest to the developing adolescent individual. An ecological understanding of development incorporates consideration of the influence of, and transactions with, culture, subculture, and sociohistorical factors on interpersonal processes across the lifespan (Bronfenbrenner, 1995; Vélez-

Agosto et al., 2017). The nested system within the immediate social environment is the microsystem, within which particular relationships are influential on adolescent development. These are namely; familial relationships, peer relationships, and teacher relationships.

### **3.5.2.1 Family Themes**

Chapter one detailed particular social contributors to adolescent pregnancy, which included having a mother who gave birth as a teenager, belonging to a social group with young mothers, and being raised by a single parent (e.g. Hudson & Ineichen, 1991; Moore & Rosenthal, 2007; Presser 1974; Ross & Sawhill 1975; Santelli & Melnikas, 2010; Smid et al., 2014; Tressell, 1988; Zelnik et al. 1981). Additionally, addressed in chapters one and two, are the significance of familial relationships, peer relationships, and other relationship bonds within the nested systems, and how they contribute to the adolescent female's identity creation and self-esteem (e.g. Ainsworth et al., 2015; Bonell et al., 2003; Bowlby, 1969; Trickey & Black, 2000).

In common with the theory and evidence provided within chapters one and two, the influence of the mother on developing adolescent females was prevalent across the LR publications (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Hatcher, 1973; Perez-Reyes & Falk, 1973; Sefton, 2002; Welch & Bergen, 2000). However, the authors present varying discourse regarding the type of interactions, and convergent views, on the interactions within the mother/daughter dynamic when experiencing pregnancy and perinatal loss. There were broadly two themes identified; (a) there was tension between the mother and adolescent daughter due to

the adolescent pregnancy; or (b) there was an identification and creation of a unifying bond centered on a motherhood identity.

Specifically, six of the publications suggested struggle, or marked tension, between the mother and the daughter as a result of the pregnancy (Barglow et al., 1973; Barnickol et.al, 1986; Hatcher, 1973; Sefton, 2002; Welch & Bergen, 2000). The authors reported that the pregnancy created tension within the mother/daughter relationship and that the mothers were perceived by the adolescents to be unhelpful following the perinatal death loss. As Barglow et al., (1973) explain: “after delivery and child loss the struggle with the mother seemed to become revitalized. This dynamic might explain why mothers were found not to be of much help to our girls with mourning work.” (p. 295). Hatcher (1973), however, states that getting pregnant is an act of rebellion against the mother and that this behaviour is competition with the mother for the father’s attention. Mother/daughter tension was explained by Sefton (2002) as anger over the initial pregnancy and Welch and Bergen (2000), and Barnickol et al. (1986), further extrapolate that tension arose due to medical professionals informing the grandparents of the death prior to the mother.

Perez-Reyes and Falk (1973), following their study of adolescent abortion, were more nuanced. The authors considered the perspectives of both the parents and the adolescents. They report that the parents they interviewed stated that there was an improvement in their daughter’s behaviour and educational attainment post event. However, whilst the parents were reporting improved behaviour, they found that 20 of the 41

participants declared poor relationships with their parents, with the mother/daughter relationship particularly prone to hostility, confirming the findings of the previous detailed studies.

Conversely, Bright (1987) suggests that during adult pregnancy there is an identification, and bonding, with the mother that resolves past mother/daughter conflicts. She also suggests that the daughter utilises her new “mother” identity to fully complete the psycho-social identity tasks to successfully transition into independent adulthood. She also suggests that during adolescence, as the sense of self is vacillating, the pregnancy heightens the girl’s sense of vulnerability so the converse may happen, i.e. that the pregnant state may interfere in successful completion of the adolescent task of identity development. Thus, Bright suggests that adolescent pregnancy, and resultant perinatal death, may contribute to a thwarting of adolescent developmental task completion which contributes to mother/daughter tension.

More expansive family narratives, within the LR, included two journal articles. The first by Wheeler and Austin (2001) found adolescent participants with higher grief responses, following miscarriage or abortion, also relayed less satisfaction with family relationships, suggesting there may be familial contributory factors to adolescent pregnancy and impact on negative bereavement experiences. The second, by Fenstermacher (2014), stated that African American participants sought support from women in their family and within their immediate social circle. The two papers highlight the significance of family interactions throughout childhood and

adolescence and the importance of family support following a perinatal death loss.

### **3.5.2.2 Previous Bereavement Themes**

Research has suggested that successive bereavements can contribute to an accumulation of bereavement responses known as “cumulative grief” (Lloyd, 2018; Mount, 2016). Additionally, scholars have suggested that the death of a significant attachment, within the framework of ACEs, can contribute to adolescent pregnancy and adverse behavioural outcomes (Hillis et al., 2004). Thus, the LR publications were interrogated to ascertain (a) if there were any significant deaths prior to the adolescent perinatal death; and (b) if there were adverse bereavement outcomes in participants with previous significant deaths in comparison to those who did not.

Only one study, Wheeler and Austin (2000), compared adolescent grief responses between participants who had experienced a perinatal death with a prior significant bereavement within the previous two years and participants who had not experienced a previous bereavement. Utilising the psychometric tool they developed, the Loss Response List (LRL), the authors determined that adolescents who had experienced a significant bereavement before the perinatal death had significantly higher grief scores than the participants who did not, thus confirming the potential for cumulative grief (Mount, 2016; Pham, 2020). The current study therefore included investigations on whether the participants had experienced a significant bereavement prior to the perinatal death.

### **3.5.2.3 Peer Themes**

Peer influence on the developing adolescent is well documented within the literature and prudent evidence was provided in chapter two (Backes & Bonnie, 2019; Balk & Corr, 2001; Eccles & Roeser, 2011; Manlove et al., 2008; Newman & Newman, 1976). Of particular interest to this study, are peer interactions following adolescent perinatal death.

Considering the proliferation of literature identifying the significance of peer relationships during adolescence, only three studies within the LR publications mentioned these relationships (Hatcher, 1973; Fenstermacher, 2014; Welch & Bergen, 2000). Hatcher (1973) was the only author that mentioned the putative father, suggesting that late adolescent females become pregnant to secure marriage. Welch and Bergen (2000) state that friends support females following a perinatal death by suggesting “partying” and they also acknowledge that some friendships are changed as a result of the death. Fenstermacher (2014) mentions that African American women turn to friends within their own culture for support. As the role of peer relationships following perinatal death loss during adolescence has hitherto been overlooked, this study will seek to understand the importance, or not, of peer support following the event.

### **3.5.2.4 Teacher Themes**

McDermott Shaefer’s (1992) article seeks to address a perceived gap in the adolescent pregnancy loss literature within schools. Grounded in the biological, historical, perspective of grief, as a series of tasks to accomplish, she provides generalisable directives to nurses under the guise of “A



School-Based Program”. Therefore a gap in the literature for the provision of information to other school staff, particularly teachers was identified.

This study therefore investigated the self-perceived retrospective views of school experiences following an adolescent perinatal death.

### **3.5.2.5 Medical Professional Themes**

As previously mentioned, 19 of the 20 publications identified for inclusion within the LR for this study were written by either medical professionals (n =17) or professionals working within a medical environment (n =3). Whilst a valued perspective, the confinement of the narratives within this one discipline may promote implicit bias towards biological discourse, and the marginalisation, or exclusion, of psycho-social constituents (Davies, 2020; Walter, 2017). Further, as the interactions between the professionals and the adolescents occurred at, or shortly following, the perinatal death, the risk of socially desirable responses to professionals who have provided services to the participants, or are a convenience sample to the authors, is high (Nederhof, 1985; O’Reilly-Shah, 2017; Servaty-Seib & Burlison, 2007). This study therefore sought to procure the adult retrospective view of the medical interactions, and support, provided at the time of the adolescent perinatal death to gain a reflective perspective.

### ***3.5.3 Theme Three: Social and Cultural Themes***

As detailed in chapter two, the mesosystem is the system nested adjacent to, and outside of, the microsystem and consists of interactions between the microsystems (Bronfenbrenner, 1986). These interactions consist of for example interrelationships between families and schools. As this study

seeks to ascertain if there were any interactions between the microsystems, i.e. the school and the parents when an adolescent becomes pregnant whilst attending secondary school, the LR publications were examined for evidence of mesosystem interactions. The researcher was unable to find any evidence of mesosystem interactions within the publications.

Within the LR publications, four publications specifically address wider environmental variables, pertinent to adolescent experiences of perinatal death, within the exosystem, macrosystem, and chronosystem, collectively (Barnickol et al., 1986; Fenstermacher, 2014; Perez-Reyes & Falk, 1973; Schodt, 1982). Whilst Schodt (1982) referred to the sociohistorical practice of medical professionals removing a stillborn baby immediately following birth, no further studies considered the sociohistorical context of perinatal death experiences, and how this may impact on current practices.

Within the context of cultural identification in the US in the early 1970s, Perez-Reyes and Falk (1973) investigated the abortion experiences of 60% white and 40% black adolescents and found that the majority of the black participants were conflicted between which identification pattern they were particularly aligned with. Some adolescents identified with the black community norm of accepting illegitimate pregnancy, whilst some participants were more influenced by the white societal stigma of lone parenthood, with educational attainment deemed of paramount importance. The second article that specifically examined black experiences within the US was conducted by Fenstermacher (2014) who specifically suggested

kinship within black communities was supportive to adolescents following perinatal death.

Within their book chapter Barnickol et al. (1986) specifically addressed societal attitudes towards adolescent pregnancy death by suggesting that both sex and death are “taboo” subjects. The authors contend that society responds to the perceived taboos by: (a) minimising the meaning of the loss, for example, by offering platitudes such as that she can get pregnant at a later time; (b) minimising the meaning of the loss of the embryo/foetus/baby to the mother for example by suggesting that the adolescent can resume “normal” life again; and (c) withholding provision of baby loss support to adolescents.

### **3.5.3.1 Relationship and Sexual Education Themes**

Chapter one detailed the potential significance of effective relationship and sex education (RSE) by presenting Switzerland as a country example that has very low adolescent pregnancy rates which has been attributed to the success of the RSE curriculum (Boyd & Bee, 2008). Within the 20 publications included in the LR for this study, one article specifically addresses RSE; Hatcher (1973) stated that sex education was inadequate at during adolescence, and that parents should take more responsibility for RSE. This study therefore seeks to ascertain if adults retrospectively perceive that RSE meets the needs of adolescents and where improvements both within, and outside of educational environments, can be made.

### 3.5.4 Questions and Objectives of Research

The overall aim of the present study was to explore the retrospective experiences of females who became pregnant during adolescence and subsequently experienced a gestational or neonatal death. In particular, the research is conceptualised within a bioecological perspective of human experience by situating the bio-psycho-social narratives of the historical event within the structural components of the nested systems model (see chapter two). Following a critical review of the LR, the researcher believes this to be the first study to investigate these experiences within a bioecological framework and to specifically assess; (a) school responses; (b) educational attainment; and (c) impact across the lifespan.

This study was designed as an exploration of “discovery”, to build upon previous knowledge, and make a modest contribution outside of medical discourse. The specific objectives of this study were thus:

- To explore “personhood” of pregnancy within the adolescent perinatal death loss cohort and potential impact on identity creation or identity reconstruction across the lifespan (Bright, 1987; Fenstermacher, 2014; Hatcher, 1973; Sefton, 2002; Welch & Bergen, 2000).
- To gain insight regarding any other issues pertaining to the experience from a bio-psycho-social retrospective perspective; “When researchers invite people to talk about their reflections on experience, they can sometimes learn more than they set out to discover.” (Hammarberg et al., 2016, p. 499).

Following a critical review of the LR, and identification of the research aims, the research question was confirmed as: “is there a bereavement impact on females across the life course following adolescent perinatal deaths?”.

### **3.6 Chapter Conclusion**

This chapter has reviewed the published empirical, non-empirical, and anecdotal literature pertaining to adolescent perinatal bereavement. Due to a dearth of publications, particularly outside of the US, and outside of the medical discipline, the current chapter has exposed the necessity for additional research in this area.

The current chapter has identified the various gaps in knowledge that required exploration to better understand the experiences of female adolescents within contemporary society following a perinatal death, and potential impact across the lifespan. A full account of the development of the research methodology for this thesis will follow in chapter four.

## **Chapter Four: Research Methodology**

“a researcher must protect the rights, dignity and wellbeing of participants.”

(Stroebe et al., 2003, p. 239)

### **4.0 Chapter Four Overview**

The aim of chapter four is to present the methodological approach adopted within which the research was conducted. The current chapter is structurally organised into three sections; the first main section of this chapter explains the research design, detailing what the research is about, the purpose of the research, what we know from the literature review (LR) and how the perceived gaps in the literature are to be addressed.

The second main section of this chapter addresses the researcher positionality, and ethical considerations, within the planning and conducting of this study. Embedded within the whole thesis is the importance of ethics as process, and the third main section of the current chapter details the ethical considerations taken into consideration throughout the study (Ramcharan & Cutcliffe, 2001). This research has taken a holistic approach to ethical considerations; they have not been viewed as a separate issue but interwoven throughout the planning, execution, and analysis of this study. Careful consideration of the issues of nonmaleficence and how best to facilitate the participant experience was integral to the research design and addressed throughout the ethics approval process (Farrimond, 2012; Steffen, 2021).

The third main section of this chapter details the research design, overall research approach, and the development of the research instruments. The research design is derived from the research question; the rationale for the selection of the methodology is linked directly back to the research question and the framework has been developed to support the inquiry. The research question; “is there a bereavement impact on females across the life course following adolescent perinatal deaths?”, determined the inclusion and exclusion criteria *a priori* for the database searches that informed the literature review (LR). The critical analysis of the LR search results, as detailed in chapter three, identified the gaps of knowledge in the area of adolescent perinatal death experiences, which informed the research design for this thesis, which is described in this chapter.

#### **4.1 Research Structure**

This research was conducted with the aim of exploring the experiences of adolescent females, of secondary school age, who had experienced a perinatal death, and potential impact across the lifespan. This study aims to make a modest contribution to the understanding of experiencing perinatal deaths during what can be a developmentally challenging period (as detailed in chapter two). The microsystem and mesosystem interactions during these events; with parents, medical professionals, and school professionals, may contribute to emotional, psychological, behavioural, physical, and/or social responses for adult women.

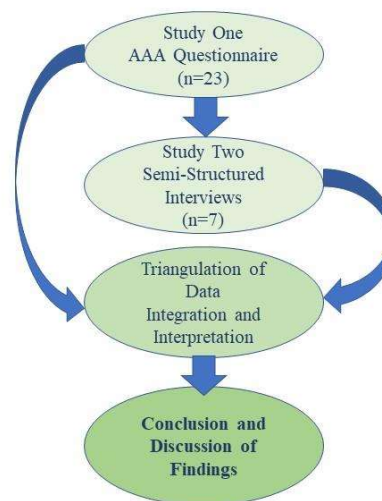
As detailed in chapter three, prior research exploring Euro-Western grief responses to perinatal death during adolescence has been sparse and

has been conducted from a predominantly medical perspective exclusively in the US. Additionally, no evidence was found, as detailed in the preceding chapter three, of perinatal death loss during adolescence having been investigated from a bio-psycho-social research design, or from an adult retrospective apperception. Therefore, the researcher turned to death studies scholarship to ascertain appropriate methodological guidance (e.g. Klass & Steffen, 2017; Neimeyer & Hogan, 2001; Stroebe et al., 2001; Stroebe et al., 2003; Valentine, 2007). Consequently, the research methodology for the current study incorporated a mixed methodological approach, utilising contemporary technology, to expand the focus to a more inclusive design (Creswell, 2009; Creswell & Plano Clark, 2011; Smith et al., 2018; Teddlie & Tashakkori, 2009). As detailed in Figure 6 below, the current thesis comprises of: (a) Phase one: The Adult Attitude to Perinatal Death in Adolescence Questionnaire (AAA); and (b) Phase two: Semi-structured retrospective interviews.



**Figure 6**

*Overview of the Research Design for the Current Thesis*



This study is based on the assumption that perception of events is important, not the actual, true remembrance of the event which may change over the course of a lifetime (Hasher & Zacks, 1988; Levine et al., 2002). Therefore, adult women were invited to retrospectively narrate their experiences (Hutti et al., 1998).

#### ***4.1.1 Research Aims***

The literature review (LR) presented in chapter three illustrates that the knowledge base for adolescents experiencing a perinatal death is exiguous. Despite the disciplinary homogeneity there is sparse overlap of findings, however, utilising the bioecological nested systems several themes were identified to determine the research aims which can be summarised as:

- To explore “personhood” of pregnancy within the adolescent perinatal death loss cohort and potential impact on identity creation or identity reconstruction across the lifespan (Bright, 1987; Fenstermacher, 2014; Hatcher, 1973; Sefton, 2002; Welch & Bergen, 2000).
- To gain insight regarding any other issues pertaining to the experience from a bio-psycho-social retrospective perspective; “When researchers invite people to talk about their reflections on experience, they can sometimes learn more than they set out to discover.” (Hammarberg et al., 2016, p. 499).

This study investigated the societal and environmental factors, in addition to the individual perspective, to expand knowledge of the adolescent experience of perinatal deaths (Bronfenbrenner, 1986; Tudge et al., 2009).

Previous research in the area of school response to bereavement has traditionally provided a critical incidence perspective to educational psychologists, for example O’Hara et al. (1994), with further studies building on this framework and expanding narratives to encompass teacher perspectives of grieving children (e.g., Lynam et al., 2018; McGovern & Tracey, 2010; O’Brien, 2015). However, whilst there is wider published research on adolescent pregnancy, and adolescent grief, as detailed in chapter two, chapter three illustrates that no studies were found that considered the subset of adolescent experiences of a perinatal death within a school context or potential long-term educational impact.

The aim of this study was to build on previous research in this area, and provide a voice to previously unheard women, in order to find some generalisable themes to provide foundational knowledge to practitioners and policy makers. Whilst the current study was situated within a bio-psycho-social framework utilising Bronfenbrenner's expanded Ecological Systems Theory (1986), the Multidimensional Theory of Bereavement (MTB) develops this framework by building upon, and updating, Sanders' (1999) Integrative Theory of Bereavement.

Having presented a summary of the structure, and detailed the aims of this thesis, the following section considers the role of the researcher in the development of the research framework for this study.

#### **4.2 The Reflexive Researcher**

As presented in chapter one, the researcher positionality is situated at the provenance of this study. Researcher emotional response within social science research, particularly pertaining to death studies, has demonstrated an ontological preference for objectivity (Visser, 2017). However, awareness of the interplay between researcher and the creation of knowledge as a shared experience, and potential emotional impact, has been gaining increasing visibility (Valentine, 2007; Woodthorpe, 2007). Therefore, as the areas of death, dying, and grief have been recognised as "sensitive" for research purposes, both for the participant and the researcher, a reflexive approach to emotional labour management was employed for this study (Borgstrom & Ellis, 2017; Hochschild, 2012; O'Brien, 2015). The researcher acknowledged the potential impact

sensitive topics can impart on both the participant and the researcher, and that there is emotional labour in listening to intimate details of lived experiences (Mallon et al., 2020). However, chapter one declared the researcher as a mature, experienced bereavement support worker, trained within an organisational framework where reflexivity and supervision are embedded within professional ethical practice (BACP, 2021). As such, the researcher was experienced in listening to hundreds of sensitive stories with clients and participants in her prior work, and was extensively trained and experienced in employing various methods to manage any emotional impact. Within the training provided by e.g. Cruse Bereavement Support, Roadpeace, Macmillan, and Cancer Research UK, volunteers are explicitly trained to actively listen with empathy, and offer support, but also to seek immediate support from a supervisor if the emotional impact extends outside of the work. As stated earlier, the PhD Supervisor was available, and responded immediately, when the researcher felt emotionally impacted following data collection. Further, the researcher had no lived experience of adolescent perinatal loss whilst attending secondary school, thus was not expecting to experience any personal impact (Jones & Murphy, 2019).

A reflexive journal was utilised throughout this research (which included field notes), and whilst one participant submitted a questionnaire disclosing a rape at 14 years old, and one interview participant also disclosed child sex abuse, these were the only two incidents throughout the study that impacted the researcher emotionally. Reflexive support was sought, and provided, by the researcher's PhD Supervisor, a Chartered Psychologist, immediately following the two incidents.

Ergo, it is the researcher's view that attention to events prior to, and following, conducting fieldwork should also be highlighted as sensitive, not just conducting fieldwork. For example, prior to data collection, the researcher was not expecting, nor prepared for, the emotional toll of obtaining ethical approval from the School of Education, which proved to be lengthy and discouraging. Secondly, dissemination through peer reviewed journals may also be subject to emotional labour (Bloch, 2002).

Having provided a statement of positionality, and consideration of researcher emotional labour, the following section presents the ethical considerations for the current thesis.

#### ***4.2.1 Ethical Considerations***

This section details the ethical considerations employed throughout this study. Steffen (2021) states: "Ethics literally translates as 'the study of morals'...morals and values can clash and compete with one another...researchers can lose sight of the values and commitments that are at stake" (pp. 35-36). Whilst ethical approval was sought, and obtained, from the School of Education (see Appendix 13) to conduct this study, the researcher's positionality as a bereavement support worker influenced the implementation of ethics throughout the design, data collection, and data analyses of this study, in its entirety, to ensure ethical integrity (Boynton, 2005; Farrimond, 2012; Ramcharan & Cutcliffe, 2001; Valentine, 2007).

Whilst the researcher had been working within the British Association of Counselling Professionals (BACP) Ethical Framework (BACP, 2021) prior to commencement of this research, the British

Psychological Society's (BPS) (2021) *Code of Human Research Ethics* provided relevant basic principles that were implemented within this study; (a) respect for the autonomy, privacy and dignity of individuals, groups and communities; (b) scientific integrity; (c) social responsibility; and (d) maximizing benefit and minimising harm. To comply within this framework, and embed ethics as process, prior to conducting any fieldwork all participants were required to read the Study Information Sheet and provide informed consent either within the online survey or prior to the interview (Appendices 7- 9) (Ramcharan & Cutcliffe, 2001). All participants were reminded that they could to exit the questionnaire, or stop the interview, at any time and that there was no requirement to answer any question if they so wished (Pullman & Wang, 2001). All participants were debriefed and provided with a list of support organisations that provide professional counselling services or specialised professional support within the areas of perinatal bereavement (Appendices 11- 12) (Stroebe et al., 2003).

A critical consideration for conducting sensitive research is ensuring participant anonymity and safeguarding all data. The researcher was aware that the General Data Protection Regulations (GDPR) came into effect on the 25<sup>th</sup> of May, 2018 during compilation of the instruments for ethical approval (General Data Protection Regulation (GDPR) Compliance Guidelines, 2018). The researcher attended to the legal and ethical GDPR regulations by writing an extensive GDPR procedural document detailing how the data would be processed, secured, and the rights of the participants, during the data collection period and following publication of the thesis (see

Appendix 15). All GDPR procedures detailed in Appendix 15 were followed to ensure integrity of the data and protection of the participants' anonymity.

Having provided a summary of the ethical considerations for this research, the following section presents the methodological development, and philosophical underpinnings, of the current thesis.

### **4.3 Conceptual Framework**

This section provides particulars regarding the philosophical underpinnings, and methodological approach, designed to explore the study research aims. The pragmatic philosophical underpinnings to this study provide a view that the data collection should be meaningful (Morgan, 2007). Therefore, a sequential explanatory design was selected to gather generalisable, broad data through an initial quantitative and qualitative questionnaire, followed by a second phase of qualitative semi-structured interviews to add richness and depth to the findings (Cresswell & Plano Clark, 2011; Ivankova et al., 2016; Tashakkori & Teddlie, 2003). The mixed methods approach to data collection aligns with the research aims by providing a complementary process through the lens of integrating both quantitative and qualitative methodological strengths to both breadth and depth of findings (Cresswell, 2009; Morgan, 2007; Teddlie & Tashakkori, 2009).

Historically, the postpositivist worldview, which holds data and objectivity as an essential aspect of inquiry, originates from 19<sup>th</sup> century writers such as Durkheim and Newton (Cresswell, 2009). This paradigm was considered the most suitable approach to conducting research until the

1970s when social constructivism, with its subjective meaning construction, became popular via publications such as Berger and Luckmann's (1967) *The Social Construction of Reality* (Cresswell, 2009). The mixed method approach has gained traction since the 1990's with its pragmatic philosophical underpinnings derived from the work of Peirce, James, Mead, and Dewey (Cresswell, 2009). Within this paradigm, the ontological position recognises the worldview of individual conceptions, and the social, "objective" worldview, are complimentary not divisive (Morgan, 2014). This study used a combination of elements of qualitative and quantitative research applications to further advance knowledge to provide a fuller understanding of the research question. As Greene (2007) elucidates, a mixed methods design affords a social world view; "that actively invites us to participate in dialogue about multiple ways of seeing and hearing, multiple ways of making sense of the social world, and multiple standpoints on what is important and to be valued and cherished." (p. 20). Whilst mixed methods approaches are considered a "new" approach, precedence exists within the subject area with Hatcher (1973), and Perez-Reyes and Falk (1973), who both utilised semi-structured interviews, psychometric testing, and questionnaires in their research methodology when investigating adolescent abortion experiences in the late 1960s and early 1970s.

A pragmatist approach was selected because this study is interdisciplinary and pragmatism allows for exploration of data from a variety of perspectives, with the ability to utilise a bespoke research design. Additionally, Biesta and Burbules (2003) argue that there are major benefits



with a pragmatic approach to research that encompasses educational environments, including the ability to be a reflective researcher. Moreover, as the research question is the most important determinant of the research philosophy for this study, no single view would provide the quality of information desired to expand and add to the existing literature. Morgan (2014) summarises this positionality within the following statement:

pragmatism presents a coherent philosophy that goes well beyond “what works.” Based on the work of John Dewey, pragmatism points to the importance of joining beliefs and actions in a process of inquiry that underlies any search for knowledge, including the specialized activity that we refer to as research (p. 1051)

Table 5 below details the research design for this research:

**Table 5***Research Design for the Current Thesis*

<b>Research Design</b>	<b>Research Approach</b>
Theoretical Paradigm	Ontology: pragmatic  Epistemology: Practical, explanatory  Axiology: Multiple
Methodology	Explanatory sequential design  Mixed method; quantitative and qualitative questionnaires & semi-structured interviews
Participants	Adults who experienced a perinatal death during adolescence, whilst in secondary education
Data Collection Method	Online questionnaires, emailed questionnaires, and paper questionnaires  Interviews conducted either in-person or via technology
Ethical Factors	Level 2 ethical approval was obtained from the School of Education Ethics Committee on the 5 <sup>th</sup> March, 2019  Ethics embedded as Process
Data Analysis	Questionnaires were to be analysed using SPSS and NVivo but insufficient numbers were received. The PGIS scoring sheet and narrative analysis were employed  Thematic analysis was used to evaluate and explore the interviews
Validity, Reliability	Measures and factors were taken into consideration to ensure that the research is as valid and reliable as possible
Limitations	Limitations are identified and acknowledged

Despite the advantages of employing a mixed methods approach, there have been allegations that post-positivist thinking is favoured over more interpretive approaches. For example, Denzin (2009) suggests that conservative regimes such as educational policy makers enforce scientific based models of research. The emphasis on performance scores, for example, with the marginalisation of qualitative data, minimizes the complexities within the ecological system for developing children and young people (Denzin, 1983). Consequently, a sequential explanatory design model was selected to provide parity to both the quantitative and qualitative data to minimise any unconscious selective or interpretive bias (Bazeley, 2017). Additional criticisms include purists who believe in the efficacy of one paradigm rather than the other (Johnson & Onwuegbuzie, 2004) and the allegation of substandard research as a result of the use of “mixed methods” to masquerade for the violation of basic assumptions of both methodologies (Morse, 2005). This study has taken into consideration the advantages and disadvantages of all philosophical positions and has selected the one believed to be the most appropriate for the research to be undertaken. Steps were taken to ensure that the data collection, analysis and interpretation were rigorous and ethical (Creswell, 2009; Farrimond, 2012).

As detailed in chapter three, prior research found within the topic area has been undertaken within the US medical environment, thereby school response and potential for educational impact have not been investigated (Shaefer, 1992; Wheeler & Austin, 2000). Additionally, whilst there is literature presenting the impact of bereavement among young

people within the school environment in Ireland (e.g. McGovern & Tracey, 2010; O'Brien, 2015; Tracey, 2011) the research does not consider perinatal deaths specifically. In the absence of any identified empirical data considering impact on the adolescent females within the short- or medium-term school environment, or on the long-term educational prospects, it may be considered speculative to inform policy, schools, or professionals in how to provide effective support or potential interventions without co-produced narratives.

As previously mentioned, an explanatory sequential design was selected to answer the research question by gathering as much generalisable data first, followed by more in-depth, targeted, probing (Ivankova et al., 2016). This methodological approach incorporates a five-phase design; (a) the collection and analysis of quantitative data is collected first (phases 1 and 2); (b) the second phase comprises of the collection and analysis of qualitative data (phases 3 and 4); and (c) the final phase is a summary and interpretation of the entire analysis (phase 5) (Creswell, 2009). This method was determined to be the most appropriate method due to the scarcity of research utilising the inclusion criteria and the precedence of use in both the LR and general bereavement studies (e.g. Agwu Kalu et al., 2018; Horowitz, 1978; Perez-Reyes & Falk, 1973; Savitri et al., 2019).

Phase one was initiated with the construction of the quantitative questionnaire that was mapped to the nested systems within the MTB. Text boxes were also added to the survey to provide an opportunity for participants to engage further with the study. Participants were recruited

utilising a social media strategy and word of mouth snowball sampling (Biernacki & Waldorf, 1981). Appendix 14 details the ethical processes and safeguards that ensured ethics as process was embedded during participant recruitment (Ramcharan, & Cutcliffe, 2001). The purpose of constructing the questionnaire prior to interviewing participants was to seek as much broad data as possible to provide a foundational knowledge of the bio-psycho-social variables that influence adolescent perinatal death experiences, and impact across the lifespan. The analyses of the submitted questionnaires (n = 23) are presented in chapter five.

Along with the questionnaires, the interview question themes were also broadly determined to correlate and map to the MTB, thus the two sets of data are connected but separate (Appendix 22). The semi-structured, retrospective interviews were employed to probe the depth of the data analyses received from phase one and were based on the phenomenological approach of aiming to identify and describe the meanings behind individual experiences (Husserl, 1970). Thus the mixing of the data occurs at this stage of the sequential approach and is designed to obtain depth of understanding to add richness to the first phase (Creswell, 2009; Ivankova et al., 2016). The analyses of the semi-structured interviews conducted following collection and analysis of phases one and two of the sequential explanatory design are presented in chapter five.

Both phases, one and two, were triangulated into a third phase; where the questionnaire data analyses, and the subsequent interview data analyses, are converged to provide contextualisation within a bio-psycho-

social summary for this thesis, the key findings are summarised in chapter six (Creswell, 2009; Creswell & Plano Clark, 2011). Mixed methodology can contribute to an increase in confidence in findings by providing more evidence that would otherwise be available from using a single approach and the sequential explanatory strategy provides a clear design that is easy to implement and report (Tashakkori and Teddlie, 2003; Creswell, 2009; Creswell and Plano Clark, 2011).

Having presented the philosophical underpinnings, and methodological development, of the current study, the following section details the development of a specific theoretical structure to investigate the research question.

#### ***4.3.1 Development of the Research Instruments***

Following the construction of the MTB, as presented in chapter three, and the detailing of the bio-psycho-social variables relevant to adolescent female perinatal death experiences, the research question and data collection methodology could be mapped to the elements of the bio-ecological system. The mapping is detailed in Appendix 16. The following section details the development of the Adult Attitude to Adolescent Perinatal Death (AAA) survey for phase one.

##### **4.3.1.1 AAA Development**

The Adult Attitude to Adolescent Perinatal Death questionnaire (AAA) was constructed to provide an exploratory survey approach to ascertain, from a bio-psycho-social perspective, a baseline of variables to consider when an

adolescent female experiences a perinatal death (Babbie, 1990). The paucity of, and limited scope of, previous studies, as outlined in chapter three, demonstrated gaps in the literature that the questionnaire seeks to address. The questionnaire is designed to collect data to suggest what “happens on the ground” with adolescent girls prior to the pregnancy, during the event, and whether there are any long term impacts on the women across the lifespan (Neimeyer & Hogan, 2001). The overall aims of the development of the questionnaire were:

- (a) To assist replication in future studies via standardisation;
- (b) To gather as much generalisable data across the relevant ecological areas that has not previously been available;
- (c) To provide a baseline summary of information on the research question;
- (d) To aid in the planning and analysis of the Phase two semi-structured interviews to “thicken” and enrich the data;
- (e) To potentially appeal to more participants due to its anonymous format and online accessibility;
- (f) To reach as many participants as possible in an accessible way in an effort to seek unbiased representation of the population;
- (g) To ensure there is no time pressure or “immediacy” to complete the survey;
- (h) To have quantifiable data; and
- (i) To reduce researcher interpretive bias.

In the absence of an existing appropriate instrument, the AAA questionnaire was developed as an audit survey for phase one and is presented in Appendix 17. The AAA was developed based upon the Mc Guckin & Lewis (2008) approach of “developing a series of questions...to examine what was ‘happening on the ground’” (p. 11). The mapping for phase one consisted of identifying the various components of the MTB that facilitated answers to the research question that were suitable within a questionnaire design.

The audit survey consists of a total of 55 questions, with 27 questions within three sections derived from the World Health Organization (WHO), and 28 questions comprised of the Perinatal Grief Intensity Scale (PGIS). The structure of the AAA is as follows;

- (a) Firstly, WHO was consulted and the relevant questions from their published list of suggested global research questions were selected (WHO, 2012). The WHO details different sections and rationale for inclusion in global research and the relevant sections for this study comprised of the following templates: (a) socioeconomic and family characteristics; (b) sources of information on, and knowledge of reproductive health; (c) knowledge of reproductive health; and (d) use and perceptions of health services and bereavement support;
- (b) Secondly, the PGIS (detailed below), a fourteen item theoretical model developed to predict grief intensity following perinatal loss, was also embedded within the AAA design (Hutti et al., 1998; Hutti et al., 2013; Hutti et al., 2017). The PGIS was selected because it



was developed in 1998, as a refinement of the Perinatal Grief Scale, which was designed to measure and predict the intensity of grief following a perinatal death (Toedter, Lasker, & Alhadeff, 1988). The PGIS has been evaluated, recognised, and used widely since its inception (Adolfsson, 2011; Hutti, Armstrong & Myers, 2013); and (c) Thirdly, the WHO templates and the PGIS were mapped to the MTB, and the resultant gaps in the research identified within chapter three, not included in the templates detailed above, were divided into open and closed questions and added to the AAA. The questions included 5 point Likert scales and open ended text box questions.

#### ***4.3.1.1.1 AAA: The Perinatal Grief Intensity Scale***

This section explores what the PGIS instrument was designed to measure, how it was implemented, and why it was embedded within the AAA. The Perinatal Grief Intensity Scale (PGIS) is a 14 item self-report instrument designed to gauge the intensity of grief experienced following a miscarriage, stillbirth, or neonatal loss (Hutti, dePacheco, Smith, 1998; Hutti & Limbo, 2019; Hutti et al., 2017; Hutti et al., 2018). The PGIS instrument was not designed to be used as a diagnostic tool but to identify women who may be at risk of developing Prolonged Grief Disorder (PGD) in order to provide the appropriate support to them (Hutti, Myers, Hall, Polivka, White, Hill, Grisanti, Hayden, Kloenne, 2018; Jordan & Litz, 2014).

The PGIS consists 14 items within three subscales from which the intensity of the perinatal loss is measured within the first six months, and/or six months or more following the loss;

- (a) “Reality”; this subscale has six questions designed to ascertain how “real” the pregnancy loss is to the woman and how invested they were in the concept of personhood towards the pregnancy. For example, questions include; “I did not think of the baby as a person” (e.g. question 2.2 in the AAA);
- (b) “Congruence”; this subscale has four designed to determine whether the experience following the loss was “acceptable” to the woman. For example, questions include; “During and after my perinatal loss, I was satisfied with the way my loss experience was unfolded, given that I had to go through it.” (e.g. question 2.11 in the AAA); and
- (c) “Confront others”; this subscale has four questions designed to ascertain how able the woman is to moderate social interactions, and gain support, following her perinatal loss. For example, questions include; “In later weeks after my loss, if people said or did things that made me feel bad, I was able to ask them to stop.” (e.g. question 2.9 in the AAA).

All items within the three subscales were measured twice; once within the first six months and again six months or more following the loss, resulting in a total number of 28 questions. The items are rated on a 4 point Likert scale ranging from “Strongly Disagree”, “Disagree”, “Agree” and “Strongly

Agree” (Hutti & dePacheco, 1998). A copy of the PGIS was obtained by the researcher from Prof Hutti directly, and is attached in Appendix 19.

In the absence of any other psychometric instrument designed to assess the whole range of perinatal losses, the PGIS, which has been tested for reliability and predictability over the past twenty years, was utilised for this study (Adolfsson, 2011; Hutti et al., 1998). As the current study investigated perinatal losses retrospectively, and included any type of death from conception to 28 days post birth, the PGIS was slightly modified from the original design:

1. The PGIS was developed to ascertain grief predictability in adult women who experience a miscarriage, stillbirth, or neonatal death. The first variation of PGIS use for this study was to investigate grief responses to adolescent experiences from an adult retrospective perspective.
2. The PGIS was developed to predict grief intensity as a response to early pregnancy loss and has been expanded to incorporate perinatal losses. The second variation for this study was that the PGIS incorporated any perinatal losses, as detailed within the research design.
3. The PGIS was developed to ascertain adult female grief response within weeks or months following a perinatal death. The third variation for this study was that the women were asked to consider the PGIS questions from a retrospective perspective several, or many, years post event.

4. The fourth variation to the PGIS for this study included utilising a five point Likert scale, not the original four point Likert scale. A “Neither agree nor disagree” option was utilised to allow for more neutral responses due to the nature of the time lapse between the event and participation in this study, and also to address the criticisms of acquiescence response bias or fallibility of memory recovery (Cooper & Roth, 2007; Porter et al., 1999; Revilla et al., 2014).

The PGIS scoring protocol was obtained from Prof Hutti and applied to the AAA questionnaire submissions following elimination of the neutral Likert responses (as detailed in the following section).

This section has presented the details of the PGIS as the psychometric tool selected for use within phase one, and the modification of the PGIS for this thesis, the following section presents the method for data analyses of the submissions embedded within the AAA questionnaire.

#### ***4.3.1.1.2 AAA: The PGIS Mode of Analysis***

This section presents the mode of analysis used to interpret the data collected from phase one. The PGIS was developed from a quantitative methodological approach; “Fourteen items were retained after factor analyses, loading at .4 or greater. The 14 items loaded on a three-factor solution as predicted and accounted for 65% of the variance. Three factors were found to influence intensity of grieving: Reality of the pregnancy and baby within (Reality), congruence between the actual miscarriage experience and the woman's standard of the desirable (Congruence), and the

ability of parents to make decisions or act in ways to increase this congruence (Confront Others). Chronbach's alpha for the entire instrument was .82, with subscale reliability scores of .89 (Reality), .84 (Confront Others), and .71 (Congruence).” (Hutti et al., 1998). Professor Hutti provided the researcher with the PGIS scoring sheet (Appendix X) which details the scoring methodology for all three factors determined to influence grieving following a perinatal death, both during the first three months following the death, and six months or more following the death.

As detailed in the previous paragraph, the PGIS incorporates a total of fourteen questions, measured at two timeframes, situated within three subscales: Reality, Confront Others, and Congruence. The scoring instructions are to aggregate the responses to provide an overall score both immediately following the loss, and again six months later. As detailed in Appendix 19, the general aggregated scoring for the PGIS, at either the first six months or six months or more following the loss, is interpreted as follows:

- (a) A PGIS score of  $\leq 3.29$  indicates a lower intensity of grief response. Lower intensity grief scores indicate a normal adjustment to the loss;
- (b) A PGIS Score of  $\leq 3.52$  but  $\geq 3.29$  indicates a medium intensity of grief response. A medium intensity grief score indicates a more significant emotional impact to the loss; and

(c) A PGIS Score of  $\geq 3.53$  indicates a high intensity grief response.

Higher grief intensity scores indicate the potential for Prolonged Grief Disorder (PGD) or Persistent Complex Bereavement Disorder.

The higher the perception of personhood, a higher perception of loss of control, or the higher perception of negative experiences, or social support, by a woman following a perinatal death, can all potentially contribute to an increased risk of developing a prolonged grief response considered maladaptive (APA, 2013; ICD-11, 2018; Maciejewski et al., 2016).

The AAA questionnaire, in its entirety, is presented in Appendix 17 and was available in both paper and online formats. The paper version of the AAA could be emailed, posted, or collected/delivered by the researcher to any prospective participants. The electronic version of the questionnaire was created utilising the online survey platform Qualtrics™. The complete list of instruments utilised within phase one comprised of:

1. Consent Form for Online Questionnaire (Appendix 7).
2. Consent Form for participants completing the paper questionnaire (Appendix 8).
3. Study Information Sheet setting out the details of the study and contact details for the researcher and supervisor (Appendix 9).
4. AAA questionnaire (Appendix 10).
5. Questionnaire Debrief which provided a full explanation of the research question. The debrief was embedded at the end of the

online survey and attached to the end of the paper questionnaire, (Appendix 11).

6. Support Organisations signposting list was provided at the end of the online survey and was attached to the paper questionnaire (Appendix 12).

Having provided an overview of the development of the AAA questionnaire, and the collective instruments, the following section details the recruitment of participants for Phase one.

#### **4.3.1.2 Phase one: Participant Recruitment**

The current section presents an overview of the recruitment process for respondents for phase one of this study. The inclusion criteria for this research stated *a priori* that participants must be female adults who had experienced an adolescent perinatal death whilst school-aged. A Social Media Processes and Safeguards (SMPS) procedural document was drafted by the researcher (Appendix 14), detailing the processes and safeguards for ethical participant recruitment utilising social media (Clark et al., 2019; Hewson & Buchanan, 2013). The document was designed to ensure, as practicably as possible, that ethical elements involving age verification, respondent vulnerability, respondent privacy, anonymity, informed consent, incentives, and risks to the participants and researcher were all considered and embedded within the concept of ethics as process (Farrimond, 2012; Hokke et al., 2018; Hokke et al., 2020; Sharkey et al., 2011). The SMPS was approved by the School of Education ethics committee on the 5<sup>th</sup> of May, 2019.

The online survey within the Qualtrics™ portal was opened on the 1<sup>st</sup> of October, 2019 and adult women who met the inclusion criteria for this study were invited to complete the AAA questionnaire utilising social media promotion and word of mouth snowballing (University, 2007; Noy, 2008). A link to the online questionnaire on the Qualtrics™ platform and request for participants, in both phases of the study, was promoted on social media utilising Twitter, WordPress, and Facebook. The WordPress analytics statistics indicate that as of the 31<sup>st</sup> of December, 2020 there were 475 views of the blog post asking for participants. The views originated from 19 countries: UK (n = 144), Ireland (n = 176), US (n = 66), Canada (n = 37), Australia (n = 24), China (n = 9), Samoa (n = 3), Singapore (n = 3), Turkey (n = 3), Germany (n = 2), India (n=2), and Belgium, Ecuador, New Zealand, Chile, Indonesia, Spain, Brazil and France all recording one view each.

Additionally, the researcher sought to find participants in Ireland via word of mouth. Within the first 48 hours following the first tweet on Twitter, 11 completed online questionnaires were submitted. A total of 23 fully, and partially, completed surveys were received via the Qualtrics™ platform between the 1<sup>st</sup> of October, 2020 and the 31<sup>st</sup> of December, 2020. Details of the anonymised participants can be viewed in Table 6:



**Table 6***Phase one Questionnaire Participants*

Participant number	Country	Age at time of submission	Gestational death type	Adolescent age at time of death
One	England	46	Miscarriage	17
Two	New Zealand	No answer	Abortion	18
Three	Ireland	34	Miscarriage	17
Four	US	58	Abortion	19
Five	England	41	Miscarriage	14
Six	US	23	Miscarriage	18
Seven	England	43	Abortion	17
Eight	England	55	Abortion	16
Nine	Northern Ireland	45	Miscarriage	18
Ten	US	25	Miscarriage	16
Eleven	England	28	Abortion	18
Twelve	England	22	Abortion	19
Thirteen	Ireland	47	Miscarriage	19
Fourteen	England	28	Abortion	18
Fifteen	Scotland	36	Abortion	16
Sixteen	Unknown	51	Abortion	18
Seventeen	Unknown	28	Unknown	Unknown
Eighteen	Unknown	23	Unknown	Unknown
Nineteen	Unknown	33	Unknown	Unknown
Twenty	Unknown	28	Unknown	18
Twenty-One	England	21	Miscarriage	16
Twenty-Two	Ireland	50	Abortion	16
Twenty-Three	Unknown	36	Abortion	16

*Note.* Further respondent details, and survey question responses can be viewed in Appendix 18.

The online survey within the Qualtrics™ portal was closed on the 31<sup>st</sup> December, 2019. The reasons for closure of phase one on this date were because no questionnaires had been submitted for over a month and the researcher felt that it was unlikely further replies would be received. Moreover, the quality and quantity of data captured was; (a) sufficient to provide a foundation of baseline knowledge from a bio-psycho-social perspective; (b) sufficient information was received to inform phase two of this study; and (c) the information received was unique (within the context of the LR detailed in chapter three) and would add a contribution to the knowledge in several areas previously unexplored (Boddy, 2016; Crouch & McKenzie, 2006; Mason, 2010; Samuels, 2019; Vasileiou et al., 2018).

The experiences under investigation for this research were acknowledged by the researcher and the supervisor at the planning stages as sensitive, and potentially sparse. Therefore, the guidance provided by Samuels (2019) stating that there is a reduction in return on investment when data volume increases, and to increase the quality and depth of analysis, data collection should be moderated at a point where representativeness and generalisability can be attained and the researcher is able to analyse the fieldwork by immersing themselves within it with quality not quantity. Small sample sizes within research studies, and academic publications, have been justified by scholars such as Boddy (2016) declaring; “Unique examples of research using a single sample or case but involving new areas or findings that are potentially highly relevant, can be worthy of publication.” (p. 427). Additionally, contemporary precedence of sample size for qualitative research within the generalisable

area of child bereavement (n = 26) was evidenced by Tracey (2011) and within the topic area (n = 8) by Fenstermacher (2014) for PhD conferment.

The over-riding intention of this study was to provide a voice to females who may have otherwise been unheard and to highlight the complex nature of each individual experience within a bio-psycho-social framework, therefore, to preserve this aim, the researcher prioritised quality, saturation, and depth of findings over quantity (Bronfenbrenner, 1986; Bryman, 2003; Crouch & McKenzie, 2006; Mason, 2010).

This section has detailed the recruitment of the respondents for Phase one, and the rationale for prioritising individuality over generalisability. The next section details the methodological approach to the analysis of the data collected within Phase one.

#### **4.3.1.3 Implementation of the AAA**

The current section details the process within which the AAA questionnaire was implemented within an internet-based platform (Corcoran & McGuckin, 2017). As mentioned above, in addition to complete anonymity, the advantages of conducting online survey research includes potential enhanced access to individuals across geographic locations, ease of access for respondents who may otherwise find the paper survey process time consuming, and the efficiency of automated data collection and analysis (Wright, 2005). However, the researcher notes the potential for social desirability responses, potential for bias, and difficulty in obtaining engagement with survey research methods (Babbie, 1990; Corcoran & McGuckin, 2017). The researcher made no assumptions as to preference, or

accessibility, for online questionnaires by respondents so also made available paper based instruments (Nulty, 2008). No requests for paper questionnaires or emailed surveys were received by the researcher in response to their availability.

The online web-based tool selected by the researcher to conduct phase one was Qualtrics™ as it is the licensed system provided, and universally adopted, by Trinity College Dublin. Qualtrics™ is a web-based survey tool that allows researchers to undertake online data collection, it also provides software tools to undertake analysis of the fieldwork collected. The AAA questionnaire, and the accompanying documents, incorporated all of the requirements for compliance with the School of Education Ethics Committee approval and were assembled within the Qualtrics™ online platform (Farrimond, 2012; Pullman & Wang, 2001). The complete online survey incorporating all of the instruments can be viewed in Appendix 17.

The AAA and supporting documents for phase one, that were integrated within the online Qualtrics™ survey tool, are detailed as follows:

- (a) Study Information Sheet (SIS). The SIS set out detailed information on the study for respondents, included contact details for the researcher and research supervisor (Appendix 9). Respondents were required to tick a box declaring they had read, and understood, the contents of the SIS before they were permitted to proceed;

- (b) Consent Form for Online Questionnaire (CF). Following the SIS, the second instrument embedded within the Qualtrics™ platform for phase one was the CF (Appendix 7). The CF document explicitly required consent to sixteen questions, as required by the School of Education Ethics Committee, and all respondents who engaged with the online questionnaire had to agree with the questions individually before proceeding through to the online survey. Additionally, following completion of the questionnaire, respondents were required to consent again before the survey could be submitted;
- (c) Research Instrument (The Adult Self-Perception of Retrospective Perinatal Death in Adolescence Questionnaire). The research questionnaire (AAA) was embedded within the Qualtrics™ online survey tool following the SIS and CF (see Appendix 10);
- (d) Online Questionnaire Debrief. The online survey, AAA, was followed by a debrief section to provide respondents with further information on the study and its aims (see Appendix 11); and
- (e) Support Organisations. Signposting to support organisations was provided within the Qualtrics™ online tool at the end of the survey, prior to submission, and can be viewed in Appendix 12. This document, embedded within the online survey, contained a list of professional therapeutic organisations, and a list of charities that provide support to people following a perinatal death.

In addition to the online Qualtrics™ survey, all the instruments listed above were available in paper format, or available for distribution via email, for any adult women wishing to participate in phase one who did not, or could not, engage in an online questionnaire. No respondents requested a paper questionnaire and no respondents requested the Word document to be emailed.

#### **4.3.1.4 Phase one: Data Analysis**

This section presents the selection process of appropriate methodological analysis tools utilised following collection of the data from the submitted questionnaires in phase one. As detailed in Section 4.3.1.1, the survey instrument was comprised of three components; (a) questions derived from WHO templates; (b) the Perinatal Grief Intensity Scale (PGIS); (c) researcher constructed 5 point Likert scale questions; and (c) researcher constructed open ended text boxes. The WHO templates for conducting health and education related research include dichotomous scales (a choice from two answers), array question types (yes, no, unsure), discrete categories (e.g. religious affiliation), and demographic data collection.

Whilst the research design planned quantitative analyses for the questionnaire responses, descriptive analysis was employed to analyse and present the data collected from the WHO templates in phase one, as a larger sample size is required for statistical analysis using SPSS: “Descriptive statistics are used to describe the basic features of the data in a study. They provide simple summaries about the sample and the measures. Together

with simple graphics analysis, they form the basis of virtually every quantitative analysis of data.” (Trochim, 2021).

Analyses of the embedded PGIS psychometric instrument was conducted using a scoring sheet developed by the authors (Hutti et al., 1998). Professor Hutti provided the Excel Scoring Sheet and addendums directly to the researcher by email.

Analysis of Likert scale data can be analysed using a multitude of parametric or non-parametric quantitative tests (Vogt, 2011). Parametric tests assume normal distribution of data within the population, whereas non-parametric tests are the converse (Sullivan & Artino, 2013). Within the cohort under investigation, the LR provided no baseline information on distribution curves from prior literature investigating adolescent perinatal experiences, therefore parametric testing was discounted for phase one. As non-parametric tests are not based on assumptions of normal distribution, they require larger sample sizes to ascertain any differences between groups for example females who experienced abortions and females who experienced miscarriages (Sullivan & Artino, 2013). Therefore, descriptive statistics, including mean, median, mode, and standard deviations have been used within analyses of phase one on the Likert scale questions, with the proviso that they are contextualised with the narratives and the limitations of the small sample are clearly established throughout this thesis (Allen, 2017). There were several comments submitted by the respondents within the open ended text boxes provided in the survey and analysis comprised of

identifying common themes utilising traditional Thematic Analysis methodology (Braun & Clarke, 2006).

Having provided an overview of the rationale for the methods employed to analyse the data submitted in phase one, the next section details the interview design, and data collection, for the semi-structured interviews conducted in Phase two.

#### **4.3.2.1 Phase two: Semi-Structured Retrospective Interviews**

This section details the interview design, and data collection, for the semi-structured retrospective interviews conducted following analyses of the phase one findings. Following analyses of the AAA questionnaire responses, as detailed in chapter five, the researcher was mindful of the balance between prior knowledge (i.e. the information gathered from phase one and the results from the LR), and building upon what was already known, whilst allowing the participants in phase two to provide their own storytelling (Leech, 2002).

A total of seven semi-structured retrospective interviews were conducted between November, 2019 and May, 2020. One participant was excluded following the interview as they did not meet the inclusion criteria determined for this study *a priori*. Details of the participants are provided in Table 7 on the next page:



**Table 7***Phase Two Interview Participants*

Participant Number	Pseudonym	Nationality	Perinatal Death Type	Age at Time of Perinatal Death	Age at Time of Interview	Length of Interview
1	Bella	English	Legal Abortion	18	28	00:38:42
2	Rosemary	English	Legal Abortion	18	43	00:20:16
3	Roisin	Irish	Legal Abortion in England	16	50	01:07:06
4	Denise	English	Legal Abortion	14	57	00:18:44
5	Afiya	Ugandan	2 Illegal Abortions	15 & 16	31	01:23:10
6	Sabine	German	Miscarriage	17	19	00:35:69

Five of the interview participants resided outside of Ireland, with one participant resident within the ROI. As the data collection period occurred immediately prior to, and during, the SARS-CoV-2 pandemic lockdowns, the researcher was able to conduct interviews using Skype as per the ethics approval granted by the School of Education. The contextual themes explored during the semi-structured retrospective interviews were consistent throughout this thesis and can be viewed in Appendix 20. Encompassing the bio-psycho-social themes identified within the LR, linked to the survey themes in phase one, the themes were followed through

within the interviews in phase two. The themes comprised of the following; individual mental health, individual identity, repeat pregnancies, individual attitude to education, individual bereavement response, family dynamics, previous bereavements, peer relationships, teacher responses, medical professional behaviours, and relationship and sex education. A full presentation of the analyses of the retrospective, semi-structured interviews using Thematic Analysis (TA) can be viewed in chapter seven (Braun & Clarke, 2006; Lyons & Coyle, 2021). As part of the ethics as process embedded within this study, following the interviews, the researcher sent emails to all of the participants to check-in, to provide a debrief sheet, and to provide a list of support organisations, (Appendices 11 and 12) to ensure support of their wellbeing (Farrimond, 2012; Smith et al., 2018).

Having provided an overview of the retrospective semi-structured interview design, the next section details the methods of recruitment for the interview participants.

#### **4.3.2.2 Phase two: Participant Recruitment**

This section provides the particulars of the recruitment for participants for phase two, the adult retrospective semi-structured interviews. The researcher recognised from the outset of this study that recruitment of self-selecting participants for this research would be challenging due to the sensitive nature of the topic (Brady et al., 2008). As highlighted in chapter one, socio-historic conditions and continuing social stigma concerning the treatment of unmarried pregnant females in Ireland, contributed to further recruitment challenges. Moreover, as detailed in chapter five, it is a finding

of this thesis that Irish adult women were reluctant to contact the researcher to speak about their adolescent experiences of perinatal death. Given that the occurrence of adolescent pregnancies and subsequent perinatal death rates may be statistically low, and also considering the statistical likelihood of many females not experiencing a negative reaction to the event, and considering the dearth of previous literature, the researcher recognised that reaching potential self-selecting adult female participants would be difficult both in Ireland and internationally.

As detailed in Section 4.3 of this chapter, a SMPSD was drafted by the researcher detailing the processes and safeguards for ethical participant recruitment utilising social media (Appendix 14). Following ethical approval, adult women who met the inclusion criteria for this study were invited to self-select to participate in the retrospective semi-structured interviews utilising social media promotion and word of mouth snowballing (University, 2007). A request for participants for phase two was promoted on social media utilising Twitter, WordPress, and Facebook. Additionally, the researcher sought to find participants in both Ireland and transnationally via word of mouth. A total of seven participants volunteered to be interviewed, with six women meeting the inclusion criteria for this study.

#### **4.3.2.3 Phase two: Conducting the Interviews**

As this study was exploring sensitive themes, the researcher was mindful that the participants may potentially be stigmatised or disenfranchised, therefore the interviews with each woman were initiated with rapport building prior to starting the recordings (Elmir et al., 2010). This strategy

was consciously employed so that the researcher could demonstrate active listening skills, with positive and encouraging body language, and provide evidence of genuine interest and respect with each participant (Boynton, 2005; Farrimond, 2012; Ramcharan & Cutcliffe, 2001). Additionally, prior to recording, the researcher reminded each participant of their right to withdraw at any time, that there was no requirement to answer any question, and checking the woman was still willing to consent to the interview (Steffen, 2021).

Once rapport was established with each participant, the researcher asked for permission to start recording the interview (Farrimond, 2012; Steffen, 2021). Once consent was obtained to record the interview, the researcher then employed a “specific grand tour” question asking the participant to detail, as comprehensively as they were willing, their phenomenological experiences prior to, during, and following the adolescent perinatal death (Spradley, 1979). Once the participant had concluded narrating their experience, the researcher asked specific questions to address any gaps pertaining to the MTB themes, and phase one analyses derived themes.

The researcher concluded the interviews by asking the participants for permission to stop the recordings (Farrimond, 2012; Steffen, 2021). The researcher then ensured that each individual woman was in emotional equilibrium prior to ending the Skype call (Farrimond, 2012; Ramcharan & Cutcliffe, 2001, Steffen, 2021). Immediately following the conclusion of the online Skype interviews, the recordings were saved in a password

protected folder on the researcher's Bios password protected laptop, and deleted within the Skype application in accordance with the GDPR policy statement and ethics approval from the School of Education. The researcher then emailed the debriefing script and signposting to support organisations sheet, and thanked them for their participation within this study (Farrimond, 2012; Steffen, 2021).

The researcher compiled field notes during each interview to initiate the analysis process of the narratives; "Analysis can, and should, start in the field." (Gibbs, 2018). Additionally, immediately following the conclusion of each interview, the analysis process continued with the researcher adding the completed field notes to a reflexive research diary (Elmir et al., 2010). Moreover, the researcher also compared the field notes written during and immediately following the retrospective interviews with the data collected from the questionnaires submitted in phase one. The process of comparing data collected from phase one and phase two aided in acquiring a feel for the narratives prior to the formal process of transcription and prior to conducting the thematic analysis (Braun & Clarke, 2006; Lyons & Coyle, 2021).

The researcher manually transcribed each interview utilising an intelligent verbatim format from the participant recordings (Eppich et al., 2019; Hickley, n.d.). The process of transcribing using intelligent verbatim involved removing "ums" and "ers" and inserting full stops at intuitive places. All of the full words were transcribed faithfully by the researcher.

Any identifying data within the interview narratives was removed from the transcripts to protect participant anonymity (Farrimond, 2012; Steffen, 2021). Additionally, each of the completed transcripts were compared with each of the recordings at least three times for accuracy and data familiarity (Lyons & Coyle, 2021). Following completion of the transcription process, the six retrospective semi-structured interviews were analysed individually using thematic analysis (Braun & Clarke, 2006).

The researcher methodically performed phases one to five of the thematic analysis process ensuring the 15-point checklist of criteria for good thematic analysis was adhered to and the themes were reviewed and balanced; "...between analytic narrative and illustrative extracts..." (Braun & Clarke, 2006, p. 96). The themes were subsequently defined and named, then aligned and integrated within the MTB framework, named as the "context", as presented in Appendix 24.

#### **4.3.2.4 Phase two: Data Analysis**

This section presents the methodological approach to analysis of the data collected from the semi-structured retrospective interviews conducted within phase two. The semi-structured interview approach utilises open-ended questions which were designed to improve the understanding of the data analysis collected from phase one within a purposive manner (Leech, 2002). This framework allows the researcher to ask semi-structured questions of the participants with a focus on the themes elicited from the LR, and phase one, and to ask more in-depth questions relevant to each participant's retrospective reflections on the adolescent perinatal death

experience, and impact across the lifespan (Banks, 2012; Spradley, 1979). As presented in chapter two, Sefton (2002) presented the only study, identified within the LR, that considered experiences of miscarriage from up to five years post death. Therefore, the expanded scope for this study, across an infinite timeline, allowed for a mature reflexive view which potentially contain less socially desirable responses (Nederhof, 1985).

There is a variety of methodology employed within qualitative approaches to data analyses, with selection of appropriate methods dependant on researcher positionality and suitability in answering the research questions (Gibbs, 2018). However, Lyons and Coyle (2021) also argue that interpretation of qualitative research; “should be evaluated along two main dimensions: first, its rigour and quality, and second, its usefulness” (p. 5). Three psychological research methods were considered for suitability in analysing the data collected from the six semi-structured retrospective interviews due to their popularity within the psychological, sociological, educational, medical, and thanatological disciplines; Interpretative Phenomenological Analysis (IPA), Grounded Theory (GT), and Thematic Analysis (TA).

IPA aims to explore how individuals make sense of their personal and social lived experiences through personal reflection and understanding (Moran, 2000; Palmer, 1969; Smith, 1995). IPA therefore involves the co-creation of meaning through the researcher lens as they interpret the sense-making of the participant (Smith & Osborn, 2015, p. 54). However, whilst IPA contributes to meaning making for significant events, and is

particularly suitable for sensitive research, the researcher discounted this method due to its cognition focus because this study has a broader bio-ecological remit.

GT seeks to discover a theory through careful consideration of data as it emerges through an inductive process based on the premise of discovery (Glaser & Strauss, 1967; Corbin & Strauss, 1990). There are divergent views on the methodological approaches to induction and whether the theory produced through the GT process is emergent or “forced” (Bryant & Charmaz, 2007). Due to the historical development of GT within the thanatological discipline it is particularly suitable for bereavement research, however, the researcher discounted this method due to the inductive “discovering” methodology as phase two built upon phase one (Glaser & Strauss, 1965).

TA is a phased methodological approach that ascertains patterns of meaning within qualitative data (Braun & Clarke, 2006). The researcher notes that the traditional process has evolved to encapsulate two divergent schools identified as “small q” and “Big Q” published following completion of analyses for this thesis (Braun & Clarke, 2021). As phase two sought to provide more depth to the findings from the breadth of phase one within this study, TA was selected as the preferred method of analysis for phase two as it supports the bio-psycho-social inquiry of the research question, supports the theoretical assumptions, produces richness of analysis from small samples, and supports the research aims (Braun & Clarke, 2006; Terry, 2021).



The five phases of TA were implemented with all six of the retrospective adult interview transcripts collectively. The process of thematic analysis for phase two involved; (a) familiarisation with the data, (b) first order coding, where initial ideas are generated from the transcripts individually, (c) second order coding, where a long list of codes are identified, (d) third order coding, where the main themes are devised from the refinement of second order coding, and; (e) writing up the results of the analysis (Braun & Clarke, 2006).

Familiarisation of the data was undertaken through manual transcription of the interviews from the recorded videos (Braun & Clarke, 2006). The researcher spent extensive time ensuring that the transcriptions were as accurate as possible, followed by re-reading, and re-checking each transcribed interview at least three times in order to; “develop a deep and familiar sense of the detail and overall ‘picture’ of the data” (Braun & Clarke, 2021, p. 133).

First order coding of each individual transcript was undertaken manually by identifying, and labelling, key analytic ideas with a code (Braun & Clarke, 2006). The researcher acknowledges the subjective nature of code identification and does not seek to present the codes in this study as definitive but representative of co-production between the participants and the positionality of the researcher (Braun & Clarke, 2021). Due to the large volume of similarities in coding labels between individual interviews, the researcher aggregated the themes for the second order coding. Third order coding of Braun & Clarke’s (2006) five phases of

thematic analysis involves defining and naming themes. This process involves the re-reading and refinement of the themes to identify sub-themes from the six retrospective interviews.

The sub-themes generated through the coding process refined the data to present an overall story derived from the six retrospective, semi-structured interviews. Twenty nine sub-themes were identified, which were then delineated within 10 main themes, and these were then aggregated into five over-arching themes.

As illustrated in Appendix 24, the five overarching themes were subsequently situated within the context aligned with the relevant ecological systems; (a) experiences associated with the social environment, i.e., the exosystem, the macrosystem, the chronosystem, and the digisystem; (b) experiences related to the school and home environments, i.e., the microsystem and mesosystem; (c) the individual ecological system, and; (d) an additional “dividual” category was generated (discussed in section 6.3.1.5) as a finding upon completion of the TA (Appuhamilage, 2017; Braun & Clarke, 2006; Strathern, 2018).

The thematic analysis process was completed in a systematic manner, across the data set, whilst following a recursive review of the sub-themes to ensure they were appropriate with respect to the coded extracts and the entire narratives. The completed process resulted in a finalised cross-case thematic map of the analysis.

Having presented the methodological approach to the data analyses for the semi-structured retrospective interviews, the following section will consider the importance of reliability and validity in data collection and data analysis.

#### **4.3.2.5 Reliability and Validity**

This section presents the issues relevant to reliability, validity, and generalisability for the data collection and data analyses contained within this thesis (Dillon, 2003). Coyle (2021) argues that; “The concepts of reliability and some aspects of validity rely on an assumption of objectivity” and that the over-arching goal of research may be to “prove” a lack of bias, but that within qualitative research, the researcher is integral to co-creation of the production of knowledge.” (p. 29). Based upon this premise, it is therefore inappropriate for reliability to be determined from an “objective” determinant for this study. Within phase one, the researcher followed the procedure for analysis of the PGIS provided by Prof Hutti therein providing reliability of the PGIS scores for the questionnaire respondents (see Appendix 19). For the qualitative analyses of the open ended text boxes within the survey, and phase two semi-structured interviews, the researcher followed the reliability procedures suggested by Gibbs (2007):

- (a) Personally transcribing all of the interviews, checking, and re-checking, for errors to ensure accuracy, and;
- (b) Following the phased procedures for TA analysis as detailed by Braun & Clark (2006), checking, and re-checking for coding drift.

Creswell (2009) states that one of the strengths of qualitative research is validating that the findings are accurate from the viewpoint of the researcher. This researcher is determining validity of this thesis using Tracy's (2010) criteria of:

- (a) worthiness of the research topic: by providing a voice to a marginalised cohort;
- (b) rich rigour: through reliability;
- (c) sincerity: as demonstrated in researcher positionality and reflexive approach;
- (d) credibility: through reliability, researcher positionality, reflexivity, and embedding ethics as process;
- (e) resonance: through reliability;
- (f) significance of contribution: whilst a modest contribution, this thesis is a unique contribution to the topic area;
- (g) ethical: as demonstrated through embedding ethics as process;  
and
- (h) meaningful coherence: through reliability, clarity, and consistency throughout the thesis.

Additionally, traditional methods of "proving" validity include convergence, which is presented within chapter six. Convergence was utilised to strengthen the integrity and reliability of the data analyses from phase one and phase two (Ivankova et al., 2016; Teddlie & Tashakkori, 2009).

#### **4.4 Chapter Summary**

The research design, methodology, and development of the research instruments have been driven by the research question and research aims. Due to the paucity of data within this area, the theory determined the research approach as illustrated in Table 5: an initial positivist, quantitative approach to gather statistical data, followed by a hermeneutic, social constructionist approach to add depth and personal perspective via qualitative interviews. The ontological view that the nature of the outside, “real” world is at opposition to the conceptually constructed, internal world does not fit within this theoretical framework; this research views both perspectives within an integrated perspective and that knowledge production occurs within a social context. The ontological approach is therefore philosophically pragmatic.

#### **4.5 Chapter Conclusion**

This chapter detailed the methodological approach employed within which this study was conducted. Section one detailed the research structure, addressed the methodological issues, the research design, and summarised the research objectives as identified within the LR. This section also presented the rationale for the study design, and methodological approach, and consideration was given to the rationale and reasoning behind the determinations made. Section one also situated the researcher within a reflexive positionality, considering the awareness of subjectivity, and potential for emotional response by the researcher to the sensitive subject under investigation. The management of emotional labour whilst

conducting this study, and disseminating findings, was examined and mitigations to manage any impact were stated.

Section two detailed the epistemological and ontological philosophical underpinnings for this research, and set out the rationale for selection of the methodological approaches to investigate the research question. A detailed description of the development of a theoretical structure to encompass a bio-psycho-social perspective of bereavement experiences, the MTB, was provided. The methodology for the development of the research instruments for phase one and phase two was provided, followed by an overview of participant recruitment for each study, and an overview of the rationale for selection of the data analyses methodology. Addressing the issues of reliability and validity of data collection, and data analyses, were also given due consideration.

Section three detailed the ethical considerations employed throughout this study and embedded as ethics as process. The BPS (2021) code of human research ethics were determined as relevant and used as a guide for this study to ensure ethical considerations were adhered to at all times. Details of the methodological approach to ensuring integrity, validity, and reliability of data collection, data analyses, and data protection were also provided.

The chapter concluded with a summary of the theoretical underpinnings, and methodological approach, employed within this research. The following chapter will present details on the collection of, and analyses of, data from phases one and two for this study.

## **Chapter Five: Study Findings**

“Of all the pregnancy losses in adolescence, elective abortion is the most common and least often recognized.”

(Joralemon, 1986, p. 119)

### **5.0 Chapter Five Overview**

The current chapter presents the results obtained from phases one and two, derived from 23 responses to the Adult Self-Perception of Retrospective Perinatal Death in Adolescence Questionnaire (AAA), and data collected from the six adult retrospective semi-structured interviews. The results in this chapter are divided into six sections.

The first main section of this chapter presents the descriptive data analyses from 23 surveys submitted through the online Qualtrics™ platform for phase one of this study. The AAA analyses are presented within a format that maps across the bio-psycho-social perspective of the historical event within the structural components of the nested systems model consistent across this thesis (Bronfenbrenner, 1986).

The second main section of this chapter provides the detailed results from the Perinatal Grief Intensity Scale (PGIS) that was embedded within the AAA in phase one of this study (Hutti et al., 1998). The purpose of the PGIS is to identify grief intensity following a perinatal death in order to predict vulnerability to prolonged bereavement responses (Hutti & Limbo, 2019). Details of the PGIS analyses of the first six months' retrospective grief scores for the respondents are provided, followed by details of the

PGIS analyses of the six months or more retrospective grief scores.

Comparison, and analyses, of the changes over time of the PGIS scores for the respondents are also presented.

The third main section of this chapter provides illustrative examples of the themes identified within the narratives submitted within the text boxes provided within the AAA (Braun & Clarke, 2006). Within the questionnaires submitted within phase one of this study, 22 respondents utilised the text boxes to provide further contextual information to supplement the closed question responses or to add additional, comments at the end of the survey.

The fourth main section of this chapter presents one individual Irish case study to illustrate a complete and unabridged analysis of a participant narration from phase two of this study. Any identifiable details were removed from the transcript to ensure anonymity of the participant, whilst ensuring the narrative is as authentic as possible within these constraints (Farrimond, 2012; Steffen, 2021).

The fifth main section of this chapter provides a cross-case thematic analysis (TA) of the six retrospective interviews from phase two of this study (Braun & Clarke, 2006). All of the six interview transcripts have been withheld from this thesis to protect the anonymity of the participants (Farrimond, 2012).

The sixth main section of this chapter presents a newly constructed model illustrating the findings of the thematic analysis of the interview



participants' narratives from phase two of this study, integrated within a bio-psycho-social framework (Braun & Clarke, 2006; Bronfenbrenner, 1986; Davies, 2020). The Bio-Psycho-Social Model of Female Experiences of Adolescent Gestational Death (BELATED) can be viewed in Appendix 25.

This section has provided an overview of the current chapter, the next section will present the descriptive analyses of the AAA responses.

### **5.1 Phase one: AAA Results**

The current section outlines the results from the questionnaires submitted during phase one exploring the retrospective experiences of females who became pregnant during adolescence and subsequently experienced a perinatal death. No requests were received for paper printed questionnaires, and no requests were received to email the survey in a Word document to prospective respondents.

The online Qualtrics™ platform records the country location of submission for questionnaires if they have been fully completed. Of the twenty three questionnaires received, six were partially completed so the geographic location of the respondent is unknown. The report obtained from Qualtrics™ at the conclusion of phase one revealed the respondents who fully completed a questionnaire were located in the following six countries: 48% from England (n=8), 17% from the ROI (n=3), 17% from the US (n=3), 6% from New Zealand (n=1), 6% from Northern Ireland (n=1), and; 6% from Scotland (n=1). No assumptions are made by the

researcher that the respondents were natives of the countries within which the surveys were submitted.

Descriptive analyses of the data submitted within the AAA questionnaires through the online Qualtrics™ platform between the 1<sup>st</sup> of October, 2019 and the 31<sup>st</sup> of December, 2019 is presented in the following sections. The sub-sections are presented correspondingly with the bio-psycho-social themes mapped to the MTB as detailed in Appendix 16.

### ***5.1.1 The Individual Ecological System***

Chapter two details the Multidimensional Theory of Bereavement (MTB) which was constructed and modified from Bronfenbrenner's Ecological Systems Theory which positions the developing individual at the centre of the nested systems model (Bronfenbrenner, 1979). The MTB expands the concept of personhood within Bronfenbrenner's (1979) "individual" nested system into two constituents; the biological element and the behavioural element. The following sections provide the data analyses collated from questions 1.10, 1.11, 1.12, 1.13, 1.14, 1.20, 1.21, 1.22, 1.24, 1.30, 1.31, 1.35, 1.36, 1.39, and 57 pertaining to the individual ecological system embedded within the questionnaires in phase one.

### ***5.1.2 Biological Characteristics***

The biological element within the "individual" component of the nested systems model of the MTB is represented within the questionnaire as demographic data. To comply with the inclusion criteria for this study, all of the respondents completing, and submitting, the survey confirmed they

were biologically female in question 1.10 (n = 23). Twenty two of the questionnaire respondents self-identified their ethnicity as “white” and one respondent self-identified their ethnicity as “black” in question 1.11. Question 1.12 asked the respondents their age at the time of the survey submission. The questionnaire respondents’ current stated age varied from twenty one years old to fifty eight years old. The respondents’ ages within phase one were distributed as follows; 41% (n = 9) in their twenties, 18% (n = 4) in their thirties, 23% (n = 5) in their forties, and 18% (n = 4) in their fifties. One respondent (4%) did not disclose their age at the time of submission.

#### **5.1.2.1 Categories of Gestational Death Loss**

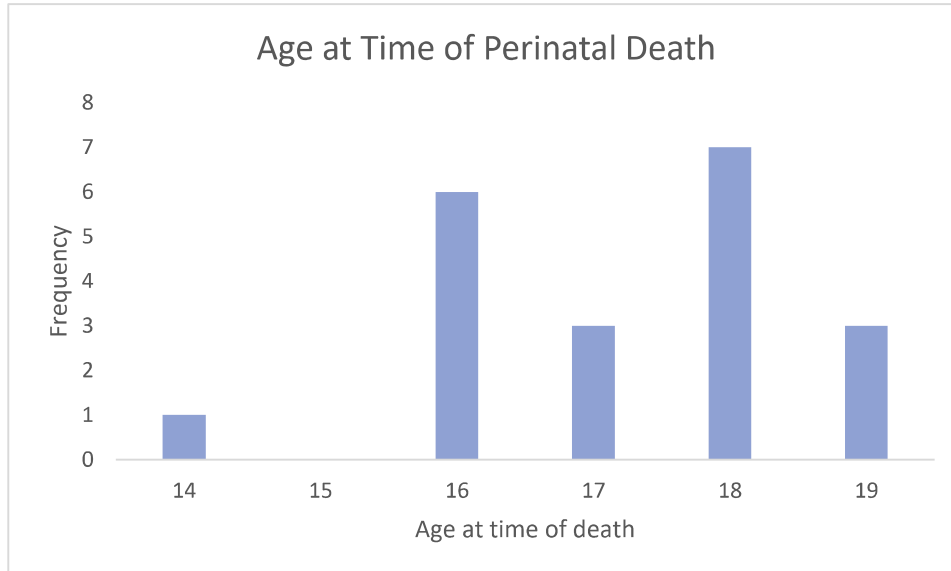
To ascertain the type of perinatal death experienced by the respondents, question 1.30 found the respondents had experienced either an adolescent abortion; 60% (n=12), or an adolescent miscarriage; 40% (n = 8).

#### **5.1.2.2 Adolescent Age at Time of Death Loss**

The questionnaire respondents were also asked their age at the time of the adolescent perinatal death loss in question 1.3. The distribution of responses are summarised in Figure 7:

**Figure 7**

*Phase One Participant Ages at Time of Perinatal Death*



Having presented the biological data within the individual nested system, the following section presents analyses of the behavioural data collected within the phase one survey.

**5.1.3 Behavioural Characteristics**

The second element within the “individual” component of the MTB is the behavioural element. The behavioural element is represented within the questionnaire as data pertaining to the behavioural aspects of the respondents prior to, during, and post adolescent perinatal loss, from an adult retrospective perspective. Descriptive analyses of the data collected from questions; 1.13, 1.14, 1.20, 1.21, 1.22, 1.24, 1.35, 1.36, 1.39, and 57 within the study are presented in this section (Babbie, 1990; Flick, 2018).

### 5.1.3.1 Adolescent Contraceptive Use

This study sought to ascertain if respondents used contraception at the time of the adolescent pregnancy, where the respondents obtained their most important source of information on sex and relationships, and if they spoke to their parents about relationships and sexual activity during adolescence.

The availability and variety of contraception has advanced over the past fifty years; but these factors are culturally dependant, and there are disparities between accessibility between developing and developed countries (e.g. Blanc & Way, 1998; Rios-Zertuche et al., 2017). The researcher, whilst not assuming cultural backgrounds, assumes the respondents in phase one shared Western cultural norms as all twenty three surveys originated in developed countries. Within Western cultural norms contraceptive availability, and use, has evidenced behavioural change since the 1980s with an increase in the availability, and use, of condoms and the contraceptive pill (Santelli and Melnikas, 2010). The respondents within phase one were adolescents during, or post, the 1980s and the researcher sought to ascertain if the respondents were using contraception at the time of their adolescent pregnancy. Question 1.24 asked the respondents; “Were you using any form of contraception when you got pregnant as a teenager?”. The data revealed 43% (n = 10) of questionnaire respondents for this study stated they were using contraception when they became pregnant during adolescence. A further 57% (n = 13) of the respondents were not using any form of contraception at the time of conception.

Whilst theoretically available, and culturally acceptable to use, there were several explanations provided by ten of the study respondents for not using contraception at the time they got pregnant, which were: “condoms ran out and decided to risk it.”, “Ignorance”, “Had not planned sex”, “I just didn’t want to. I had been having sex without it for 2 years and felt like nothing would happen.”, “ Not really confident in using condoms and was naïve”, “Was too ashamed to ask Dr”, “Did not think of the consequence”, “Too scared to talk to parents about it”, “sort of on and off the pill”, and “was afraid of the side effects”. Additionally, there was no relationship with contraceptive use and age at the time of the pregnancy, with respondents failing to use contraception from as young as 14 through to aged 19.

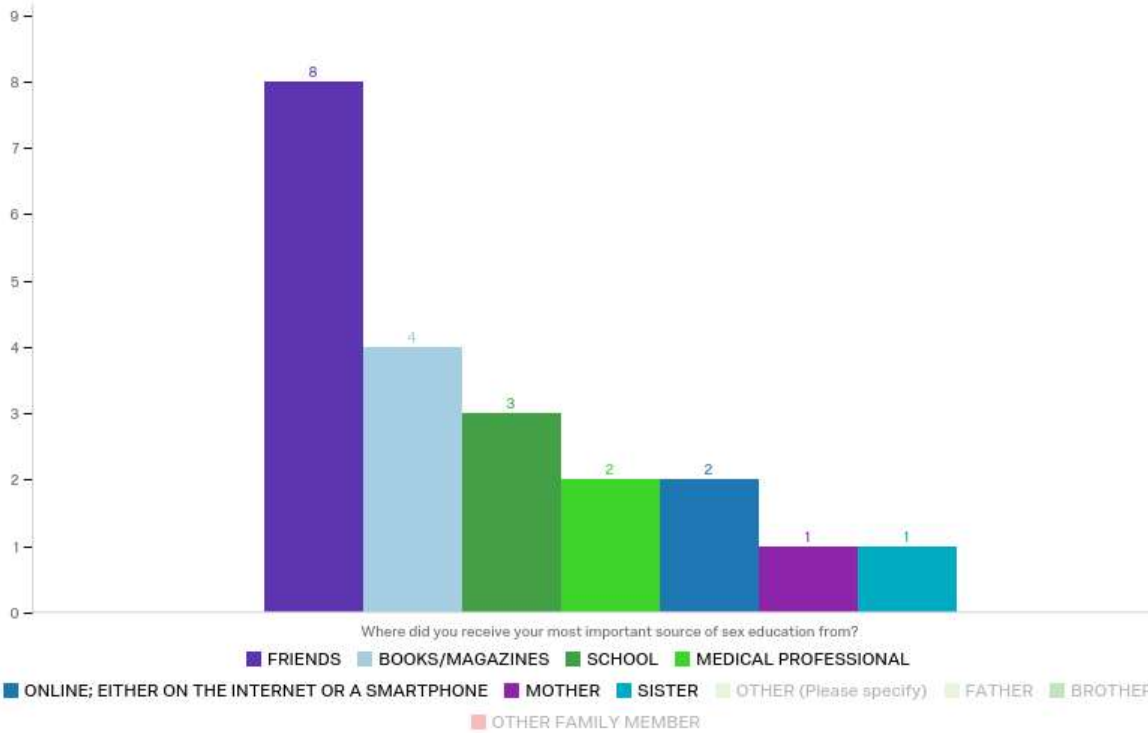
Question 1.21 began the section on reproductive health knowledge by asking; “Did you receive classes on puberty, sexual or reproductive health, and/or relationships in school?”. All 23 respondents answered this question, stating they all attended schools that provided Sex and Relationship Education (RSE) classes. Twenty-two of the respondents affirmed that they attended some, or all, of the classes, with one respondent stating she did not. However, the respondent that stated she did not attend the classes also stated in question 1.22 that her most important source of sex education was “school”.

Question 1.22 sought to identify the sources of information on reproductive health during adolescence by asking respondents; “Where did you receive your most important sex education from?”. Figure 8 detailing

the responses to this question is presented below, evidencing that; 35% (n = 8) of respondents reported that they obtained their most important sex education from their friends, an additional 17% (n = 4) responded that books/magazines and school equally were their most important source of sex education, followed by 9% (n = 2) equally reporting medical professionals and online resources as their most important source of sex education, and a resultant 4% (n = 1) each stating that their mother, their sister, and “other” (no details provided) were their most important source of sex education.

**Figure 8**

*Participant Most Important Sources of Sex Education During Adolescence*



A further related question, 1.23, asked respondents; “Whilst in secondary school, did you ever discuss sex-related matters with either your

mother or father?”. The answers and analysis to this question is provided in section 6.3.2.1 within the family subsection to the microsystem.

All 23 respondents received RSE education in school but it is clear from the responses to question 1.22 that adolescents place a higher value on sex information received from friends, books, and magazines, than the curriculum content provided in school. Therefore, whilst adults and educators argue persuasively for formal sex education, and research suggests there are benefits to providing such information, this study suggests that collaborations between educators and adolescents on the content and delivery of formal RSE education should be a joint venture (O’Higgins & Gabhainn, 2010; Parker et al., 2009; Secor-Turner et al., 2011).

However, further information both within the AAA responses, and the interview participant narratives, revealed one disclosure of rape (one AAA respondent) and suggestions of coercive control, manipulation, and consent issues (see section 5.5.5.1). It is therefore a finding for this thesis that Welch and Bergen’s (2000), assertion that a lack of contraceptive use is due to “poor decision making” is an oversimplification that does not consider the complex interplay of psycho-social factors. Further, public discourse promoting narratives of irresponsible adolescent sexual behaviour contribute to the stigmatisation females experience when they become pregnant during this developmental phase (and impact across the lifespan).

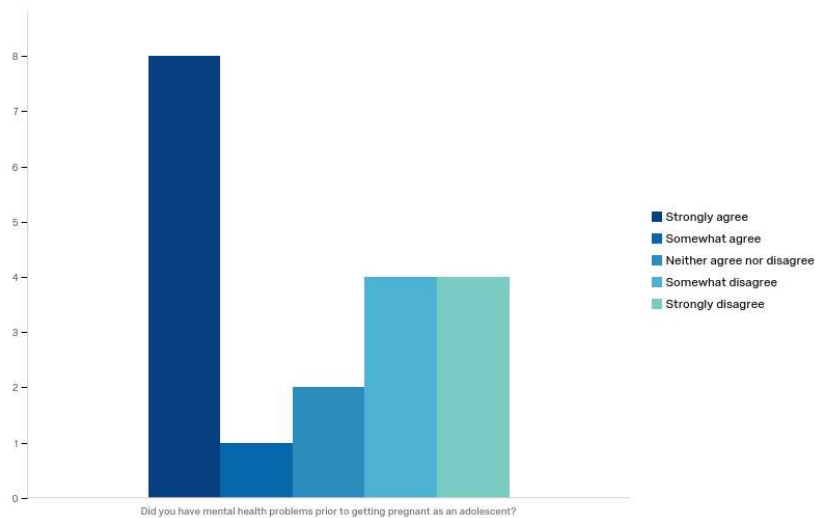


### **5.1.3.2 Adolescent Mental Health**

To ascertain if the respondents self-identified mental health problems prior to the adolescent pregnancy, question 1.36 asked; “I had mental health problems prior to getting pregnant as a teenager.” (Barglow et al., 1973; Trickey & Black, 2000; Wheeler & Austin, 2001). The data collected from the 5-point Likert scale revealed that almost half of the respondents, 43% (n = 10), stated that they had self-identified the presence of mental health problems during adolescence. A further 35% (n = 8) of the respondents stated that they did not perceive mental health problems prior to their adolescent pregnancy, and the resultant 9% (n = 2) of the phase one respondents declared that they neither agreed nor disagreed with self-identifying mental health problems prior to their adolescent pregnancy. An additional 13% (n = 3) of submitted questionnaires were returned with this question unanswered. The summarised results from question 1.36 are presented in Figure 9:

**Figure 9**

*Participant Self-identification of Mental Health Problems During Adolescence*



Another finding for this study is that seven of the nine respondents who self-declared mental health problems prior to getting pregnant during adolescence also indicated that they would have liked to have received bereavement information/support following their perinatal death.

Additionally, eight of the same nine respondents who stated that they had suffered mental health problems prior to getting pregnant also agreed that their experience of perinatal death during adolescence had affected their education at the time (Krosch & Shakespeare-Finch, 2017). Further research would be necessary to establish if self-identified, or professionally identified, mental health problems during childhood/adolescence may lead to increased risk of negative outcomes following a perinatal death loss during this developmental stage.

To ascertain if the phase one respondents felt they were affected negatively, neutrally, or positively following their perinatal death loss, they were asked question 1.39; “As an adult looking back, how do you think your perinatal loss as a teenager in secondary school affected you?”. Of the respondents that answered the question, 50% (n = 9) stated that; “It was a traumatic experience that has enabled me to change my life in a significantly positive way; I wouldn’t be the person I am today if it hadn’t happened”. Of these nine respondents, six experienced an abortion and three experienced a miscarriage during adolescence. All of the nine respondents self-declaring potential post traumatic growth stated in a separate question that they would have liked to have received bereavement information/support. This collective response suggests that their self-reported “traumatic experience” was impactful (McGovern & Tracey, 2010). Educational attainment of the nine respondents who self-declared potential post traumatic growth is as follows; one woman is currently in third level education, and the other eight women have graduated university, with two of the eight women having attained postgraduate qualifications (Calhoun et al., 2010). These results suggest that self-perceived traumatic response following a perinatal death loss during adolescence may be the impetus for engagement, or re-engagement, with education and potential for greater educational attainment.

A further 22% (n = 4) of the respondents responding to the question; “As an adult looking back, how do you think your perinatal loss as a teenager in secondary school affected you?” responded with; “It was an event in my life that has had neither a bad or good effect in my life overall”.

However, 28% (n = 5) believe that their experience of perinatal loss; “It had a bad effect on me and it still affects me today” (Hutti et al., 2018; Ritsher & Neugebauer, 2002). Four of the respondents experienced a miscarriage and one respondent experienced an abortion, suggesting that further studies would be useful to ascertain whether miscarriage loss during adolescence may have a more negative lasting impact on adult women across the lifespan. Of these respondents, none had experienced a bereavement prior to their perinatal death during adolescence, ruling out potential confounding effects from that possible contributory variable (Pham, 2020). All of the five respondents stated that their secondary education was affected at the time, with four women stating that their education was affected negatively and one woman stating that her education was affected positively (O’Brien, 2015). Of these five respondents, two have completed university level education, two have completed college level education and one has completed secondary level education and is currently studying part time in college (Shear & Shair, 2005). Thus, compared with the self-reported post traumatic growth responses, where two thirds of the respondents had experienced an abortion, results from this question indicate more research is needed to ascertain if miscarriage losses during adolescent result in greater risk of long term negative impact, and lower educational attainment.

Five respondents declined to answer the question as to whether they considered their secondary education was affected at the time of their perinatal death.

### 5.1.3.3 “Parent” Identity

All the publications identified within the LR have conferred the Euro-Western cultural norm of mother identity status on women who experienced a perinatal death during adolescence (see chapter three). However, there is no indication in any of the publications to establish if the females had been consulted before parental identity had been conferred by the authors following an adolescent perinatal death.

Therefore, to ascertain identity attribution as “bereaved parent”, by adult women who had experienced an adolescent perinatal death loss, the respondents were asked question 57; “Following my loss whilst in secondary school, I would describe myself as a ‘bereaved parent’”. Sixteen respondents engaged with this question resulting in the following findings; 24% (n = 4) strongly agreed with the statement, 12% (n = 2) somewhat agreed with the statement, 12% (n = 2) neither agreed nor disagreed and the resulting 52% (n = 9) either somewhat or strongly disagreed with the statement. Of the six women who self-identified as a “bereaved parent”, five experienced an adolescent miscarriage and one experienced an adolescent abortion. All six women stated that they had wanted bereavement information and/or support at the time of the perinatal death. Of the six women that self-identified as a “bereaved parent”, all five of the women who experienced miscarriage also stated that they had self-identified mental health problems prior to the pregnancy. The respondent who experienced an abortion, who self-identified as a “bereaved parent”, stated that she neither agreed, nor disagreed, with the statement that she had mental health problems prior to getting pregnant. Five of the six women

identifying as “bereaved parents” scored highly on the PGIS at the time of the event, with only one female adjusting to a normal score over time (Hutti et al., 1998). These results suggest that females who experience miscarriage during adolescence may ascribe personhood to the pregnancy, may experience a grief response, may identify as a bereaved parent, and may be at risk of prolonged grief disorder (Layne, 1990; Hutti et al., 1998).

However, the correlation between negative bereavement outcomes and prior mental health problems cannot be overlooked (Aldwin, 2007; Felitti et al., 1998; Flay et al., 2009; Silvers et al., 2012). Similar findings for women who experienced abortion are less common but are present (Steinberg & Tschann, 2013). Further exploration with larger samples specifically addressing prior mental health problems, psycho-social transitions, and Adverse Childhood Experiences (ACE) may illuminate correlation, or causation, of adverse bereavement outcomes following an adolescent perinatal death, within specific individuals (Berger, 2014; Hillis et al., 2004; Milman et al., 2019).

#### **5.1.3.4 Adolescent Repeat Pregnancies**

Several LR studies reported rapid repeat pregnancies following a perinatal death during adolescence, indicating a desire to fulfil the societal role of parent (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Horowitz, 1978; Schodt, 1982; Sefton, 2002; Welch & Bergen, 2000; Wheeler & Austin, 2001). When asked in question 1.35 if the respondents had any living children, of the nineteen respondents that answered the question, 30% (n = 6) do not have any living children. Their ages were:

22, 28, 28, 34, 36, and one declined to answer the question; one experienced a miscarriage and five experienced an abortion. Of the six respondents that do not have any living children all are university graduates, with three having completed postgraduate qualification. These findings suggest that females who experience abortion during adolescence may be more likely to delay parenthood to complete third level education, and potentially achieve post graduate qualifications. Further research would be required to ascertain if these results are applicable to the population, not just the sample.

#### **5.1.3.5 Retrospective Views of Education**

Research suggests that bereavement experiences during adolescence may contribute to poor school performance and lower school attendance (e.g., Balk, 1983; Gray, 1987; Hogan & Desantis, 1994; Lynam et al., 2018; McGovern & Tracey, 2010; O'Brien, 2015). The current study therefore sought to provide an initial exploration of whether perinatal death during adolescence impact on educational attainment (Büchi et al., 2007; Krosch & Shakespeare-Finch, 2017; Tedeschi et al., 1998).

Twenty of the 23 respondents who submitted the questionnaire for phase one of this study declared in question 1.13 that they had completed college, university, or postgraduate education. Of the three resultant respondents, question 1.14 ascertained that two were attending college at the time of submission, with one resultant female who, at that time, had only completed secondary education. Furthermore, a total of six of the 23 respondents were attending college or university at the time of submitting

their questionnaire, indicating that not only is education a lifelong pursuit, but that experiencing perinatal death loss during adolescence may indicate the impetus to engage or re-engage in educational pursuit (Perez-Reyes & Falk, 1973; Sefton, 2002).

#### **5.1.3.6 Religiosity**

Religious edicts on adolescent sexual behaviour, pregnancy outside of marriage, and views on elective abortions, can be pervasive (e.g. Manlove et al., 2008; Studer & Thornton, 1987; Thornton & Camburn, 1989).

Therefore, the questionnaire design for phase one incorporated an exploration of whether the adult respondents identified with any particular religious or spiritual group.

Question 1.20 within the AAA survey asked the question; “Do you associate with a religion or religious/spiritual group?”. Twenty three respondents answered the question, with the majority 74% (n = 17) answering that they do not associate with a religion or religious/spiritual group. The respondents who identified with a religion or religious/spiritual group comprised of 26% (n = 6), and stated that they identify as Roman Catholic (n = 1), Goddess-centered Paganism (n = 1), Christian (n = 1), Jesus follower (n = 1), Asatru (n = 1), and one did not state their religious/spiritual affiliation. Due to the generalisable perception of personhood at the point of conception by some religious groups, the researcher expected that women who associated with a religion might self-identify as “bereaved parent”. However, a finding for this thesis was that the six women that identified with a religion or religious/spiritual group did



not identify as a “bereaved mother”. The six women that self-identified as a “bereaved mother” were not affiliated with any religious or spiritual group (Kissling, 1993; Maguire, 1989).

#### ***5.1.4 The Microsystem***

As detailed in chapter two, the MTB was constructed, and modified, from Bronfenbrenner’s (1979) nested systems model, which positions the microsystem as the ecological system directly situated outside of the individual component. This section explores the data collected from questions 1.15, 1.19, 1.23, 1.27, 1.28, 1.29, 1.32, 1.33, 1.34, 1.37, and 1.38, pertaining to the microsystem; the family, the peers, the medical professionals, the school professionals, the work interactions (if relevant), and any other bereavements within the immediate environment.

##### **5.1.4.1 Family**

The literature review in chapter three suggests that the family, particularly the mother, has an influential impact on adolescent females who experience pregnancy, and subsequent perinatal loss (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Hatcher, 1973; Perez-Reyes & Falk, 1973; Sefton, 2002; Welch & Bergen, 2000). The researcher chose to explore these relationships within the semi-structured interviews in phase two of this study due to the complexity of the subject. However, one related question was included in the questionnaire to ascertain whether the respondents spoke to their parents about sex-related matters during adolescence (Berger, 2014; Shtarkshall et al., 2007).

Results from the responses to question 1.2.3 revealed that 48% (n = 11) of the respondents' parents never discussed sex-related matters with them during adolescence. A further 43% (n = 10) stated that they occasionally discussed sex-related matters with a parent during adolescence, and 9% (n = 2) of the respondents declared that they talked to their mother or father "often" about sex-related matters during adolescence.

#### **5.1.4.2 Other Bereavements During Childhood**

Research suggests that successive bereavements can contribute to an accumulation of bereavement responses known as "cumulative grief" (Mount, 2016). Therefore, prior significant childhood bereavements could potentially impact on the experience or PGIS scores of the respondents (Oltjenbruns, 2001). Additionally, scholars have highlighted that the death of a significant attachment during childhood, within the construct of Adverse Childhood Experiences (ACEs), can contribute to pregnancy during adolescence and/or adverse behavioural outcomes (Hillis et al., 2004).

Therefore, prior bereavements of a significant attachment could potentially be influential on the grief response to the adolescent perinatal death: "Adolescence is a developmental period marked by growth and potential, but it is also the point in the lifespan that many individuals first experience the deep grief induced by the death of a loved one." (Servaty-Seib & Burlison, 2007, p. 208). Accordingly, the AAA questionnaire included question 1.37 which enquired as to whether the respondents were bereaved prior to their perinatal loss, in order to allow for the potential of

confounding contributors to their responses. Approximately one third (n = 6) of the respondents that engaged with this question responded that they had experienced a significant bereavement prior to their perinatal loss. These bereavements were detailed as: a best friend at the age of thirteen, grandparents, pets, and a father at eleven years old. An additional comment was added by one respondent who considered herself bereaved by divorce: “My parents had a nasty divorce and my Father did not want to see us”. The PGIS scores for the six respondents who experienced prior significant bereavements revealed higher grief responses for four of the six women. The respondent who disclosed experiencing a “nasty” divorce during childhood scored highly on the PGIS, with an increased score over time, indicating a potential complicated grief response. Research by Lynam et al., (2018) investigating child responses to death, separation, and divorce, indicate that all three events can be impactful on young people, confirming that prior experiences can contribute to perinatal death loss impact.

#### **5.1.4.3 Peers**

As detailed in chapter two, peer influence on developing adolescents is well documented within the literature, specifically on attitudes towards, for example, sexual activity, attitudes towards lone parenthood, attitudes towards abortion services, attitudes towards adolescent pregnancy, and response to adolescent loss (Backes & Bonnie, 2019; Balk & Corr, 2001; Eccles & Roeser, 2011; Manlove et al., 2008; Newman & Newman, 1976).

Due to the nuances within the various adolescent development theories, and variations within the findings in the literature review, the

researcher decided to explore peer relationships within phase two of this research within the semi-structured interviews. However, one area of peer interaction, and influence, was explored in phase one. Choukas-Bradley et al. (2014) state: “Boys learn about sex from other boys (Henry et al., 2012), girls from other girls, with the strongest influence being what peers say they have done, not something abstract.” (p. 525), therefore question 1.22 asked the respondents; “Where did you receive your most important source of sex education from?”. As detailed in section 5.1.3.1, the greatest percentage of the questionnaire respondents, 36% (n = 8), stated this was from their friends (see Figure 8).

The results from these questions, identifying the importance of knowledge sharing within peer relationships, raise a further question as to how peers are obtaining said information on relationships and sex. It also raises the question as to the quality of the information being shared and whether these exchanges help, or hinder, relationship and sexual decision making (Shtarkshall et al., 2007). Moreover, as detailed in section 5.1.3.1, 22 of the 23 respondents stated they had attended RSE within school, providing a further question as to efficacy of the sex education provided when only 17% (n = 4) of respondents are declaring school as their most important source of sex education and 36% (n = 8) are stating their friends are the most important source of sex information.

#### **5.1.4.4 Teachers**

As previously detailed in chapter three, the studies identified from the database searches for the LR were predominantly focussed on the medical

perspective of adolescent perinatal losses. Therefore, it could be argued that the role of teachers, within secondary schools, have hitherto been excluded from the adolescent perinatal bereavement literature. The researcher therefore added pertinent questions to the survey within phase one to ascertain a baseline level of information regarding the school experiences of females who became pregnant, and subsequently experienced a perinatal death.

As an introductory exploration, question 1.27 was embedded within the AAA questionnaire, asking respondents; “Is there anything your school or teachers could have done better to support you after your perinatal loss?”. A dichotomous “yes/no” response was provided and over half of the respondents, 55% (n = 11), responded that their school or teachers could have supported them better. A comment box was provided for respondents to add contextual information. Two themes were generated from the comments submitted within the text box attached to this question (Braun & Clarke, 2021);

1. The lack of support (or signposting) from teachers, for example:

I was bullied due to pregnancy/termination and guidance teacher informed me it was all my own fault and I brought the bullying on myself, I needed support and when I reached out for it, it started a downward spiral of depression

2. Silence, for example:

I didn't actually tell any adults but I was also never educated about terminations. Furthermore, because it was never

talked about at school, no one was ever highlighted as the support person to go to, should you need support. I feared being shamed for being irresponsible

The second question, 1.28, further explored the school experience, asking the respondents; “Did your experience of perinatal loss whilst in secondary school affect your attitude towards education at that time?”. A dichotomous “yes/no” response was provided and the submissions revealed that the majority of adult women who answered the question, 70% (n = 14), stated “yes” and 30% (n = 6) answered “no” in response to whether their attitude towards education was affected following their perinatal death experience at that time. A comment box was provided for the respondents to submit any comments to supplement their answer. Thirteen comments were submitted in response to this question; 10 of the comments were negative (“disengaging with school”) and three of the comments were positive (“feeling the need to do well educationally”). The two themes generated from the comments submitted within the text box attached to question 1.28 are illustrated below (Braun & Clarke, 2021):

1. Disengaging with school, for example: “I had always been a bright student but I rebelled and took less interest in school”.
2. Feeling the need to do well in their education, for example: “Interestingly, it made me feel as though I HAD to achieve”.

The third question, 1.29, expanded investigations into the school experience from a retrospective perspective; “As an adult, do you think your perinatal

loss affected your education in any way?”. The responses revealed 58% (n = 11) of respondents stated their education was affected in a negative way. This response is consistent with the findings from question 1.27 where half of the respondents, 55% (n = 11), responded that their school or teachers could have supported them better whilst in secondary education. A further 21% (n = 4) stated that as adults the respondents think that their perinatal loss affected their education in a positive way confirming the results from question 1.28. The remaining 21% (n = 4) reported that they did not think their perinatal loss affected their education in any way.

The results from questions 1.27, 1.28, and 1.29 regarding school response and the perceived impact on education, both at the time and over the lifespan, suggest that the predominant narrative of educational attainment were negatively impacted by the school response, or lack thereof, immediately following the perinatal death experiences.

However, 20 of the 23 respondents who completed the AAA questionnaire had attained college, university, or postgraduate qualifications at the time of submission. Of the three resultant respondents, two were attending college at the time of submission, with one further female who, at that time, had only completed secondary education. Furthermore, a total of six of the 23 respondents were attending college or university at the time of submitting their questionnaire, indicating that not only is education a lifelong pursuit, but that experiencing perinatal death loss during adolescence may indicate an impetus to engage or re-engage in educational pursuit (Perez-Reyes & Falk, 1973; Sefton, 2002).

#### **5.1.4.5 Medical Professionals**

The publications identified within the LR are situated within either the medical discipline or within a medical establishment, with most utilising convenience samples within healthcare environments, and all demonstrated empathic views towards females who experienced perinatal losses during adolescence (Barglow et al., 1973; Barnickol et al., 1986; Bright, 1987; Fenstermacher, 2014; Hatcher, 1973; Horowitz, 1978; Joralemon, 1986; Nykiel, 1996; Nykiel, 2002; Perez-Reyes & Falk, 1973; Schodt, 1982; Sefton, 2002; Sefton, 2007; Shaefer, 1992; Soto, 2010; Tonelli, 2006; Welch & Bergen, 2000; Wheeler & Austin, 2000; Wheeler & Austin, 2001; Wheeler & Sefton, 2021).

However, research studies in Ireland investigating the experiences of concealed pregnancies revealed many adolescent girls experience these events without seeking medical attention (Conlon, 2006; Murphy Tighe, 2017). This study therefore acknowledges the potential lack of representation of adolescent females within the medical microsystem due to these factors (Taylor, 2020).

To ascertain if any of the respondents had experienced a perinatal loss without seeking medical services, question 1.32 asked; “Did you seek medical services during or following your perinatal loss?”. Of the 19 respondents that responded to this question, 80% (n = 16) stated that they did seek medical services and 20% (n = 4) of the respondents stated that they did not. A second question, 1.33, sought to elucidate further information on the medical experience; “If you sought medical services



during or following your perinatal loss, were you given any advice, support information or signposting to helpful organisations?”. Of the 16 respondents that sought medical services, only 38% (n = 6) were given any advice, support information, or signposting to helpful organisations.

The four respondents that did not seek any professional medical services during, or following their loss, stated that they experienced a miscarriage. They also stated that their education was affected negatively at the time of the miscarriage but have all completed third level education to date. Three of the same four respondents have self-declared their identity as “bereaved parents” as a result of their adolescent miscarriage. Furthermore, all four of the respondents who did not seek medical attention scored higher than average on the PGIS (Hutti et al., 1998). The respondent that disagreed with the identification of “bereaved parent” stated she became pregnant at fourteen years old due to rape and that the event still had a negative effect on her.

As only 38% (n = 6) were given any advice, support information, or signposting to helpful organisations, a third question, 1.34, asked respondents; “Following your perinatal loss, what would you have liked information on?”. Seventy percent of the questionnaire respondents (n = 16) stated that they would have like to have received more information following their perinatal loss, with 14 respondents stating they specifically wanted bereavement information, one respondent stating that she wanted contraceptive advice, and one respondent stating she wanted more information on “the potential impact of the medical procedure”.

These results indicate that an undetermined number of adolescent females experience miscarriage without seeking medical attention and may self-identify as bereaved parents during adulthood. Additionally, these findings suggest adolescents who seek medical services for a perinatal death should be provided with bereavement information, contraceptive information, and advice on the medical procedure.

#### **5.1.4.6 Employment During Adolescence**

Early employment may be a potential contributor to negative educational outcomes, and as detailed in chapter two, adolescents from lower socioeconomic groups, who may be susceptible to starting work at earlier ages, are more vulnerable to adolescent pregnancy (Barone et al., 1996; McCoy & Smyth, 2007). McCoy & Smyth (2007) suggest that adolescents that work whilst attending secondary school; “are found to underperform academically compared to non-workers” (p. 227).

Within the AAA questionnaire, question 1.15 asked; “How old were you when you started working for pay?” to ascertain if early employment may be a potential contributor to negative educational outcomes. Twenty two of the adult women responded to question 1.18 and Table 8 below highlights the distribution of ages at which the respondents started work:

**Table 8**

*Ages Phase one Respondents Started Paid Employment*

Class Intervals	Midpoint	Frequency	Relative Frequency	Percentage
11-13	12	2	10%	10%
14-16	15	10	48%	48%
17-19	18	7	33%	33%
20-22	21	1	5%	5%
23-24	23.5	1	5%	5%

Table 8 highlights the fact that 90% of the respondents within phase one were working for pay whilst attending secondary education, with 58% working before the age of 16.

Question 1.19 of the AAA asked respondents; “Are you currently working for pay?” to ascertain if there was any perceived negative impact on future employment as a result of the adolescent perinatal death loss experience. All 23 respondents answered this question with 91% (n = 21) stating they were working at the time of submitting the survey. Only 9% (n = 2) of the women were not working, of which one was 21 years old and attending college at the time of submission.

These results show the majority of women in phase one were working whilst in secondary school. Despite the preponderance of negative reflections on their educational experience at the time of the perinatal death, as reported in section 5.1.4.4, overall attainment of third level education

across the lifespan, and employment, appear to be unaffected. This raises the question of what is being measured; educational experience or educational achievement. McCoy & Smyth (2007) found Irish adolescents that work are more likely to underperform academically in secondary school. However, the respondents of phase one had all achieved secondary school qualifications, with most also achieving graduate and post-graduate qualifications, indicating a prevalence of adjustment, resilience, and possible post traumatic growth across the lifespan (Joseph, 2011; Tedeschi et al., 1998).

#### **5.1.4.7 The Techno-Subsystem**

The techno-subsystem is a new addition to Bronfenbrenner's (1992) ecological systems theory (Johnson & Ptoplampu, 2008). Communication that would previously occur between humans in a face to face manner are now increasingly conducted utilising technology, particularly within adolescent populations (Valkenburg & Peter, 2011). The widespread use of the internet and smartphones, that allow communication by videoconferencing and mobile software applications (apps), have significantly changed the facilitation of proximal relationships (Craft & Garcia, 2016). Adolescents are now able to access information online instantly, and connect with anyone within their microsystem via apps such as Snapchat, WhatsApp, and any other interactive technology, for example, Skype, resulting in a generation of digital natives (Kennedy et al., 2008).

To ascertain if the internet, and/or smartphones were particularly useful during their experience of adolescent perinatal death, at the time of

the event, respondents were asked question 1.38: “Online/smartphone resources (websites, blog posts, social media, WhatsApp etc.) helped me during and/or after my perinatal loss”. Nineteen respondents engaged with this question, with 58% (n = 11) stating they “strongly disagree”. Of these 11 respondents, the youngest was twenty one years old and the second youngest was twenty eight years old, suggesting that both would theoretically have access to relationships via the techno-subsystem and access to any online information. The older respondents who stated technology was not helpful comprised of two women both aged 36, with the resultant respondents in their 40’s and 50’s, rendering the question irrelevant to them at the time of the event. Twenty one percent (n = 4) of the survey respondents answered that they “somewhat agree” that online resources helped them during or following their perinatal loss. A further 21% (n = 4) of respondents answered that they “neither agree nor disagree” that online resources were helpful either during or after their perinatal death during adolescence. The results from this question are predictably mixed and the researcher would suggest that for the respondents who are digital natives, i.e. the younger females with access to the techno-subsystem at the time of the event, online resources were not particularly helpful due to the lack of relevant information (see chapter one).

### ***5.1.5 The Mesosystem and The Exosystem***

The MTB was constructed and modified from Bronfenbrenner’s (1979) Ecological Systems Theory which positions the mesosystem as the ecological system directly situated outside of the microsystem. The

mesosystem incorporates the interconnections between two or more microsystems.

The next system, the exosystem, is situated directly outside of the mesosystem and incorporates indirect influential variables. Due to the complexity of the potential interconnections, or lack thereof, within the adolescent's mesosystem and exosystem before, during, and following the perinatal death, experiences within these systems were explored within phase two of this study.

### ***5.1.6 The Macrosystem***

The macrosystem is the ecological system directly situated outside of the exosystem (Bronfenbrenner, 1979). The macrosystem encompasses the values and normative attitudes within cultures and subcultures. This section presents the results from questions 1.16 and 1.25 within phase one pertaining to the macrosystem.

#### **5.1.6.1 Religion**

Organised religion can significantly influence political, economic, social, and cultural norms both individually, and collectively (e.g. Levitt & Lamba-Nieves, 2011). These include gender based behavioural expectations and how that manifests apropos to sexual activity (e.g. Kissling, 1993; Regnerus, 2007; Thornton & Camburn, 1989).

A major conduit for doctrinal cultural norms are organisations such as schools and medical facilities affiliated with religious organisations (Bourke et al., 2014; Mishtal, 2017). Schools influence what pupils are

taught in relationship and sex education (RSE), with normative structures varying across, and within, cultures and subcultures; “Underlying the social conflicts that surround sex education programs are disagreements about the role of government in family life and sex education; parental control of the content of sex education; core values to be included in sex education, such as gender equality and personal responsibility; and, fundamentally, what constitutes appropriate adolescent sexual behavior.” (Shtarkshall et al., 2007, p. 116). For example, Parker et al., (2009) report that in Ireland; “Teachers have the ultimate responsibility for provision... This discretionary aspect means that comprehensive sexuality education is not available to all pupils.” (p. 236).

Medical professionals influence what medical services females can access, for example, by refusing to perform the termination of a pregnancy or refusing to provide contraception. Moreover, Fiala and Arthur (2014) suggest that the religious beliefs of medical professionals can determine action, or inaction, in providing healthcare services citing; “Conscientious objection (CO) in the West originates in Christianity in the form of pacifism – the belief that taking human life under any circumstances is evil”. (p. 12). Thus religious influences within the macrosystem influence attitudes, and subsequent behaviour, across, and within, all connective nested systems.

To gain an understanding of the impact of religious influence within the respondents’ school environment, question 1.16 within the AAA questionnaire asked; “Was your school associated with a particular religion or religious group?”. Twenty two respondents engaged with the question,

with 73% (n = 16) stating their secondary school did not have a particular religious affiliation. The remaining 27% (n = 6) of respondents attended secondary schools governed by a particular religious group, which comprised of; Catholic (n = 4), Roman Catholic (n = 1) and Christian (n = 1).

The six women who attended a secondary school affiliated with a religious organisation stated that they attended sex education classes but that their most important source of information was from their friends or books. Four of the six women who attended a secondary school affiliated with a religious group were not using contraception when they became pregnant, with one adding a text box comment that she was too ashamed to ask the doctor for it.

#### **5.1.6.2 Sex and Relationship Education**

Chapter one detailed the potential significance of effective relationship and sex education (RSE) curriculum and perceived resultant low adolescent pregnancy rates (Boyd & Bee, 2008).

As detailed in section 5.1.3.1, the first question, 1.21, asked respondents; “Did you receive classes on puberty, sexual or reproductive health, and/or relationships in school?”. All twenty three of the respondents responded to this question within the AAA study with 100% confirming that their school had provided RSE classes during secondary school. These results, encompassing female respondents of varying ages and in different countries, confirm the existence of RSE classes within schools but do not indicate efficacy or quality of content. However, the results from question



1.22, presented in Figure 8, revealed only 17% (n= 4) of the respondents stated that school was the most important source of sex education.

### **5.1.6.3 School Bereavement Policy**

Chapter two presented the theoretical foundations for understanding adolescent bereavement experience, however, O'Brien (2015) found that; "[bereavement] policy for pupils who are bereaved in Ireland is limited, both from a national perspective, and from a school perspective." (p. 31). For consistency within this thesis, Ireland has been selected as a country example to examine school bereavement policies, and the inclusion or exclusion of perinatal death experiences.

At an Irish governmental level, O'Brien (2015) stated: "there is no categorical provision made for the support of young people who have been bereaved." (p. 24), and with a lack of discourse around implementation of school bereavement policies within the LR publications, or any compulsion at Irish policy level, the implication is that there is no obligation for schools to provide one. As such, the researcher conducted a brief search engine exploration of bereavement policies evidenced online within Irish secondary schools in 2016, and found huge variations in quality within the schools that did have a bereavement policy, and found many secondary schools did not have a bereavement policy. Specifically with regards to the research question for this study, in the absence of consistent bereavement policies, and a complete lack of recognition of perinatal death losses within Irish secondary schools, the RSE curriculum was interrogated to ascertain if there was any recognition of perinatal death within the context of sex

education. As of the 4<sup>th</sup> of January, 2021, the Irish RSE curriculum does not mention perinatal death or abortion (Department for Education, 2019). Ireland is not unique, as historically secondary school RSE curriculum in most Euro-Western cultures neglect to directly address the potential for any type of death during pregnancy or postnatally. However, the UK revised curriculum from September, 2020 includes factual information on miscarriage and abortion (Gov.UK, n.d.).

The AAA question 1.25 therefore asked; “Did your secondary school have a bereavement policy?”. All respondents answered this question with 39% (n = 9) stating their school did not have a bereavement policy, and 61% (n=14) stating they were “unsure” of whether their school had a bereavement policy at the time of their attendance. With no respondents stating their secondary school had a bereavement policy, and many respondents stating they had wanted bereavement information and/or support at the time of the event, it could be concluded that adolescents experiencing any perinatal loss may not be able to access the information or support they require within the school environment.

### ***5.1.7 The Chronosystem***

The chronosystem is the ecological system directly situated outside of the macrosystem within the MTB (Bronfenbrenner, 1986). The chronosystem encompasses sociohistorical conditions and, due to the nature of these influences, were explored within the semi-structured interviews in phase two of this study.

## **5.2 Psychometric Measurement of Perinatal Grief**

Following identification of the lack of impartiality in previous publications (see chapter three) related to adolescent perinatal bereavement responses, this study sought to introduce a psychometric measurement to enable replicability and universality (e.g. Hutti et al., 1998; Lasker & Toedter, 2000; Ritsher & Neugebauer, 2002). Presentation of the rationale for selecting the PGIS for phase one is detailed in chapter four.

This section presents analyses of the PGIS scores for the adult women who experienced a perinatal death loss during adolescence who participated within phase one of this thesis. (To clarify: the researcher acknowledges grief responses, and bereavement experiences, are confluences of connected bio-psycho-social variables and not just measurable on one psychometric scale, the PGIS is simply one element to this study.

### **5.2.1 AAA PGIS Data**

This section presents analyses of the PGIS data collected from the AAA questionnaire submissions for phase one of this research. Nineteen of the 23 questionnaire respondents completed the embedded 28 PGIS questions, retrospectively for the first six months following the loss, and six months or more following the loss.

#### **5.2.1.1 AAA PGIS Within the First Six Months Analyses**

This section presents the results of the aggregated “Reality”, “Congruence” and “Confront Others” subscales, within the first six months, as self-

reported retrospectively by adult women who experienced a perinatal death during adolescence. Nineteen respondents completed the PGIS questions embedded within the AAA, and the submitted responses have been analysed using the scoring sheet provided by Prof Hutti (see chapter four, section 4.3.1.1.2).

The detailed data collected for the retrospective “within the first six months” PGIS questions, and the resultant scoring, is presented in Appendix 20. A summary of the retrospective “within the first six months” scores is presented in Table 9:

**Table 9**

*Phase One Respondent PGIS Scores Within the First Six Months*

First Six Months	Totals		Distribution		Percentage	
	Total	Percentage	Miscarriage Total	Abortion Total	Miscarriage Percentage of Total	Abortion Percentage of Total
High	9	47%	5	4	56%	44%
Medium	3	16%	1	2	33%	67%
Low	7	37%	2	5	28%	72%
Totals	19	100%	8	11		

As detailed in Table 9, 47% (n = 9) of the respondents who engaged with the embedded PGIS questions within the AAA survey scored in the high intensity grief response category within the first six months following the perinatal death. An additional 16% (n = 3) scored within the medium grief intensity range, with the resultant 37% (n = 7) scoring within the low PGIS grief intensity response parameters.

The distribution of grief intensity scores for respondents who had experienced adolescent miscarriage, 56% (n = 5), and women who had experienced adolescent abortion, 44% (n = 4), were almost equally distributed within the “High” PGIS category. Within the “Medium” PGIS category, the grief intensity scores comprised of 33% (n = 1) for women who experienced an adolescent miscarriage and 67% (n = 2) for women who experienced an adolescent abortion. The “Low” PGIS grief responses comprised of 28% (n = 2) of respondents who experienced adolescent miscarriage and 72% (n = 5) of respondents who experienced adolescent abortion loss.

The results suggest that miscarriage losses may result in higher grief responses immediately following the event, indicating a higher potential risk for Prolonged Grief Disorder (PGD) for young women within this cohort. However, the results also show that 44% of the women within the high PGIS range experienced terminations thereby indicating they are also at potential risk for PGD.

The analyses for the scores within the first six months following adolescent perinatal death indicate that (a) personhood can be ascribed

during adolescent pregnancy, regardless of mode of death, resulting in emotional attachment and grief response; and (b) both miscarriage and abortion during adolescence can potentially result in PGD. Furthermore, the PGIS scores calculated from the AAA submissions were from an adult retrospective perspective, comparison with PGIS scores immediately following adolescent perinatal death could prove enlightening.

#### **5.2.1.2 AAA PGIS Six Months or More Analyses**

This section presents the results of the aggregated “Reality”, “Congruence” and “Confront Others” subscales, six months or more following the loss, as self-reported retrospectively by adult women who experienced a perinatal death during adolescence. Nineteen respondents completed the PGIS questions embedded within the AAA, questions 2.1.2 to 2.14.2, and the submitted responses have been analysed using the scoring sheet provided by Prof Hutti.

A summary of the retrospective “six months or more following the loss” scores, with the abbreviated “High”, “Medium”, and “Low” labels, to indicate grief intensity responses six months or more following the perinatal death during adolescence, is presented in Table 10:

**Table 10***Phase One Respondent PGIS Scores Post Six Months*

Six Months or More	Totals		Distribution		Percentage	
	Total	Percentage	Miscarriage Total	Abortion Total	Miscarriage Percentage of Total	Abortion Percentage of Total
High	7	37%	3	4	43%	57%
Medium	4	21%	3	1	75%	25%
Low	8	42%	2	6	25%	75%
Totals	19	100%	8	11		

As detailed in the previous section, almost half, 47% (n = 9) of the nineteen respondents who engaged with the embedded PGIS within the questionnaire scored in the high intensity grief response category, within the first six month following the perinatal death. This has reduced to 37% (n = 7) six months or more following the death.

Within the medium range, 21% (n = 4) of the respondents were still experiencing higher grief intensity levels six months or more following the death. This was an increase of one person who previously scored in the high percentile, thereby indicating a reduction in grief intensity six months

or more post loss. Furthermore, the “low” PGIS grief scores within the six months or more following the loss category have increased to almost half at 42% (n = 8). The increase in low PGIS intensity scores would be expected following normative adjustment to grief over time (Hutti et al., 2017).

The distribution of perinatal grief intensity scores between miscarriage and abortion deaths, six months or more following the loss, were almost equally distributed within the “high” category, with 43% (n = 3) of women who experienced miscarriages and 57% (n = 4) of women who experienced abortions. These scores indicate a reduction in miscarriage grief intensity over time, however, the abortion grief intensity remains the same within the “high” scale. The disparity of normative grief adjustment over time between miscarriage and abortion experiences may indicate possible higher PGD prevalence within the abortion cohort or may indicate potential for disenfranchised grief (Doka, 2002; McAll & Wilson, 1987).

Within the “Medium” grief intensity scores, six months or more post loss, 75% (n = 3) of respondents experienced miscarriages and 25% (n = 1) experienced abortions. These scores indicate a reduction in miscarriage grief intensity over time. Within the abortion category, one respondent scored in the “medium” category immediately post loss and registered in the “low” score six months or more post loss, also indicating normative adjustment over time.

Within the “Low” PGIS grief intensity scale responses, six months or more following the loss, 25% (n = 2) of the respondents experienced miscarriages and 75% (n = 6) of respondents experienced an abortion. The



scores indicate only one respondent in the abortion category adjusted from a “medium” grief intensity response, immediately post loss, to the “low” grief intensity range six months or more post the event.

Within the group of seven respondents scoring the highest PGIS grief intensity post six months, only two of the adult women identified as ‘bereaved parents’; one was neutral and four of the respondents declared that they “somewhat disagree” with self-identifying as a bereaved parent due to the adolescent loss. These results create another paradox; with the PGIS scores partly resultant on ascribing personhood and “reality” to the pregnancy, higher scores indicate grief as a result of an attachment loss. Further research could determine how adult women interpret the definition of “bereaved parent” to ascertain if their response is defined, and determined, by the definition of “parent” as giving birth to a baby, and/or parenting a child. Moreover, within the group of seven women reporting high PGIS grief intensity scores post six months, all of them declared within their questionnaire that they wanted advice and bereavement support following the loss but that they did not receive any.

The combined, overall results from the first six month PGIS grief intensity scores, and six months or more PGIS grief intensity scores, within phase one, suggest a reduction in intense and mid-level grief over time to an adjusted integration of the event within the respondent’s lives. These results are consistent with generalisable normative bereavement outcomes as detailed in chapter two. However, high and medium intensity PGIS scores, which may indicate susceptibility to PGD, still remain at 58% (n =

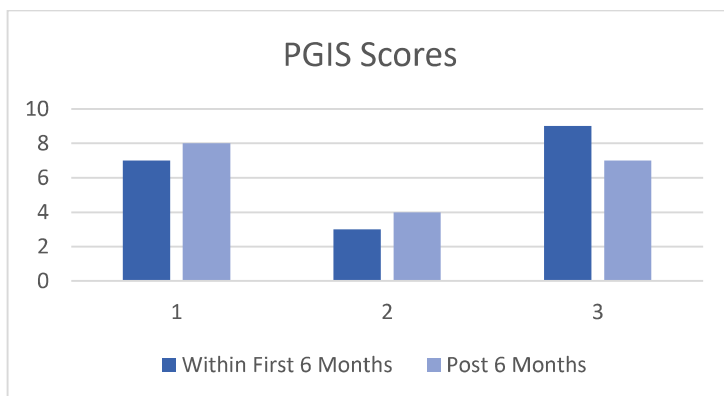
11) six months or more following the event, and potentially may continue to affect the adult respondents across the lifespan. Also of note is that within the analyses of miscarriage and abortion responses over time, 57% (n = 4) of the “high” grief responses were presented by the women who experienced an abortion during adolescence.

### 5.2.1.3 AAA PGIS Combined Analyses

Whilst the previous sections presented the PGIS grief intensity results embedded within the AAA both during the first six months and six months or more post loss, these only illustrate general movements across the scales. Figure 10 below pictorially illustrates the PGIS scores during the first six months following the perinatal loss (dark blue) and the PGIS scores post six months following the perinatal loss to illustrate the changes (light blue). Group 1 illustrate the number of respondents in the lower grief range, group 2 represent the number of women in the medium grief range and group 3 illustrate the number of respondents in the higher grief range:

**Figure 10**

*Phase one Participant Combined PGIS Scores*



The following section presents the details of the comparative movements highlighted above in Figure 10 and the individual PGIS score changes divided between responses to adolescent miscarriage and adolescent abortion experiences.

#### 5.2.1.4 AAA PGIS Score Movements

Table 11, below, presents the individual changes within the scales and illustrates that five of the 19 respondents that completed the PGIS within phase one showed an increase in PGIS score over time. The increase in grief intensity scores over time may indicate a lack of adaptive, normative adjustment and a susceptibility to PGD (APA, 2013; Hutti et al., 2017).

**Table 11**

*Comparative Changes in Phase One Participant PGIS Scores Over Time*

Change in PGIS Score over Time	Totals		Distribution		Percentage	
	Total	Percentage	Miscarriage Total	Abortion Total	Miscarriage Percentage of Total	Abortion Percentage of Total
Increased	5	26%	3	2	60%	40%
Same	7	37%	2	5	29%	71%
Decreased	7	37%	2	5	29%	71%
Totals	19	100%	8	11		

Of the five respondents with increased PGIS grief intensity scores, two of the women were located within the US, and three of the women were located in Ireland at the time of completing the questionnaire. Three of the five respondents with increased grief intensity scores self-identify as “bereaved parents” whilst the other two “somewhat disagree”; all five respondents had living children at the time of submission, suggesting there was no correlation with active parenting/child free status and identification of “bereaved mother” status. Four of the five respondents with increasing PGIS scores stated that their perinatal loss during adolescence was a traumatic experience that had enabled them to change their lives in a significantly positive way, creating a paradox narrative that contradicts the increased scores that may indicate potential PGD (APA, 2013).

Conversely, one of the five women with an increased PGIS grief intensity score stated her experience of perinatal loss during adolescence had a bad effect on her and it still affects her today. This particular respondent was, at the time of submission, 25 years old, within the US, and had experienced a miscarriage at 16 years old which she did not seek medical help for. These facts may indicate a hidden pregnancy, and resultant hidden pregnancy loss, which may confer potential disenfranchised bereavement status on the respondent.

The four respondents who stated their adolescent perinatal loss was traumatic but had enabled them to change their lives in a significantly positive way are all over 45 years old which may suggest that; “...the

finding that coherent positive resolution was predictive of increasing ego-resiliency from young adulthood to midlife suggests that narrative identity processing may operate as a mechanism of personality change in adulthood...Put simply, changes and new developments in how people interpret their lives may trigger corresponding changes in enduring patterns of thinking, feeling, and behaving—i.e., personality traits—over time.” (Pal, 2006, p. 1105).

This section has presented the PGIS results, and analyses, collected from the AAA questionnaire submissions from 19 respondents. The following section details the comments submitted within the free text boxes embedded within the AAA online survey.

### **5.3 AAA Text Boxes**

As detailed in chapter four, free-text comment boxes were integrated within the AAA survey design to provide the respondents with an opportunity to provide an explanatory voice to specific question responses (Babbie, 1990; Flick, 2018). There was high percentile engagement with the free-text options, with 19 of the 23 respondents adding supplementary text. These results suggest that; (a) experiences need to be contextualised outside of the standardised scales; and (b) respondents want to share their stories within the confines of an anonymised, accessible, and convenient online questionnaire.

Questions 1.27, 1.28, 1.34, and 1.37 were all supplemented with open ended free-text boxes, and at the end of the questionnaire, question 2.15 asked the respondents; “If you have any further comments please write

them here”. Six women added free-text comments in response to the final open ended question. The research question, and researcher positionality, specifically sought to provide adult women who had experienced a perinatal death in adolescence a voice, and to that end, with such a small sample, all of the unabridged comments are presented here, without the imposition of qualitative methodological constraints (Flick, 2018). The comments are presented unabridged and in order of receipt as submitted through the Qualtrics™ platform:

1. “Abortion was a very positive experience and pregnancy was a very negative one. There was no grief involved.”
2. “Initially, thoughts and feelings were married, and I went on with my life as if nothing had happened . Decades later, I can see how the whole experience affected not only me and my partner, but our subsequent children and families . #DeeperStill”
3. “I was pregnant after rape and have never told my family about it.”
4. “This was before the internet and research was limited. All the advice I received (including from my GP and nurse) was biased and religious”
5. “The abortion was not pleasant and i was embarrassed both at my stupidity and the pain i caused to family members. I have spoken to people about it but it is still something I tend to keep to myself. I don't feel it defined me but it was a steep learning experience. For a few years i did reckon up how old the child would be often with incredulity that i could have been a parent rather than who i was. It was a situation which i should have avoided but i didn't. It hasn't defined me though.”
6. “It was a traumatising experience amplified by the silence of no one speaking about it. When others did say things they felt at the time like callous and cruel statements. Today they seem thoughtless and hurtful.”
7. “in my experience, i didn't feel empowered to speak out. I had been told not to and not to 'cause a fuss.' It felt easier to appear okay. Behaving in this way is partially a response based on previous life experiences, however, I fell that if someone was there to support me in expressing my pain and vulnerability, I might have been less

likely to develop an eating disorder at a later date. I feel a large part of this mental health condition enabled me to get the support and attention from my mum that I craved at the time of having an abortion. Further, I had control of what went in and out of my body. It also numbed many difficult feelings. I had never been educated about early pregnancy. I had been taught to be ashamed of it and taught that if you fell pregnant early, you were irresponsible. Retrospectively, I wish I had been less compliant and more able to speak out as I am now!”

8. “I feel lack of support from health care practitioners, my school, parents and friends let me down, I do still carry some guilt. I am now a nurse and the experience has helped me care for others going through difficulties in their lives.”

Having explored, and presented, the comments submitted within the free-text comment boxes the following section will summarise the findings of phase one as presented throughout this chapter.

### **5.3.1 Summary of Phase One**

This section presents a summary of the findings and analyses of phase one of this study, which explored female experiences of adolescent perinatal from a bio-psycho-social perspective. Phase one AAA questionnaire provided a baseline exploration of the potential themes within the structural components of the nested systems model, as presented from a retrospective adult perspective (n = 23). The survey analyses, as detailed in this chapter, demonstrate that perinatal death losses during adolescence are not just emotionally impactful at the time of the death, as previous studies have demonstrated (see chapter three), they are also potentially impactful across the lifespan. Additionally, the analyses also suggest that influences prior to the event, and interactions within and across other bio-psycho-social

systems, may also contribute to the experiences, perceptions, and potential long term impact of an adolescent miscarriage or abortion.

Within the individual ecological system, this chapter first looked at the demographic data collected within phase one. All respondents (n = 23) utilised the online Qualtrics™ platform between the 1<sup>st</sup> of October, 2019 and the 31<sup>st</sup> of December, 2019, with submissions from six countries; England, ROI, US, New Zealand, Scotland, and Northern Ireland. Within the biological characteristics of the individual nested system, all 23 respondents confirmed they were female, with 22 respondents identifying as white and one respondent identifying as black. The ages of the respondents within phase one ranged from 21 years old to 58 years old with 60% (n = 12) reporting that they had experienced an adolescent abortion and 40% (n = 8) stating they had experienced an adolescent miscarriage. Three respondents failed to complete the questionnaire in full and did not provide details of the type of perinatal death that they experienced during adolescence. The ages of adolescent pregnancy experienced by the respondents ranged from 14 years old to 19 years old.

Within the behavioural characteristics of the individual nested system, six sub-sections were presented; (a) adolescent contraceptive use; (b) adolescent mental health; (c) “parent” identity; (d) adolescent repeat pregnancies; (e) retrospective views of education during adolescence; and (f) religiosity.

Within the first individual behavioural sub-section, all respondents confirmed that they had received sex education in school during



adolescence, with one respondent stating she did not attend the classes but did obtain her “most important” source of sex education from school. However, the quality of information provided within the sex education curriculum, and the information provided to adolescents from any source, must be questioned as over half, 57% (n = 13), of the respondents were not using any type of contraception at the time of conception and friends were determined by 36% (n = 8) of the respondents as the most important source of sex information during adolescence.

Within the second individual behavioural sub-section exploring adolescent mental health, analyses revealed that almost half of the respondents; 43% (n = 10) self-identified as experiencing mental health problems prior to getting pregnant as adolescents. Furthermore, most of these respondents indicated that they would have liked to have received bereavement information and/or support following their adolescent perinatal death. This may suggest that prevention and/or support with mental health issues during childhood may obviate some adolescent pregnancies, and that provision of information and/or support related to bereavement following a perinatal loss may counteract potential long term mental health impacts resulting from the event.

With 36% (n = 6) of the survey respondents stating they considered themselves “bereaved parents” following their adolescent perinatal experience, this highlights the lasting bereavement impact of the event for some women and the need for better information and support at the time of the event. The researcher also observed that the women who experienced

abortion during adolescence were more likely to identify as “bereaved parents” than the miscarriage cohort; one possible explanation for this is the possibility of disenfranchised grief (as detailed in chapter two). This observation highlights the potential emotional impact of the loss, regardless of the mode of death.

Previous studies within the LR identified a proclivity for repeat pregnancies following a perinatal death loss during adolescence, however, this was not indicated within phase one of this thesis.

With 22 of the 23 respondents either currently studying within higher education or having completed third level education, there appeared to be no lasting impact on educational attainment over the lifespan. However, it is acknowledged that within such a small sample it is possible that respondents who were adversely affected educationally may not have engaged with the study for a variety of reasons which could include barriers to access (e.g. lack of technological ability or internet access). With 50% (n=9) of the respondents reporting that their adolescent miscarriage or abortion was a traumatic experience that has enabled them to change their lives in a significantly positive way, the combined results suggest that the event may be a catalyst for some females to engage, or re-engage, with education.

During the analyses process of the AAA questionnaire submissions, the researcher noted that the six women who identified as a “bereaved mother” as a result of their adolescent perinatal loss, were not affiliated with any religious group, whereas the women who did identify with a

religious group did not, thereby challenging the notion of perceived personhood at the time of conception from a religious perspective.

Analyses from the AAA questionnaires exploring microsystem variables pertaining to experiences of adolescent perinatal deaths provided introductory knowledge within the following seven areas; (a) family; (b) other bereavements during childhood; (c) peers; (d) teachers; (e) medical professionals; (f) employment during adolescence; and (g) the techno-subsystem.

As the family environment is so important to the development of children and adolescents, the semi-structured interviews in phase two focussed on the relationships and dynamics within the family home. Phase one only asked one question related to communication with parents regarding sex during adolescence and found that almost half of the respondents had never spoken to either parent about sex-related matters during adolescence.

The questionnaire respondents were asked if they had experienced any earlier significant bereavements prior to their perinatal loss to ascertain if there may be external influencers on the individual perinatal grief intensity scores. Results from the AAA responses show that four of the women with prior bereavements scored highly on the PGIS indicating that there may be a cumulative grief affect.

Within the school environment, analyses revealed two narratives from the respondents of their experiences with teachers following the

perinatal deaths during adolescence; that of a perceived lack of support from the teachers and within the school, and a culture of silence. Within an environment reportedly not conducive to supporting pregnant, and potentially bereaved, adolescent girls, most respondents expressed disengaging with their secondary school with a resultant negative effect on their education at that time. However, this study also explored the educational impact across the lifespan, and from a retrospective perspective, individual educational attainment at higher education for this sample does not appear to have been adversely affected. However, the researcher recognises, and acknowledges, that there may be barriers to accessing many adult women who experienced adolescent perinatal deaths that may not have had successful educational outcomes.

Phase one also explored experiences by the respondents within the medical environment during their perinatal death loss. The analyses revealed that not all adolescents seek medical support during or following a miscarriage, that hidden pregnancies occur, and on rare occasions, following a lack of engagement with medical support, feticide can occur. For the females that do seek medical attention, the majority, 70%, stated there was a lack of information and signposting to bereavement support that they would have like to have received.

The majority of the women in phase one were working whilst in secondary school and all have worked across their lifespan. There was no evidence from this limited, exploratory study to indicate that their

educational attainment has been adversely affected by working during adolescence.

The analyses presented from the questions within the AAA survey regarding the efficacy of the techno-subsystem were predictable mixed when considering the varying ages of the respondents. However, the younger respondents suggested that the techno-subsystem was not particularly helpful during, or following, an adolescent perinatal loss. One reason identified for these responses was identified in chapter one: there is a dearth of relevant or informative information available on adolescent perinatal deaths.

Transactional elements pertaining to the mesosystem were not specifically addressed within phase one. However, analyses of variables within the microsystem revealed there is a potential lack of communication about RSE between the parents and the schools. All of the questionnaire respondents stated they attended RSE classes within school, but less than half claim to have used contraception at the time of conception, citing various reasons related to the microsystem. Additionally, with most of the women in phase one stating they never, or rarely, spoke to their parents about sex, there appears to be a gap in connectivity across the mesosystem; between parents, schools, peers, and medical provision.

Variables investigated within phase one connected to the macrosystem included religion, RSE, and school bereavement policies. Analyses revealed most of the respondents did not attend a school associated with a religious affiliation, however, notably, the five

respondents with increased PGIS scores attended secondary schools related to a religious group, including the three Irish women who attended Catholic schools.

As increased PGIS scores over time for some of the respondents indicate failure to adjust to grief over time, the broader findings from phase one suggest that interconnections between the bio-ecological systems are complex and that the PGIS scores cannot be considered in isolation. All respondents reported that their schools either did not have a bereavement policy, or they were not aware of one, and this finding combined with the desire to receive bereavement information and/or support at the time of the event suggests that school bereavement policies that include information on gestational and neonatal death losses would be advantageous.

The analyses derived from the PGIS reveal that three quarters of the respondents either exhibited decreased grief intensity scores over time or no change in grief intensity scores across time. It should be noted that of the five respondents with increased PGIS scores, all of the survey respondents from Ireland (n=3) were within this group, suggesting there may be some external influences from other ecological systems contributing to emotional adjustment to a perinatal death. These findings exhibit similar parallels with general normative bereavement adjustments and post traumatic growth narratives within the individual ecological system.

The results are presented with the proviso that they are understood within the limitations of the small sample size and within the constraints of

the recruitment methods, including the pandemic restrictions in 2020, at the time of data collection.

Following the provision of analyses of phase one within the current chapter, the next section will detail the results of phase two.

#### **5.4 Phase Two: Thematic Analysis of Six Retrospective Interviews**

Following the AAA questionnaire submissions in phase one of this study, as detailed above, seven adult women volunteered to participate in interviews for the second phase. Six of the women interviewed met the inclusion criteria for this programme of research. The researcher interviewed the six participants utilising a semi-structured format with themes derived from the mapping to the MTB (Appendix 16) and themes generated from analyses of phase one.

##### ***5.4.1 Section One: Case Example A***

Following completion of the five phases of the thematic analysis (TA) of the six semi-structured interviews, one case study, case example A, is provided in this section as an illustrative example of the adult retrospective perspective of a perinatal death during adolescence (Baxter & Jack, 2015). A single case study has been chosen to illustrate, within a constructivist paradigm, the importance of the human creation of meaning from the participant's perspective (Creswell, 2009). Case study A has been anonymised with the pseudonym name of "Roisin". Roisin contacted the researcher by email following the Twitter recruitment requesting interview participants from women who met the inclusion criteria for this study.

Roisin is white, in her 50's and was born, raised, and has always lived in the ROI. Roisin experienced an elective abortion at the age of 16. Elective termination of a pregnancy was an illegal act in the ROI until 2018, so Roisin travelled to England to undertake a legal surgical abortion.

Roisin was raised with two parents, and multiple siblings, within a strict Irish Catholic environment. Roisin states, almost at the beginning of the interview, that she was sexually abused from the age of six by a family member. Roisin believes the child sexual abuse (CSA) had a significant impact on her mental health, and findings from Noll et al.'s (2009) meta-analysis suggest that CSA places children at higher risk for adolescent pregnancy.

Roisin describes her friends in secondary school calling her a “frigid Bridget” because she was not engaged in consenting sexual activity prior to the event that resulted in her pregnancy. Relaying narratives of peer pressure to engage in sexual behaviour, Roisin became pregnant at the age of 16, during her first consenting sexual experience with her first boyfriend. Roisin recalls her thoughts on her childhood situation; “I remember thinking...I'm such a lovely human being, I'm just fucked in my head”.

Roisin was a particularly articulate participant who generously provided a full and open account of her experiences of a perinatal death, from a bio-psycho-social retrospective perspective across the lifespan, with little prompting from the researcher. Due to her age, Roisin was able to provide a mature, emotionally balanced, reflective account of her



experiences, displaying evidence of reflexivity (Dowling, 2006; Seery et al., 2010).

#### ***5.4.2 Over Arching Themes***

Following a recursive, systematic TA process of the six aggregated semi-structured interviews (Braun & Clarke, 2006), five overarching themes, 10 main themes, and 29 sub themes were identified, and are presented in Appendix 24. The overarching themes comprise of:

- (a) Theme one: Pregnant adolescent girls are stigmatised
- (b) Theme two: Schools should provide relevant information and appropriate support
- (c) Theme three: Families are complex structures
- (d) Theme four: Female adolescents as vulnerable and voiceless
- (e) Theme five: Impact across the lifespan

Roisin's narrative is utilised in case study A to illustrate, explain, and contextualise the five over-arching themes detailed above in the following sub-sections.

##### **5.4.2.1 Theme One: Pregnant adolescent girls are stigmatised**

The nuances of stigmatisation, for this thesis, are presented from the positionality of Goffman (1963) who defined stigma as; “an attribute that extensively discredits an individual, reducing him or her from a whole and usual person to a tainted, discounted one” (p. 3). To further expand, and explore, the definition of stigma within the context of this study, two

commonalities were considered: (a) the assumption that stigmatised people possess an attribute or characteristic that makes them different than others; and (b) that being different from others devalues or denigrates that person from the perspective of other people within society (Shellenberg et al., 2011). Further, there are three “types” of stigma relevant to this study;

- (a) Perceived stigma is the perception by the individual that others are discriminating or devaluing them for certain behaviour or having particular attributes (Shellenberg et al., 2011);
- (b) Experienced stigma is described as; “When a person becomes negatively labelled, not only do expectations of rejection become activated, but actual experiences of rejection occur as well.” (Link et al., 1997, p. 179); and
- (c) The third type of stigma is internalised; “the extent to which the stigmatised individual incorporates negative perceptions, beliefs and/or experiences into his/her own self” (Fife & Wright, 2000).

When reviewing the three conceptualisations of stigma, it is evident there are interactive transactional exchanges between the individual and the environment, consistent with the bioecological perspective of this research framework (Bronfenbrenner, 1986; Vélez-Agosto et al., 2017).

Roisin talked extensively about her perception of, the internalisation of, and her lived experiences of, both self and social stigma due to her adolescent pregnancy in the ROI:

my mother had always said the big scandal was not to come home pregnant, a girl on our road had become pregnant some years before...one of the very religious ladies that lived on our road had written to the local newspaper saying that they should be outcast so I knew the burden...that would have on my family and the scandal.  
(Roisin, abortion, 30+ years ago)

Roisin explained that following the discovery of her pregnancy at the age of 16, she sought help from a support organisation in Ireland that provided advice on how to obtain a legal abortion outside of Ireland; “under the pretext of something else”. Roisin further elaborated on how her boyfriend’s father, upon finding out about the pregnancy, provided the money for an abortion in another country whilst labelling her a “whore”, thus illustrating Link et al.’s (1997) definition of experienced stigma. She stated:

All I could hear was you’re immoral, you’re going against everything you’ve been taught that’s right, you’re now a dirty whore and now someone is going to pay you to murder your child.  
(Roisin, abortion, 30+ years ago)

The putative father, Roisin’s boyfriend at the time of the pregnancy, was not of Irish nationality, and Roisin narrated that he was “absolutely heartbroken” because he wanted to keep the baby; “coming from an [nationality anonymised] perspective he could not understand the Irish attitude to abortion and to getting pregnant, he was like, can you not keep it? and I was like good god no, that’s just not an option”.

As detailed in chapter one, prior to the legalisation of abortion in the ROI in 2018, many Irish women, with the means and ability, travelled to Britain to obtain safe, legal terminations. Roisin obtained a legal and safe elective surgical termination of her pregnancy in London after travelling to England with her boyfriend. However, upon her return to Ireland she kept the experience of her abortion in England a secret and explained:

It was then that the horror started for me, I remember there was a little moment where I thought to myself I don't feel one bit guilty, I'm so happy this is done because what I would have to deal with, the, the public shame, the relationship with my family, my parents, that seems way worse than going and having the termination, if I'd have kept the child it would have been way worse. (Roisin, abortion, 30+ years ago)

Roisin stated she believed the stigma “came externally”, that it was inflicted on her by her mother who would speak negatively about girls who got pregnant outside of the culturally accepted norms within Catholicism. Roisin conveyed her opinion that pregnancy outside of marriage was stigmatised by the Catholic church, by the Irish media, and from “all the adults around me”. She explained that it was “seeping in” through words both direct and indirect, through societal norms, and environmental conditions, which supported and promoted the stigmatisation of pregnant unwed females. Roisin’s reflective narrative thus confirms her perceived experience of Shellenberg et al.’s (2011) definition of perceived stigma:

I realise how much that affected me, not the direct words but just...social norms, the idea that those who stepped out of those norms, those that did anything that was against church or whatever were...somehow to be ostracised or, or judged and criticised.

(Roisin, abortion, 30+ years ago)

She further elucidates on her perception of how society imposes stigma, and how she internalised it, not just at the time of the event but continually throughout her lifespan thus illustrating the third type of internalised stigma (Fife & Wright, 2000):

I internalised that, more shame, more guilt...I did do self-harm for a while, I, I often felt suicidal...I was very depressed, I was anxious...I was...drinking...all I could hear was the voice of the church, the voice of my close family ties, the voice of society which was so loud...the message was the same, no compassion for women, for girls who got pregnant. (Roisin, abortion, 30+ years ago)

Throughout the interview, Roisin's narrative, and the extracts provided, evidence all three types of stigmatisation; perceived, experienced, and internalised. Moreover, her narrative of stigmatisation encompassed the entire bio-ecological system, as is evidenced in the selected vignettes, the interactions within and between them, from a life course perspective (Bronfenbrenner, 1986/1995).

#### **5.4.2.2 Theme Two: Schools should provide relevant information and Support**

Theme two highlights the influence secondary schools exert in contributing to cultural opinions on, and responses to, adolescent sexual activity as narrated from the retrospective perspectives of the female participants in phase two (n = 6). Within case study A, Roisin illustrates, by example, the influence of the Irish sociohistorical culture on attitudes towards adolescent sexuality and pregnancy within her school (Hyde et al., 2004).

Roisin attended an Irish Catholic school throughout her childhood, and during her interview, she continuously referred to the extensive influence Catholicism has exerted across her lifespan. The religious influences were perceived by Roisin as societal; perpetuated throughout her educational environment, her home environment, and her entire bio-ecological environment; illustrating the reciprocity of the nested systems (Bronfenbrenner, 1986).

Similarly to theme one, Roisin states; “school was literally a reflection of what was going on in the bigger world” and that there was; “no opportunity to speak” to anyone about relationship or sexual health issues within her secondary school. Roisin further elucidates:

All we knew in school is that if you got pregnant everybody was going to be talking about you, there’s few teachers that allowed a conversation that was not judgemental...nobody cared...it was wrong, that was it, you were wrong...girls in my class got pregnant,

left school, never saw them again, don't know what happened.

(Roisin, abortion, 30+ years ago)

Roisin recounted an incident that occurred after she returned to secondary school following her termination in England. Roisin confided in the curate at her secondary school about her termination because she was feeling the need to talk to someone who she knew was ethically required to keep her secret. She describes him as; “apoplectic with rage” and states she only unburdened herself to him because she knew he could not tell anyone. Roisin describes how the curate further maintained the stigmatisation in school by stating he would move to the opposite side of a corridor if he was approaching or passing her, and that he would also avoid her gaze.

Roisin confirmed that there was no provision of information or support available at her secondary school for planned parenthood or counselling. Roisin proffered; “nobody cared”. Within an environmental norm that criminalised healthcare for girls and women, Roisin felt, experienced, and internalised stigma both within and outside of the school environment.

#### **5.4.2.3 Theme Three: Families are complex structures**

Theme three explores the intricacies of the family environment and the transactional, and sometimes complicated, nature of these relationships. Roisin referred to two significant familial influences throughout her interview that had a significant impact on her entire lifespan: her mother and her sexual abuser. Illustrative of her mother's influence is the

following vignette that describes how her mother's strict Catholic faith has influenced every aspect of Roisin's life:

it was immoral to sleep with anybody, it was immoral to have sex before marriage, mind you it was also immoral not to go to church, it was pretty much everything was immoral in our home [smiles and laughs] and, and I was very conscious of not letting my parents down so to speak, particularly my mother, my mother had a huge influence on me and also I had never told anybody about the abuse... my mother was very Catholic...pretty much everything was immoral in our home...she was in SPUC [Society for the Protection of Unborn Children], the most vile organisation...my mother would have literature all over the house...there would be pictures of dead babies and dead foetuses and it was everywhere. (Roisin, abortion, 30+ years ago)

Whilst Roisin's mother was advocating the protection of gestational developing life, her child Roisin was sexually abused within the home, from the age of six, by a family member: "it was all very complicated...so I had a lot of frustration and anger at my mother...she and dad would go out and I knew what was going to happen that night".

The relationship Roisin had with her mother and abusing family member, during childhood and adolescent development, were interwoven and complicated. For example, despite her self-declared anger for her mother, and fear of her abusing relative, Roisin still didn't want to disappoint her mother or bring "shame" on the family.



#### **5.4.2.4 Theme Four: Female adolescents as vulnerable and voiceless**

The fourth theme explores self-narratives of the participants as vulnerable “good girls”, and their perceived inability to speak out, at the time of their pregnancy and perinatal death during adolescence. Roisin recounts how her friends would call her “frigid Bridget” because they conferred a “good” girl characterisation on her for publicly complying with the idealised Catholic behaviour of sexual abstinence (with her adolescent boyfriend) expected from society. However, concurrently, Roisin was being silent about her familial sexual abuse: “I never told anybody about the abuse”. So instead of being nurtured within the home environment throughout her childhood, Roisin was silenced and vulnerable; “when you’re being abused you’re being told that it is your fault”.

Roisin felt at 16 that she needed to “catch up” with her friends because: “a lot of my friends were having sex at the time, I remember feeling...to be part of them”. Despite living in a cultural environment that disapproved of sex before marriage, and adolescent pregnancy, Roisin as a 16 year old vulnerable sexually abused child, felt the need to fit in with her peers. She engaged in sexual activity with her boyfriend and stated that she became pregnant from her first sexual encounter with him.

In a country that legally prohibited abortion, Roisin recalled visiting the Dublin Rape Crisis Centre to obtain information and seek advice on how to obtain a safe termination of the pregnancy:

I remember going in and the woman saying you cannot say where you got this information, and everything was a secret, it was, it was

tainted, it was, it was horrible, it, you felt all the time that you were, it had to be kept a secret and that you were a bad human being and, like at 16, I remember being utterly overwhelmed by the emotion of this and having to keep everything a secret. (Roisin, abortion, 30+ years ago)

Roisin conveyed how she remained silent about her sexual abuse during childhood, adolescence, and throughout her early adulthood. Roisin then expanded the discourse of silence to extend to her pregnancy, and obtaining information on and securing a surgical termination in England. In her suggested advice to teachers she explained how she felt alone and vulnerable and how that was compounded in secondary school which she attributed to teacher attitudes:

if there could be a person within the school either a teacher or an, an outside person who was available should anybody find themselves pregnant, but also for teachers to be educated to be made aware that what they say when there's a vulnerable child in the classroom impacts on them especially with a child who is pregnant without having told anyone or thinks they may be pregnant or is vulnerable in some way, we hear things differently, what might seem a passable remark by a teacher about um oh like for example "Oh I hope none of you now are having sex and end up pregnant" even something like that can compound and prevent somebody from speaking out and seeking help from going to talk to somebody. (Roisin, abortion, 30+ years ago)

Roisin stated she believes that the child sexual abuse and the termination; “are connected; “cause if one hadn’t happened the other might not have happened”.

#### **5.4.2.5 Theme Five: Impact across the lifespan**

Theme five revealed the emotional attachment women may experience toward their adolescent pregnancy across the life course. This theme also explored how the emotional attachment may not be recognised by society, particularly in the case of “elective” terminations. The label “elective” may suggest that the course of action, either legal or illegal, taken to procure an abortion is a conscious desirable choice. However, in the case of adolescents, there may be no perceived choice, for example, where the parents of a female under 16 decide on the course of action.

The perception of non-choice for Roisin was explored within theme one, with reference to social stigma across the different ecological systems, and theme three regarding families as complex structures, both of which highlighted the influence of religiosity and its pervasiveness within Ireland.

As detailed previously in theme three, “families are complex structures”, Roisin’s mother was actively involved in an organisation, SPUC, that postulates termination of a pregnancy is an act of “murder”:

She delighted when she came home one day and gave us these badges with two little feet like this which you pinned [taps her chest] and everyone was wearing them because that showed that you were in SPUC, and it was a great thing, and I remember wearing

that on the train to London to the [family planning] clinic...and I kept it for years in a little matchbox. (Roisin, abortion, 30+ years ago)

Despite the apparent juxtaposition of this illustrative performative act, Roisin kept her SPUC badge during adulthood as a connection to the adolescent pregnancy that she terminated when she was 16 years old. She elucidates;

When you're lying in bed and it's just you and them...it was very difficult to parse out what, what was I thinking about this child, but for me it was always a little girl...I do remember saying sorry an awful lot, I'm so sorry, so sorry. (Roisin, abortion, 30+ years ago)

Roisin stated throughout the interview that terminating the pregnancy was the right decision for her at that time and that; "there is a warmth when I think about the pregnancy, there's a warmth, a maternal warmth".

Theme five also illustrates the connective threads from childhood and adolescent developmental events that are embedded throughout the entire lifespan:

until I was about forty I literally just floundered my way through life..I was drinking heavily...the [her] kids were terrified of me...I was angry at...getting pregnant...I was angry that I couldn't talk to anyone, I was angry I was made to feel shit, I was angry at everybody...I felt such a failure as a mother, as a woman, how could I be a mother...I remember a Spike Milligan poem which

spoke about a woman who had had an abortion and it said;  
“pretending to be a woman like my mother was” and I remember  
that seared into my soul, that I was never going to be a proper  
woman...I was always a whore. (Roisin, abortion, 30+ years ago)

Roisin was in her 50's at the time of the interview and further evidence of  
lifespan impact of the adolescent pregnancy, and abortion, throughout the  
ecological systems was evident within her dialogue:

I did a bit of work last year on anything that was left over from the,  
the termination. It's a huge journey but for me looking back  
internally it was the right thing to do but that voice was very quiet,  
all I could hear was the voice of the church, the voice of my close  
family ties, the voice of society, which was so loud...the message  
was the same, no compassion for women, for girls who got  
pregnant...nobody cared...2018, that referendum changed my  
life...I told both my children about the termination on the day of the  
referendum because I was a weeping mess...because we carry round  
all of ourselves, well I think we do, the parts of ourselves that were  
broken and not healed and we carry that through with us in our  
conversation and our lives and our interactions with everybody.  
(Roisin, abortion, 30+ years ago)

Roisin mentioned several times, throughout the interview, that deciding to  
terminate her pregnancy at the age of 16 was the right decision for her, at  
that time, despite the perception of no choice due to societal stigma.

Having presented an anonymised exemplar case study to illustrate a representative sample of the overarching themes identified from the TA in phase two, the next section will detail the cross-case analysis of the six retrospective interviews.

## **5.5 Section Two: Cross-case Analysis of Six Retrospective Interviews**

This section will detail the cross-case analysis of the six retrospective interviews from phase two collectively. The results are presented from a bio-psycho-social perspective, starting from the positionality of the social environment.

### ***5.5.2 Context One: The Social Environment***

The recognition of societal attitudes, and socio-historic influences, on gender based behaviour, and expectations, was highlighted in chapter one, and the predominant themes generated from the TA process within the individual, the microsystem, and the mesosystem reflected these contributors (21 sub-themes). However, the views of wider society towards expected adolescent female behaviour, as distinct and separate from male developmental expectations, was also prevalent across the interview narratives (7 sub-themes). The use of the phrase “wider society” is used in this context to denote the nested systems situated outside of the mesosystem; the exosystem, the macrosystem, the chronosystem, and the digisystem collectively (Bronfenbrenner, 1986).

The overarching themes, main themes, and subthemes identified within the aggregated interviews relating to societal attitudes towards

females who become pregnant whilst attending secondary school are presented in Table 13 below:

**Table 13**

*Social Environment Themes*

Context	Over-arching Theme	Main Theme	Sub-Theme
Social Environment	Pregnant adolescent girls are stigmatised	<ol style="list-style-type: none"> <li>1. Girls are to “blame”</li> <li>2. “Damaging” males</li> </ol>	<ol style="list-style-type: none"> <li>1. Patriarchal society</li> <li>2. Religious dogma influences societal stigma</li> <li>3. Society blames girls</li> <li>4. Girls are called names (sluts, “frigid”)</li> <li>5. There are cultural expectations of girls vs boys</li> <li>6. Abortion as “right” decision due to societal stigma</li> <li>7. Social, empathic support is important</li> </ol>

Narratives of social attitudes towards developing females within the ecological systems are clearly influenced by socio-historic contexts, and prevailing social attitudes, which situate females within patriarchal hierarchies. Within the societal nested systems, the themes suggest female adolescents who become pregnant are blameworthy, stigmatised, and bullied.

Historically, religious organisations have penalised females for not behaving “appropriately” within expected social constructs (Michael Garrett, 2017). For example, as highlighted in chapter one, the prevailing cultural norm in the ROI is of the female as the adult head of a nuclear, married family and pregnancy during adolescence rejects this cultural norm, thus posing a potential challenge to successful societal identity achievement (e.g., Gray & Ryan, 1997; Inglis, 1987/2007).

The following sections will present the thematic details of the overarching themes generated from the TA process, supported by interview extracts, within the bioecological contexts (Braun & Clarke, 2006; Bronfenbrenner, 1986; Strathern, 2018).

#### **5.5.2.1 Theme One: Pregnant adolescent girls are stigmatised**

The first over-arching theme generated from the TA, within the social environment context, was defined and labelled as; pregnant adolescent girls are stigmatised. Section 5.4.2.1 within this chapter explored the various definitions of stigma, and all interview participants (n = 6) expressed feelings of perceived, experienced, and internalised stigma regarding their adolescent pregnancy and perinatal death. This finding was universal within the narratives of all six adult women; irrespective of their nationality, social status, age, religious background, type of gestational death, or ethnicity.

As presented in Table 13, theme one explored seven sub-thematic areas within the social environment. The sub themes were defined as: (a) patriarchal society; (b) religious dogma influences societal stigma; (c)



society blames girls; (d) girls are called names: sluts, whores, “frigid”; (e) there are cultural expectations of girls vs boys; (f) abortion as “right” decision due to social stigma; and (g) social, empathic support is important. The seven sub-thematic areas were refined to produce two main themes: (a) girls are to “blame”; and (b) “damaging” males.

Patriarchy, as a social system of male dominance directed at women, is evidenced within all of the interviews (n= 6) (Walby, 1990). At the more extreme end of the spectrum, Roisin and Afiya were both victims within cultural environments dominated by strict religious diktats that prohibit legal abortions and had/have restricted healthcare services for women. Roisin’s narrative, as presented in case study A within this chapter, is laced with religious reference and is evident within the anecdotes previously provided. However, patriarchal narratives within more secular cultural environments, where abortions are legalised and socially acceptable, were also evidenced.

Afiya, a black woman in her 30’s, who experienced two illegal abortions at the ages of 15 and 16 in Uganda, stated at the beginning of her interview that girls are instructed in pubertal “education” by an aunt. She further explains that girls within her environment are taught by their aunts that the sexual maturation of adolescent female bodies is to enable facilitation of pleasuring men; “to aid you in your marriage in keeping your relationship with your husband”. Afiya summates that her “sex” education was a descriptor of how her body will change during puberty to accommodate sex to please a man, and did not encompass any information

on relationships, contraception, or any other sexual education. She appends that; “you can’t ask” any questions [to any adult]. She continued by explaining that within her community parents do not talk about sex with their children, except to tell girls: “stay at home don’t move at night cos the boys will do this or you will be raped...girls are supposed to be at home learn housework that’s all”. Thus furthering the narratives of society “blaming” girls for their pregnancy; one of the main themes.

Denise, a white woman in her 50’s, who experienced an abortion at 14 in England, echoed Roisin and Afiya’s patriarchal narratives stating: “they don’t get slut shamed, it isn’t a boy’s fault...its society’s view that its always the woman, you know, that’s in the wrong”.

The second main theme, “damaging males”, was derived from three interview participants stating they were sexually abused as children by males: Denise, Roisin, and Sabine, and narratives of male abuse, male neglect, male control, and contraceptive irresponsibility from all six women.

Sabine, a white woman who was 19 at the time of the interview, experienced a miscarriage in Germany at the age of 17. Sabine stated within her interview that; “I got sexually abused by my [family member]”. She further explained that her boyfriend; “got really controlling and really, yeah, just he tracked me, he always wanted to know where I am, not like hey please be safe, but like ooh are you down there, are you hooking up with my best friend”.

Four of the six adult participants experienced negative name calling for example, “whore”, “slut” following disclosure of their adolescent pregnancy. Denise, an English woman in her 50’s who experienced a legal abortion at the age of 14, used the phrase “slut shaming” to denote the victimisation of girls when they are perceived to violate social expectations of behaviour. Denise explains: “I was the school slag, the school bike, the school, you know, and I think the thing was at that time I knew damn well there was people around me that were having sex and had not got pregnant”, echoing the same narrative provided by Roisin in Case Study A. Denise also speculates that; “social media amplifies slut shaming” and believes; “with the likes of Facebook, and everything like that, can you imagine what these poor girls have to put up with, being named and shamed”.

Sabine, a 19 year old German participant who experienced a miscarriage at 17, countered these speculations with her positive experience of sharing on social media, narrating: “I think there are so many women that go through this and don’t share it because they are ashamed...I didn’t intend to share it publicly but I, it almost felt like I had to, to yeah, to move on”. However, she also experienced the in person slut shaming stating: “yeah, for sure but like slut and whore and everything like that...but so like they called me slut before so I don’t know if it’s really because of the miscarriage”. Sabine adds: “so my friend was bullied so bad...because she had an abortion that she had to move and change schools, she started self-harming”. Also later in the interview Sabine added: “so I know this girl...I think she had like four abortions and she’s 18 now and people call her like

[air quotes] the worst slut of the whole city because of it”. Heidensohn’s (1996) assertion that girls are expected by society to be the guardian of morality is confirmed within the narratives of all six adult participants within this theme.

Afiya also relayed that adolescent girls are blamed for the pregnancy, not boys, in Uganda and the negative name they are called is “spoilt girl”. Roisin, the Irish participant highlighted in case study A, stated: “I remember [her boyfriend] saying I’ve told my dad and he’s going to pay for it [the abortion in England] and I remember going down’ to [her boyfriend’s] house one time...and there was a note, a letter on the kitchen table and he said here’s the money for your whore”.

Cultural expectations of male and female behaviour, extending to sexual behaviour, was detailed in chapter one. Using the ROI as a country example, females were deemed to have contravened their socially expected roles as virtuous, or heads of nuclear households, if they were to become pregnant when unmarried. They were firstly stripped of their social freedom, followed by a denial of their rights within the mother and baby institutions (‘Irish Mother and Baby Homes’, 2021; Maloney, 2021; Michael Garrett, 2017;). The female residents were often subjected to sexual abuse, physical abuse, and mental abuse, and many of the babies born to the unwed mothers resulted in death due to deliberate acts, and deliberate neglect.

Despite the negative societal attitudes towards girls who have abortions, all five of the participants who undertook elective terminations

during adolescence, whether legal or illegal, stated it was the “right” decision at the time. For example, Denise, in her 50’s, explained that she doesn’t often think about the abortion she experienced at 14, as it was historical, but she did state emphatically that it was the right decision: “I was far too young...I think had I had been 17, 18, 19 and a bit more aware I think that would have been completely different”.

A commonality of narratives identified by the researcher was the concept of the pregnancy as a “doll” like baby, without due consideration of the realities of parenting a developing child. Rosemary, who was 18 when she experienced abortion, stated: “I’d thought about, you know, a tiny little baby, I hadn’t thought about the next twenty years, I’ll be honest, and then also no-one wanting to date me, and just things like that that might come up”.

Social, empathic support was also a prevalent theme within all of the adult retrospective interview narratives, both for women who experienced an abortion (n=5) and a miscarriage (n=1). Within a Ugandan context, Afiya narrated an inability to access any information or support regarding contraception and medical services. She stated; “I blame the society for...making us feel like we are so inferior for making us feel like we are responsible for so many things and for not being able to provide us with services...we need friendly services”.

Within an Irish context Roisin stated that in the absence of available information or support: “the Dublin Rape Crisis Centre were allowing young women, girls, whatever, to go to their centre under the pretext of

something else and get advice and I remember going in and the woman saying you cannot say where you got this information and everything was secret, it was, it was tainted, it was horrible..like at 16 I remember being utterly overwhelmed by the emotion of all of this”.

Within a German context, Sabine experienced a miscarriage without recognising the symptoms. She stated that it would be helpful if girls were aware that these events can occur and to not judge girls for becoming pregnant.

Within an English context, whilst legal medical services are free at point of service, and available to everyone, signposting to sexual health and contraceptive information, and post event (abortion) support, was reported lacking by Bella, Rosemary, and Denise. Furthermore, four of the six women specifically mentioned details from their medical experiences, and these are summarised below:

1. Roisin, the Irish participant who procured a legal abortion in England at 16, revealed that the doctor that examined her prior to authorising the abortion sexually assaulted her.
2. Bella, the English participant who experienced a legal abortion at 18, stated that prior to her medical abortion the nurse that conducted an ultrasound scan prior to the termination was insistent that she look at the screen during the process.
3. Denise, the English participant who experienced a legal abortion at 14, stated that some of the medical staff were friends with

parents at the school she attended so her pregnancy was disclosed publicly.

4. Afiya, the Ugandan participant who experienced two illegal abortions at 15 and 16, detailed how the medical professionals refuse to issue contraceptive pills to adolescents, claiming their use causes infertility. She also narrated the often fatal consequences of procuring illegal abortions from medical professionals in Uganda.

The seven sub themes within the environmental context provided examples to support overarching theme one; “pregnant adolescent girls are stigmatised”. Within all of the adult, retrospective interviews, participant narratives were woven with details of perceived stigma, experienced stigma, and internalised stigma both at the time of the pregnancy and across the lifespan (Fife & Wright, 2000; Link et al., 1997; Shellenberg et al., 2011; Taylor, 2020).

### ***5.5.3 Context Two: The School Environment***

Within context two, the microsystem, the face to face interactions within the school were explored within retrospective narratives of adult women (n =6) who experienced an adolescent abortion (n = 5) or miscarriage (n = 1). Chapter three highlighted the gap in the literature specifically addressing teacher interactions, teacher knowledge, and teacher education with adolescents who have experienced a perinatal death loss.

Phase one analyses found that over half of the AAA respondents, 55% (n = 11), stated their school or teachers could have supported them better whilst in secondary education; that there was a lack of support (or signposting) from teachers, and a second theme of “silence” surrounding adolescent pregnancy and perinatal death was evident. Phase two therefore sought to add more contextual depth to these exploratory findings.

The overarching themes, main themes, and subthemes identified within the aggregated interviews relating to school microsystem variables prior to, during, and following a perinatal loss towards adolescent females who experienced a gestational death are presented in Table 14 below:

**Table 14**

*Microsystem Themes (School)*

Context	Over-arching Theme	Main Theme	Sub-Theme
School Microsystem	School should provide relevant information and support	3. Pregnant girls are marginalised	1. Education is important
		4. Sex and relationship education is inadequate	2. Pregnant girls drop out of school and “disappear”
			3. Teachers contribute to judgemental attitudes
			4. Sex education as biological function only or non-existent
			5. Lack of information and signposting
			6. Lack of contraceptive knowledge and use



Narratives within the context of general societal attitudes towards developing females, as presented in the previous section, are further echoed within the school environment.

The following section presents the thematic details, supported by interview extracts, of the overarching theme within the school microsystem generated from the TA process.

### **5.5.3.1 Theme Two: Schools should provide relevant information and support**

The second over-arching theme generated from the TA, within the microsystem (school) context, was defined and labelled as; “schools should provide relevant information and support”. This theme was common to the adult interview participants (n = 6) who experienced a gestational death during adolescence, irrespective of their nationality, social status, age, religious background, type of gestational death, or ethnicity.

Sex and Relationship Education (RSE) was deemed to be “inadequate” by five of the participants; Bella, Rosemary, and Denise in England, Roisin in Ireland, and Afiya in Uganda. Conversely, Sabine, a 19 year old German female who experienced a miscarriage at 17 years old, stated her RSE was adequate but that miscarriage was excluded from the curriculum. There are two potential explanations for the different perceptions; (a) Sabine is younger than all of the other participants and therefore may be benefitting from a modern RSE curriculum; and (b)

Sabine experienced miscarriage, the other five women experienced abortion.

Theme two explored six sub-thematic areas, defined as: (a) education is important; (b) pregnant girls drop out of school and “disappear”; (c) teachers contribute to judgemental attitudes; (d) sex education as biological function only or non-existent; (e) lack of information and signposting; and (f) lack of contraceptive knowledge and use. All of the sub themes contribute to the main theme that “pregnant girls are marginalised”.

One example of inadequate RSE education is derived from Afiya, who experienced two abortions in Uganda at the ages of 15 and 16. Afiya, and her peers, did not receive formal RSE education in school, but are “educated” by their aunt during adolescence who explained how to “please” men sexually. The detail provided by Afiya contributed to the sub theme “sex education as biological function only or non-existent”.

Whilst RSE curriculum is non-existent in Uganda, Afiya stressed how important it is for girls to complete their secondary education. Within the context of the sub theme of “education is important” Afiya specified within her interview that being educated in school was important in order to gain male acceptance: “[speaking about telling the putative father following the illegal abortion] you wouldn’t even love me if I wasn’t educated”. She spoke about being; “very committed to finish school” and narrated stories of her school friends attempting many ways to abort an unwanted pregnancy. These included the use of wire coat hangers, toothpicks, and

tealeaves, amongst others, and the prevailing attitude is that the health risks and potential mortality risks, alongside the mental and physical pain, were “worth it” to stay in school. Detailing her friend’s experience, Afiya stated; “she was in pain but at the same time she was like you know what at least I’m going to still be in school..so let me endure this...so she was bedridden, she was admitted to hospital... she wasn’t found out... she still continued in school”.

However, whilst the attainment of further education was important to the interview participants, it was recognised that many girls who become pregnant in secondary school drop out and “disappear”. Afiya, a woman in her 30’s who experienced two adolescent abortions, explained that the teachers’ attitudes to adolescent pregnancy in Uganda was not; “finding a solution for what was happening” but; “it was easy for them to just say you know what you girls are just so spoilt you better go back home, they all to expel you”. Additionally, Sabine, a German 19 year old female who experienced miscarriage at 17, detailed how her friend was forced to leave secondary school due to bullying following her abortion.

School staff attitudes were also explored with the phase two participants, with five women expressing negative experiences with teachers, but one participant stated she confided in a teacher and received a supportive response. In Case Study A, as detailed earlier in this chapter, Roisin recounts how she confided in the Catholic school curate about her abortion at 16 in England, how he became “apoplectic with rage”, and that he ostracised her from further contact with him. Roisin succinctly

expressed that teachers, and other school employees, bring their societal beliefs, including biases, into the school and that it is a micro-climate that reflects pervading environmental attitudes. All six adult participants expressed that the teachers in school did not provide adequate information related to sex, contraception, pregnancy, perinatal death, and bereavement support. The six adult women also stated that they were not signposted to organisations to obtain any information or advice on these subjects. Bella, an English female in her 20's, who experienced an abortion at 18 explained:

looking back now there might be one teacher in school that I could identify as the teacher that I could have gone and told...the only teacher that I remember ever talking about sex with anyone, and it was probably one or two classes, but she was the teacher that got the kids, but I still didn't feel empowered to do that...whether we had school counsellors I didn't know, I didn't speak to anyone at school, but I think that if there was a programme that explored all of those, you know, the whole, the whole subject, and that you know said if you ever get in the situation...this is the space you know we, we can create, we can talk together and decide what your next steps are gonna be (Bella, 20's, abortion at 18)

Despite the negative narratives of experiences during secondary school, all six of the adult interview participants within phase two have either attained an undergraduate degree ( $n = 2$ ), are studying towards an undergraduate degree ( $n = 2$ ), or have attained post graduate qualifications; a master's degree ( $n = 1$ ) and a PhD ( $n = 1$ ). Thus providing evidence that

education is important across the lifespan, not just in secondary school, and that some marginalised and/or stigmatised women will return to education as adults.

In conclusion, with overarching theme two; “school should provide relevant information and support” the TA analysis generated themes that suggest education is important to all female pupils and that RSE curriculum should include information, support, and signposting that ensure girls are not only educated in the topic areas, but are also provided with teacher contacts, or other school staff, who can be approached should they be needed.

Within the construct of inclusive policies and practices within secondary schools, Prof Sharma argues that inclusion should include all pupils and not just focus on what an individual cannot do (Banks, 2021). The interview themes within the school microsystem suggest that female adolescents who become pregnant are presented with barriers to the; “presence, participation and achievement of learners” during secondary school (Azorín & Ainscow, 2020, p. 61). Therefore, measuring inclusion within schools should also include the student voices of females who become pregnant, and/or experience a perinatal death loss, and disengagement due to negative teacher/pupil experiences (Banks & Smyth, 2021).

#### ***5.5.4 Context Three: The Home Environment***

Within context two, the microsystem, the face to face interactions within the family were explored within retrospective narratives of adult women (n

=6) who experienced an adolescent abortion (n = 5) or miscarriage (n = 1). Chapters one, two, and three, all provided evidence of research and theory pertaining to the particular relationship between mother and daughter during development, however, all familial relationships were explored within the phase two interviews (e.g., Hudson & Ineichen, 1991; Moore & Rosenthal, 2007; Presser 1974; Santelli & Melnikas, 2010; Smid et al., 2014; Zelnik et al. 1981).

The overarching themes, main themes, and subthemes identified within the aggregated interviews relating to variables in the microsystem home context prior to, during, and following a perinatal loss towards adolescent females who experienced a gestational death are presented in Table 15 below:

**Table 15**

*Microsystem Themes (Home)*

Context	Over-arching Theme	Main Theme	Sub-Theme
Home Microsystem	Families are complex structures	5. Mothers are influential	7. Not wanting to let the family “down”
		6. Adverse Childhood experiences are influential	8. ACEs: divorce, sexual, emotional, and physical abuse
			9. Secrets and lies within families
			10. Mother is influential

Chapter two of this thesis presented a parsimonious classical overview of adolescent developmental theories, from varying perspectives, with consistent narratives of the importance of the primary caregiver relationship (e.g., Ainsworth & Bell, 1970; Berger, 2014; Bowlby, 1969; Hazan & Shaver, 1990). Additionally, the themes derived from analyses of the LR, in chapter three, acknowledged the significance of the role of the mother, however, the findings were divergent, thereby necessitating exploration within phase two. The second main theme; “Adverse Childhood Experiences [ACEs] are influential” was an unexpected finding, and a contribution for this thesis.

The following section presents the thematic details, supported by interview extracts, of the overarching theme within the family microsystem generated from the TA process.

#### **5.5.4.1 Theme Three: Families are complex structures**

The third over-arching theme generated from the TA, within the microsystem (home) context, was defined and labelled as; “families are complex structures”. The theme was a finding that was universal across all participants, irrespective of their nationality, social status, religious background, age, or ethnicity. Theme Three was derived from four sub-thematic areas, defined as: (a) not wanting to let the family “down”; (b) ACEs: divorce, sexual, emotional, and/or physical abuse; (c) secrets and lies within families; and (d) mother is influential.

Three of the four sub themes; (a) not wanting to let the family “down”; (b) secrets and lies within families; and (c) mother is influential,

all contained significant narratives of the symbiotic mother and daughter relationship. For example, Rosemary, an English woman in her 40's who experienced an abortion at 18, detailed how she didn't want to let her mother "down":

I think that's why she was so annoyed because I was going to be the first person in my family to go to university...and I think she had great hopes for me and this was potentially gonna to ruin my life in her eyes, so yeah, she was just, I think, just quietly furious  
(Rosemary, abortion at 18)

All participant interview chronologies disclosed, without prompting, the nature of the relationship the participant had with the mother at the beginning of each interview. For example, Bella, an English woman in her 20's who experienced an abortion at 18, explained that her boyfriend instructed her that she was not "allowed" to tell her family or he would break up with her. She suggested that keeping the pregnancy, and resultant abortion, a secret from her mother led to her developing an eating disorder to gain the attention, and support, she wanted from her mother:

I was trying to get back to that state of dependency, that you have, you know omnipotence, that children have over mum because when I was essentially being very manipulative in not eating things, I was getting my needs, I was getting the attention that I wanted from her  
(Bella, abortion at 18)



In the case of Sabine, a German 19 year old who experienced a miscarriage at 17, her mother was the bearer of a secret that significantly impacted on Sabine. Sabine described the relationship she had with her mother, after finding out that her father is not her biological relative, and that her mother, her sister, and her father all knew this fact but withheld the information from her:

I would say its pretty distant because, and I always blamed myself for that because as I, I discovered that my dad isn't my father it was because of her cheating on him so I think I remind her of my biological father a lot and of like potential danger for her real family because my sister is my dad's biological child so I'm, so they are like the perfect family and I'm just like there, I'm the the mistake and I blamed myself for that so yeah, it was pretty distant (Sabine, miscarriage at 17)

As illustrated in case study A, earlier in this chapter, the interactionism between the mother/daughter relationship, the familial interplay, including silence and lies, and the hidden ACEs, all converge within the environment that the child is developing within, thereby influencing individual behaviour and long term health (Dube et al., 2001; Felitti et al., 1998; Fry & Elliott, 2017).

The seminal study that presented findings concerning potential links between multiple Adverse Childhood Experiences (ACEs) and adverse health outcomes was published by Felitti et al. (1998). The authors identified seven categories of childhood experiences within definitions of

abuse and household dysfunction, which comprised of: child psychological abuse, child physical abuse, child sexual abuse, living with a household member abusing a substance, living with a household member with a mental illness, living with a mother as a victim of domestic violence, and living with a household member who went to prison.

A further study by Dube et al. (2001) suggested that experiencing ACEs in childhood dramatically increases the incidence of mental health problems and attempted suicide. ACEs were evidenced in five of the six adult interview participants, as evidenced in Table 16:

**Table 16**

*Prevalence of ACEs in Participant Interview Narratives*

ACE	Bella	Rosemary	Denise	Roisin	Afiya	Sabine
Psychological Abuse			✓	✓	✓	✓
Physical Abuse			✓		✓	
Child Sex Abuse			✓	✓		✓
Living with someone who is an alcoholic			✓			
Parental Divorce		✓				

The prevalence of ACEs, as experienced by the phase two participants, was a contribution for this thesis. As detailed in chapter three, only the Barglow et al., 1973 study sought to investigate prior mental health states in the participant group. However, the Barglow et al. (1973) study pre-dates ACEs literature.

The prevalence of ACEs within the narratives of five of the adult interview participants (n = 6) were interwoven within the story of their experiences across, and within, the nested ecological systems. For example, Denise, an English woman in her 50's who had an abortion at 14, explained that in the 1970s adolescent girls obtained RSE information from teen magazines, with details of physical abuse and alcoholism interspersed:

at that time you've got problem pages in the backs of magazines like Jackie and Mates...and there was only really the problem pages and things like that to talk about...I'd been physically abused by my alcoholic mother for most of my life and yes, I just started to puke and realised that oh my god, I think I am pregnant and then my mother saw me puking and that was it, she knew (Denise, abortion at 14)

Four of the adult participants (n = 6) relayed narratives of psychological abuse during childhood within their retrospective interviews. For example, Sabine, a German woman aged 19 who experienced a miscarriage at 17, relayed: "I found out that my dad is not my father, my biological father, at ten years old and everybody in my whole family knew except me".

Two of the adult interview participants (n = 6) relayed narratives of physical abuse during childhood within their retrospective interviews. For example, Afiya, a Ugandan woman in her 30's who experienced two illegal abortions at aged 15 and 16, detailed:

when I was around ten... a teacher beat me here around my waist so I told my mum that you know what I feel pain here I think she was so taken by her own problems so ...she ignored, so what happened I started bleeding like urinating blood black blood so of course I did tell her like ok this is what is happening...I was like this is weird how can a person be having urinating blood so I told her she told me no you're lying so...I got a bucket and after urinating I took it to her it was a lot of it so she panicked and that is when she took me to a nearby clinic... I wasn't taking in fluids so they were like you know what she has a kidney problem so they took me to the national hospital here in Uganda so the national hospital said she has her kidney was damaged by the force yeah and um that teacher beat me because I came in late in class it wasn't because I was stubborn he beat me because I came in late ... because we were waiting for food at home you could end up going back ... to school when it is around two thirty that is thirty...minutes past we usually have lunch from one pm to two thirty so the teacher beat me because he said it was my fault (Afiya, abortions at 15 and 16)

Three of the adult interview participants (n = 6) were victims of child sex abuse. Whilst Sabine and Roisin explicitly detailed experiences

of child sex abuse by adults within their family, Denise's experience of becoming pregnant by "sort of having sex" at 14 constitutes rape under the 2003 Sexual Offences Act in England and Wales, which states: "The 2003 Act provides that the age of consent is 16. Sections 9 -13 clarify that any sexual activity involving consenting children under 16 is unlawful". Denise also explicitly stated that her mother was an alcoholic; an additional ACE.

One of the interview participants relayed narratives of parental divorce, Rosemary stated that her father lived in another country and was largely absent from her life, responding to her pregnancy and abortion decision thus; "he just was his usual self and didn't really wanna get involved and just said; you can come here for a holiday if you want and that was kinda it". As mentioned previously in this section, Sabine's "father" was not her biological father, so whilst her parents may not be divorced, there is a complicated family dynamic that she stated has impacted her mental health.

The identification, and measurement of outcomes, across the lifespan as a result of experiencing multiple ACEs in childhood is a relatively new, advancing area of research. Struck et al. (2021) conducted a bibliometric analysis of publication trends on ACEs research from 1998 to 2018 and concluded that there was no consistency in measurement parity and state:

Recently, work has been conducted to advance how ACEs are defined and conceptualized ...More work in this area, including further investigations of ACEs measurement tools is encouraged.

New studies in the ACEs field may move beyond the traditional medical ACEs field and focus on better understanding the relationship between ACEs and social and education outcomes and the complex interconnection between ACEs and individual-, community- and structural-level factors including gender and race. Continued research in this expanding area is warranted as scientists continue to understand the complex interactions between childhood experiences and later outcomes.” (p. 7).

In conclusion, with overarching theme three; “families are complex structures” the TA analysis generated themes that suggest the mother daughter relationship is significant within the lives of developing females, that living up to familial expectations weighs heavily on adolescent girls, that secrets and lies are prevalent within families, and that ACEs contribute to complicating family dynamics.

#### ***5.5.5 Context Four: The Individual***

The fourth context within the bio-psycho-social framework consists of the individual (Bronfenbrenner, 1977). As detailed in chapter two, the MTB expands Bronfenbrenner’s (1977) individual nested system category into two components; the biological and the behavioural. This section presents the findings which explored the behavioural component.

The overarching themes, main themes, and subthemes identified within the aggregated interviews relating to the individual perspectives of the adult women who become pregnant whilst attending secondary education are presented in Table 17 below:

**Table 17**

*Individual Themes*

Context	Over-arching Theme	Main Theme	Sub-Theme
Individual	Female adolescents as vulnerable and voiceless	7. Lack of confidence leads to consent “blurring”	11. Self-stigma, guilt and shame
		8. Lack of information and support leads to isolation, self-stigma, and mental health issues	12. Never told anyone 13. Lies, silence, and loneliness 14. Scared and overwhelmed 15. “Good” girls and “good” pupils 16. Inability to say no/consent blurring 17. Mental health issues

Narratives within the context of the individual echo societal attitudes and microsystem themes, as detailed within the previous sections, thus illustrating the interconnectedness of the bioecological systems.

The following section presents the thematic details, supported by interview extracts, of the overarching theme within the individual microsystem generated from the TA process.

#### **5.5.5.1 Theme Four: Female adolescents are vulnerable and voiceless**

The fourth over-arching theme generated from the TA, within the individual context, was defined and labelled as; “female adolescents are vulnerable and voiceless”. Section 5.4.2.1 within this chapter explored the various definitions of stigma, and all participants expressed feelings of either self, social, or both self and social stigma regarding their adolescent pregnancy and perinatal death, which led to feelings of vulnerability and silencing. For example, Bella, an English woman in her 20’s who experienced an abortion at 18, stated her boyfriend silenced her by threatening to leave her if she told anyone of the pregnancy, she therefore attended the clinic and experienced the medical abortion home alone, whilst her boyfriend was out drinking.

Theme four explored seven sub-thematic areas, defined as: (a) self-stigma, guilt and shame; (b) never told anyone; (c) lies, silence and loneliness; (d) scared and overwhelmed; (e) “good” girls and “good” pupils; (f) inability to say “no”/consent blurring; and (g) mental health issues.

The perceived lack of information, and support, leading to isolation, self-stigma, and mental health issues was relayed by all six of the adult interview participants. Five of the seven sub-thematic areas within the individual context; self-stigma, guilt & shame, never told anyone, lies, silence & loneliness, scared and overwhelmed, and mental health issues, may be categorised as “individualistic” within the behavioural individual system of the MTB. However, behavioural responses are reactions to



societal expectations, social norms, and environmental conditions (Taylor, 2020).

Arguably, the central contribution of this thesis, to knowledge of adolescent experiences of perinatal death, is the connection of individual narratives to wider social influences within the bioecological environment (Bronfenbrenner, 1986; Heidensohn, 1996). For example, within the sub-theme of “lies, silence & loneliness”, as mentioned above, Bella narrates how she was explicitly silenced by her boyfriend, and she also conveyed the desire to be a “good girl” within her social environment.

Roisin, in the case study example in this chapter, also relays the details of lying to her parents, the social silence of her teenage abortion, and the loneliness of the whole experience as a result of getting pregnant within her ecological environment; “I literally wanted to die is the truth, I hated the loneliness, this awful idea about what I thought about myself”.

The lies, silence & loneliness theme were not just applicable to the interview participants who had experienced abortion during adolescence, Sabine, a 19 year old who experienced a miscarriage at 17, relayed that lies and silence were endemic within her family. Sabine discovered at 10 years old that her father figure was not her biological father, that her mother and sibling knew this fact and had been silent about it. She also stated that, due to rumours circulating in school about her pregnancy, she decided to address the issue directly by posting on social media. She states this was a positive experience for her:

So I publicly shared it on my Instagram page I think a year later...there were actually two girls that wrote me DMs on Instagram and said they had experienced that too and I would have never guessed it...I think it's really helpful if people share their stories and encourage others to do the same so you don't feel as alone (Sabine, 19, miscarriage at 17)

The second main theme within the individual context is defined as; “lack of confidence leads to consent blurring”. The two sub-themes related to the generation of this main theme are; (a) “good” girls and “good” pupils; and (b) inability to say no/consent blurring. Another finding for this thesis is that consent in adolescence, particularly with young women who have experienced ACEs, was a difficult concept to define or ascertain. A detailed overview of the prevalence of literature within the area of consent is outside of the scope of this thesis, however, for the purpose of this theme, an explanatory context is provided.

The prevalence of voicelessness and vulnerability was also extended to consent (or not) for sexual activity. Defining what sexual consent is, or is not, is a concept that is not universal, with a generalisability that it is an “agreement to engage in sexual acts” (Graf & Johnson, 2021, p. 449). Further conflating the issue, within the bioecological environment, are the varying statutory laws that determine the age of consent which vary between 12 years old in Angola, to 20 in South Korea (AgeOfConsent, 2020). Further, many countries have no age of consent, determining sexual activity to be legal within marriage. Thus, from a social environmental

context, variability of definition of, and perceived capacity to consent influence individual understanding and behaviour (Beres, 2014; Brady et al., 2018). To clarify; “sexual consent even when it is defined at its most basic as agreement, is mired within layers of personal, contextual, and societal standards” (Graf & Johnson, 2021, p. 449). Schulhofer (2017) argues that the issue of what consent is, or is not, are further blurred by historical court rulings that determined rape did not occur where there was no physical violence. Therefore, the issues of coercion, manipulation, or capacity to consent are not wholly understood by some individuals as issues of non-consensual activity or rape (MacKinnon, 1989).

For example; “A recent study among young people in slum areas in Kampala, Uganda indicated that 34.3% agreed that it was okay for a boy to force a girl to have sex if he had feelings for her and 73.3% affirmed that it was common for strangers and relatives to force young females to have sexual intercourse with them without consent...coercion, like the drivers of transactional sex itself, can include both interpersonal and structural aspects.” (Kyegombe et al., 2020, p. 233). Afiya, a Ugandan woman in her 30’s who experienced two illegal abortions at 15 and 16, detailed how she was taught as a child that she had to subvert herself to men, and that if a male raped her, it would be her fault for being outside of the home.

Within the individual context, the prevalence of ACEs, as detailed in section 5.5.4.1, experienced by five of the interview participants, may influence neurological development that contributes to capacity to consent to sexual activity (e.g. Galván, 2017; Silvers et al., 2017; Teicher, 2002).

For example, Roisin, detailed in the case study example within this chapter, narrated her perception of her inability to convey her non-consent to sexual activity that she attributes to her child sex abuse:

I was very wary of boyfriends, I think I'd only one thereafter who was not sexually abusive, sexually manipulative and because as from the the earlier abuse as a child I, and then the termination and all of that, I had no voice or no way of putting boundaries up and saying no I don't want this (Roisin, 50's, abortion at 16)

In conclusion, with overarching theme four; “female adolescents are vulnerable and voiceless”, the impact of the sociological determinants within which females develop has a significant effect on individual girls during adolescence. This theme illustrates how early childhood conditions, i.e. how girls are socialised and the impact of ACEs, may contribute to adolescent pregnancy, and the experience during and immediately after a perinatal death.

The following theme explores the long term impact on the individual woman across the lifespan.

#### ***5.5.6 Context Five: The Individual as “Dividual”***

As detailed in chapter two, the MBT framework constructed for this thesis incorporated the concept of the “dividual” (Davies, 2017). Re-conceptualising Durkheim’s concept of both an individual and a social being within one person, and Mead’s internalisation of social attitudes towards the individual, amongst others, Davies (2020) situated dividual

theory within continuing bonds theory (Klass et al., 2014; Klass & Steffen, 2017). Thus, for this study, the researcher positioned the individual female, and pregnancy, as one biological unit that were investigated from a bio-psycho and *internalised social* perspective across the lifespan.

The overarching themes, main themes, and subthemes identified within the aggregated interviews relating to the individual perspective, within the individual nested system, of the adult women who experienced an abortion or miscarriage during adolescence, and the societal impact on the individual across the lifespan, are presented in Table 18 below:

**Table 18**

*Individual (Dividual) Themes*

Context	Over-arching Theme	Main Theme	Sub-Theme
Individual/Dividual	Impact across the lifespan	9. Identity creation and reconstruction	18. Constructing and reconstructing identity narrative
		10. Emotional attachment	19. Emotional connection to pregnancy
			20. Varying grief reactions over time
			21. Self-identifying as “bereaved parent”
			22. Challenging the concept of “motherhood”

Narratives of social attitudes towards developing females within the ecological systems were reflected within the previous social environmental context, the microsystem contexts, and the individual context themes during adolescence. The themes generated within the individual “dividual” context reflect internalised social constructs of female adolescent pregnancy and impact on adult women as reflected across the lifespan.

The following section presents the thematic details, supported by interview extracts, of the over-arching theme within the individual dividual system generated from the TA process.

#### **5.5.6.1 Theme Five: Impact across the lifespan**

The fifth over-arching theme, generated from the TA, was defined and labelled as; “Impact across the lifespan”. The main themes generated from the TA within the individual dividual context consisted of; (a) identity creation and reconstruction; and (b) emotional attachment. The main themes were common narratives to all six adult interview participants irrespective of age at the time of interview. Theme five encompassed five sub-thematic areas, defined as: (a) constructing and reconstructing identity narrative; (b) emotional connection to pregnancy; (c) varying grief reactions over time; (d) self-identifying as “bereaved parent”; and (e) challenging the concept of “motherhood”.

Chapter two presented a parsimonious overview of adolescent development from a classical perspective, and included Social Identity Theory (SIT) which provides relevant insight into how an individual determines their identity within a group setting (Tajfel, 1979). To review:

identification with a social group is an important source of identity as cohorts are divided into “us” and “them” through a process of categorisation. When social groups are divided, prejudice results from an awareness that there is a perceived lesser “out-group” (i.e. the other group), and positive self-esteem is derived from feeling a belonging to the perceived desirable “in-group” (Turner et al., 1979).

Within the interview narratives, stigmatisation and negative labelling during adolescence has had a lasting impact on identity, and reconstruction of identity across the lifespan, for the phase two participants (Link & Phelan, 2001). However, whilst narratives of stigma during adolescence are associated with negative experiences, and resultant negative emotional responses across the lifespan, the re-negotiation of identity was positive for five of the six participants (Crocker & Major, 1989). Rosemary, an English woman in her 40’s who experienced an abortion at 18, was the only participant who relayed negative identity narratives across the lifespan. These were due to adult infertility and babyloss experiences, with resultant ascription of guilt and regret to the adolescent abortion in response to the adult events.

Conversely, Denise, an English woman in her 50’s who experienced an abortion at 14, conveyed a narrative illustrative of the predominant discourse in phase two of positive adaptation in adulthood:

I’m now a doctor and I think that that is linked to this feeling of I want a new title and ...I want a new identity, I want to be who I am

as an adult, not as who I was as a 14 year old child so I think it is, it never leaves you (Denise, 50's, English, abortion at 14)

Continuing bonds theory was detailed in chapter two, and subsequently supported in phase two by narrations of an enduring emotional connection to the pregnancy by all participants (Klass et al., 2014). The enduring link between the internal, biological pregnancy, the psychological (emotional) connection, and the social influencers, internalised as the individual, are illustrated by Roisin in the following vignette:

I've two positions, I've the 16 year old me and the adult me, 16 year old me maintained a relationship for many years until I found atheism, the greatest joy and guilt giver upper of my life and so 16 year old me thinking about a soul, thinking about, despite the fact that the physical body was gone, that they were going to a spiritual entity there yes, there was a connection but as I believe in nothing now, no, but there is a warmth when I think about the pregnancy, there's a warmth, a maternal warmth (Roisin, 50's, Irish, abortion at 16)

This study set out to ascertain the presence, and impact, of grief following a perinatal loss during adolescence. The interview narratives within phase two did convey prevalence of grief, but with varying reactions over time. For example, Sabine, a 19 year old who experienced a miscarriage at 17, stated the following:



of course there's grief but it also quite life giving and its been that I had to live life to the fullest because it's so precious and it can get taken away so easily and I feel like I have to live life for **my baby** as well, if that makes sense (Sabine, 19, German, miscarriage at 17)

The LR in chapter three also detailed the prevalence of US based publications using assumptions of bereaved parent status. This thesis sought to elicit self-identification of identity narratives in both studies. The sub theme “challenging the concept of “motherhood”” found that two participants self-identified as bereaved parents; Sabine and Rosemary. Sabine, a 19 year old, experienced a miscarriage and described the pregnancy as a “baby” thus conferring personhood status. Rosemary, a woman in her 40's, had experienced subsequent baby losses and infertility during adulthood and provided a story of a changing relationship with the pregnancy that responded to subsequent adult events. Roisin, the Irish woman in her 50's, detailed in the case study, self-identified as “neutral” to the concept of identifying as a bereaved mother in response to the abortion she experienced at 16.

Conversely, three women; Bella, Denise, and Afiya, stated that they did not self-identify as a “bereaved mother”, thus refuting the assumption provided by the US narratives in previous publications and studies. Afiya, a Ugandan woman in her 30's who experienced two abortions stated:

I blame the society I blame the system I blame but I don't call myself as a bereaved mother no...sometimes I think I might, I wish I knew better...I wish someone talked to me and told me this what

you had to do, I wish someone challenged my misconceptions that I had, it all comes to someone talking to you telling you what the consequences of this actions really will bring (Afiya, 30's, Ugandan, abortions at 15 and 16)

Thus it can be concluded that the individual, internalised experiences of the event, and impact across the lifespan, are uniquely individualised and complex.

This section has presented the cross-case analysis process, and detailed the context, over-arching themes, main themes, and sub-themes, as illustrated in Appendix 24. The following section will present the theoretical model created from the data analyses as presented in this section.

#### ***5.5.7 The BELATED Model***

Following the TA theme generation process, and alignment within the contextual bio-psycho-social nested systems, as detailed within this chapter, a model was constructed to illustrate the over-arching themes, the main themes, and their implied or actual transactional connections. The Bio-Psycho-Social Model of Female Experiences of Adolescent Perinatal Death (BELATED) is presented in Appendix 25.

The BELATED model commences within the chronosystem with a presentation of the social stigmatisation of adolescent females who are blamed for their pregnancy status within inherent patriarchal norms (Cole, N, 2020; Katz et al., 2018). Societal variables influence females within the

microsystem, and dynamic interactions within and between the mesosystem, via the school environment and the home environment (Silk & Romero, 2014). Sex and relationship education has been deemed unfit for purpose by the research participants, of all ages and nationalities, who spoke of teachers perpetuating societal views of gender based behavioural expectations (De Vere, 2018). Within families, it is evident that mothers are influential and ACEs are prevalent, thus further complicating individual perceptions of expected societal behaviour and views (Hillis et al., 2004; Noll et al., 2009).

The individual context was subdivided between early development (adolescent: immediate) and impact across the lifespan (adult). Within individual narratives adolescent girls painted a picture of confusion, silence, mental health issues and stigma (Shellenberg et al., 2011; Simelela, 2021). Consent, manipulation, and blurring of consensual understanding were complicated by early life stressors within the home such as child sex abuse (Graf & Johnson, 2021). Impact across the lifespan was evident with identity creation, and re-creation, a continuous navigational process that does not end when girls are deemed “adults” (Davies, 2020). The emotional attachment to the pregnancy was enduring, whether the women self-identified as a “bereaved mother” or not (Valentine, 2008).

The BELATED model is encased within the “dividual” category: that which is outside of us, is also within us. We cannot separate the individual from society; we absorb, and contribute to, external influences

throughout the lifespan (Davies, 2017). Valentine (2008) summarised this perspective, within the context of continuing bonds, as thus:

...the self was constructed through social interaction and intimately linked to the selves of others. They represented a more fluid, relational and intersubjective expression of agency and personhood than can be encompassed by the concept of a unitary, bounded, embodied, performative selfhood (p. 83)

The BELATED model, as presented in Appendix 25, therefore summarises the experiences of adolescent perinatal deaths, and impact across the lifespan, from a bio-psycho-social perspective for this study.

## **5.6 Chapter Conclusion**

The first section of this chapter presented the descriptive data analyses from the AAA questionnaires, utilising the framework constructed for the MTB, employed within phase one for this study (n = 23). The analyses detailed the respondent responses to questions determined appropriate for a survey instrument.

The second main section of this chapter provided the detailed results from the Perinatal Grief Intensity Scale (PGIS) that was embedded within the AAA in phase one of this study (Hutti et al., 1998). The analyses detailed the grief impact of adolescent miscarriage and abortions; a contribution for this thesis.

The third main section of this chapter provided illustrative examples of the themes identified within the narratives submitted within the text boxes provided within the AAA (Braun & Clarke, 2006).

The fourth main section of this chapter presented one individual Irish case study to illustrate a complete and unabridged analysis of a participant narration from phase two of this study. Utilising a case study example, Roisin's narrative provided a "whole person" story of an adolescent girl's experience and how that has impacted her as an adult (Bronfenbrenner, 1986).

The fifth main section of this chapter provided a cross-case thematic analysis (TA) of the six retrospective interviews from phase two of this study (Braun & Clarke, 2006). An overview of the thematic analysis process was provided to situate the findings within the context of the methodological approach chosen (see chapter four). The five over-arching themes generated from the TA process were presented within the associated bio-psycho-social contexts. Additionally, verbatim participant narratives were provided in order to provide illustrative evidence.

The sixth main section of this chapter presented the BELATED model (see Appendix 25) to illustrate the thematic findings, within the bio-psycho-social contexts, from the cross-case TA analysis of the adult retrospective interviews. The interconnectedness of the relational dynamic reactions within and between the nested systems, and the identification of the individual as all encompassing, is a main contribution for this thesis.

This chapter has provided the findings of phases one and two for this study. The next chapter will summarise the key converged findings from phase one, the AAA questionnaires (n = 23) and phase two, the semi-structured interviews (n = 6).