Policy

Clinical Guideline

Concealed or Denied Pregnancy

Policy developed by: SA Maternal & Neonatal Clinical Network
Approved SA Health Safety & Quality Strategic Governance Committee on: 24 June 2015
Next review due: 30 June 2018

Summary Clinical practice guideline for the management of a woman with a concealed or denied pregnancy.

Keywords Concealment, concealed, denied, denial, affective, pervasive, psychotic, undetected, infanticide, schizophrenia, depression, high risk notification, Concealed or Denied Pregnancy clinical guideline

Policy history Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y v1.0**
Does this policy replace an existing policy? **N**

Applies to All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS

Staff impact All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG213

Version control and change history

Version	Date from	Date to	Amendment
1.0	12 Apr 2011	24 Jun 2015	Original version
2.0	24 Jun 2015	Current	Reviewed

Government of South Australia
SA Health

South Australian Perinatal Practice Guidelines

concealed or denied pregnancy

Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

SA Health does not accept responsibility for the quality or accuracy of material on websites linked from this site and does not sponsor, approve or endorse materials on such links.

Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:
The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown prior to the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world yet we experience the worst health outcomes in comparison. Our Aboriginal women are 2-5 times more likely to die in childbirth and our babies are 2-3 times more likely to be low birth weight. Despite these unacceptable statistics the birth of an Aboriginal baby is an important Cultural event and diverse protocols during the birthing journey may apply.

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup
at:cywhs.perinatalprotocol@health.sa.gov.au

Government of South Australia
SA Health

Introduction

- Concealed or denied pregnancy may occur in childbearing women of all ages and parity, either single or in a partnered relationship
- It is of concern because of the risk to the fetus and newborn as well as the mother's health with late or no presentation for antenatal care [1,2]
- In some cases, newborns may be abandoned or killed. There are a variety of underlying factors (psychiatric and sociological) leading to concealment or denial of pregnancy[3]

Definitions

Concealment of pregnancy occurs when the woman knows she is pregnant but actively conceals it from her partner, family and friends [4,5]

Denial of pregnancy - can be organised into 3 categories

1. Affective Denial - there is an intellectual awareness of the pregnancy but no emotional or physical preparations are made for the infant's arrival
2. Pervasive Denial - existence of pregnancy is kept from the woman's own awareness
3. Psychotic Denial - the woman is suffering from a psychotic illness and tends to deny her pregnancy in delusional ways [6]

Undetected - the pregnancy, when discovered, is a complete surprise to the woman and those providing her care (usually not associated with psychological or mental health issues)

Infanticide commonly refers to the killing of an infant within the first 24 hours of birth[3]

Incidence

- There are no known Australian statistics on its incidence and incidences documented elsewhere vary largely. Rates in Europe (Britain and Germany) have been estimated as 1 in 2,500 births[1, 7.] Hatters-Friedman et al. (2007) from the USA rated concealment of pregnancy as 1 in 1,750 births with denial until the time of birth being three times more frequent[4,5]. A more recent Irish article showed a much higher incidence[8]

Risk factors

- Adolescent girls were traditionally thought to be most likely to deny or conceal[3], but recent studies found women to be predominantly in their early to mid-twenties and multiparous[1,4,5]
- Denial of pregnancy is not bound by race, ethnicity or social class[9]. However, there are various familial and sociocultural situations that enhance denial of pregnancy (e.g. fear of ostracism in some social groups, pressures for termination). Social isolation is strongly associated with most known cases of pervasive denial[1,2]
- Women with poor intelligence or minimal knowledge of reproductive anatomy and physiology are at increased risk of denying / concealing a pregnancy[9,10]. However, high achieving women with above average intelligence may also conceal or deny pregnancy[3,9]
- Undetected pregnancy may occur in women who are peri-menopausal, have irregular periods, are using contraception, are obese or who have minimal weight gain. These women may have presented to medical services but their pregnant condition has been overlooked[2]
- Women with a history of neonatal loss are at risk of affective denial (by distancing themselves from the pregnancy). Some women who have a history of infants being removed from their care may conceal their pregnancy to avoid the same situation occurring again[1,4,5]
- Psychiatric disorders, such as schizophrenia[10], and depression[3], have been reported to contribute to denial and concealment of pregnancy

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

Pregnancy symptoms - misinterpreted

- Pregnancy and labour symptoms are often attributed to other causes (see table 1 below)
- Women with pervasive denial may have fewer and less obvious physical symptoms of pregnancy, such as marked obesity or minimal weight gain, no nausea and menstrual like bleeding[2,4,5,10]
- Labour often takes women by surprise and it is not unusual for these women to present to hospital with severe abdominal and back pain, or the need to empty their bowels
- Feelings of dissociation are usually present at delivery
- Case studies report that women with mental health issues, especially dissociation, experienced minimal pain in labour and often gave birth without assistance[2]

Table 1: Denial of signs and symptoms of pregnancy

Pregnancy signs and symptoms	Alternative explanations
Nausea and vomiting	> Indigestion > Anxiety > Medical illness like 'flu'
Amenorrhea	> Seen in very active, athletic women > Eating disorders affect menstruation > Not attentive to timing of menses > Early in menarche, teens may have anovulatory periods with long intervals between them
Fatigue	> Lack of sleep > Anxiety > Feeling depressed
Weight gain	> Poor dietary habits > Not exercising > Gain not apparent if fetal growth restriction > Gain not apparent because of restrictive or oversized clothing
Fetal movements	> Gas > Hunger related peristalsis
Breast tenderness	> Premenstrual changes > Breast injury
Uterine growth	> Abdominal growth from weight gain

Adapted from Vallone DC & Hoffman LM. Preventing the tragedy of neonaticide. Holistic Nursing Practice 2003; 17: 223-28

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

Government of South Australia
SA Health

Infanticide

- Denial is a substantial risk factor for abandonment and infanticide[2]
- An Australian study investigating 32 maternal filicide cases found all three killings of newborn infants (within first 24 hours of life) to be characterised by total denial of pregnancy and birth rather than a motivation to kill the infant[11]
- The more serious the state of denial, the more at risk the fetus is of neonaticide[3]
- Women in severe denial are often in a state of shock and emotional dissociation at the time of delivery
- The most common cause of death in newborns related to denial of pregnancy is through drowning after birth into the toilet[3,9,12]. A fracture to the neonate's head can occur if the mother delivers in a crouching position or by standing up with no assistance. Mothers who have actively contributed to their newborns death are often in dissociative or near dissociative states and usually have difficulty recalling the details of the event and make minimal to no effort to hide their actions[3,9]

Management[13]

Antepartum

- Early identification in pregnancy provides increased opportunity to prevent complications, however concealment or denial of pregnancy may prevent this[14]
- Antenatal clinic staff need to be aware of normal emotional reactions to pregnancy versus those that are compromised as well as women who may be at increased risk for this condition of pregnancy[3]. Intimate partner violence is known to be associated with a higher rate of concealed termination of pregnancy[15]
- All women who book late (> 20 weeks of gestation) should complete the Edinburgh Postnatal Depression Scale (EPDS) and psychosocial risk questionnaire (Questionnaires should only be used by appropriately trained staff) at antenatal booking (link to 'screening for perinatal anxiety and depression' at www.sahealth.sa.gov.au/perinatal in the A to Z index)
- Assess the need for referral to any other services e.g. Social Worker, Mental Health liaison, Psychiatric review, Case discussion meeting, Obstetric Consultant, General Practitioner (GP)
    - Where possible, arrange ongoing care with a service that provides continuity of carer e.g. midwives clinic, high risk pregnancy service, obstetrician, GP, midwifery continuity of carer models, whichever is most appropriate

Intrapartum

- Treat as high risk if the first hospital presentation is in labour
    - May have little or no antenatal care or medical history
    - Obtain detailed history (either from the woman or support person if present)
- Estimate fetal gestation and presentation (abdominal palpation, portable or formal ultrasound)
- Where possible, and depending on timing of presentation, obtain the following:
    - Booking bloods
    - High and low vaginal swabs (including for Group B streptococcus)
    - MSSU and urine toxicology
- Risks at this time include precipitous labour, undiagnosed pregnancy complications and unknown fetal gestation
- Ensure paediatrician is present at time of birth

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

- Neonatal septic workup
- Monitor baby for withdrawals

- Social Work Involvement is likely to be beneficial and may include:
  - Counselling regarding keeping baby or consider adoption
  - Assessment of home situation, support and practical help regarding parenting skills and other routine family maintenance
- Consider the need for a high risk infant notification to Families SA (CARL on 131478)

Postpartum

- Offer mental health review (consider if any other psychiatric co-morbidities)[16]
- Parenting assessments should be made by midwifery and other relevant staff in a supportive manner every shift in the postnatal period, observing and documenting the quality of mother's interaction with her baby – referrals to provide support with mother-infant interaction may be appropriate (Staff at Helen Mayo House [on 08 70871047] may be able to provide information on referral sources) – for further information, link to "assessing parent infant relationship" at www.sahealth.sa.gov.au/perinatal in the A to Z index
- Family Planning – it should be a mandatory part of pre-discharge planning that these women are offered sex education and advice on birth control options

Other considerations

- There is some evidence from Europe, USA and other countries that the introduction of "anonymous delivery" in maternity hospitals and the availability of "baby hatches" (newborn infants can be left at designated safe locations) may reduce the incidence of infanticide related to concealed pregnancies[17]

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

References

1. Nirmal D, Thijs I, Bethal J, Bhal P. The incidence and outcome of concealed pregnancies among hospital deliveries: An 11-year population-based study in South Glamorgan. Journal of Obstetrics and Gynaecology 2006; 26: 118-121.
2. Ali A, Paddick SM. Exploration of undetected or concealed pregnancy, British Journal of Midwifery 2009; 17: 647-51.
3. Vallone D, Hoffman L. Preventing the tragedy of neonaticide. Holistic Nursing Practice 2003; 17: 223- 228.
4. Hatters Friedman S, Heneghan A, Rosenthal M. Characteristics of Women Who Deny or Conceal Pregnancy. Psychosomatics 2007; 48:117-122.
5. Hatters Friedman S, Resnick PJ. Child Murders by mothers: Patterns and prevention. World Psychiatry 2007; 6:137-141.
6. Miller L. Denial of Pregnancy. In: Spinelli M, editor. Infanticide; Psychosocial and legal perspectives on mothers who kill. Washington DC: American Psychiatric Publishing Inc; 2003. p. 81-104.
7. Wessel J, Buscher U. Denial of pregnancy: a population based study. British Medical Journal 2002; 324:458.
8. Thynne C, Gaffney G, O'Neill M, Tonge M, Sherlock C. Concealed pregnancy: prevalence, perinatal measures and socio-demographics. Ir Med J. 2012 Sep; 105:263-5.
9. Spinelli M, editor. Infanticide; Psychosocial and legal perspectives on mothers who kill. Washington: American Psychiatric Publishing Inc; 2003. p. 81-104.
10. Walloch J, Klauwer C, Lancczik M, Brockington I, Kornhuber J. Delusional denial of pregnancy as a special form of cotard's syndrome. Psychopathology 2007; 40: 61-64.
11. Adler C, Baker J. Maternal Filicide; More than one story to be told. Women and Criminal Justice 1997; 9:15-39.
12. Dressler J, Schmidt U, Hanisch U, Demmler G, Riehn A, Pollak S. Neonatal freshwater drowning after birth in the bathroom. Am J Forensic Med Pathol. 2011 ;32: 119. Doi:10.1097/PAF.0b013e318187dff9.
13. Brezinka C, Brezinka C, Biebl W, Kinzl J. Denial of pregnancy; Obstetric aspects. Journal of Psychosomatic Obstetrics and Gynecology 1994; 15: 1-8.
14. Hall M, Chappell L, Parnell B, Seed P, Bewley S. PLoS Med. Associations between intimate partner violence and termination of pregnancy: a systematic review and meta-analysis. Jan; 11(1):e1001581. doi: 10.1371/journal.pmed.1001581. Epub 2014 Jan 7.
15. Friedman SH, Heneghan A, Rosenthal M. Characteristics of women who do not seek prenatal care and implications for prevention. JOGNN 2009; 38:174-181.
16. Moyer P. Pregnant Women in denial rarely receive psychiatric evaluation. Medscape Medical News [serial online] 2006 [cited 2010 Dec 20]; [1 screen]. Available from URL: http://www.medscape.com/viewarticle/533814
17. Klier C, Grylli C, Amon S, Fiala C, Weizmann-Henelius G, Pruitt S, Putkonen H. Is the introduction of anonymous delivery associated with a reduction of high neonaticide rates in Austria? A retrospective study. BJOG. 2013 Mar; 120(4):428-34. doi: 10.1111/1471-0528.12099. Epub 2012 Dec 5.

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

Useful resources

About a Girl, 2001, Short Film, B Percival (director), UK.
(Google "About a Girl" to purchase. View entirety on U tube. Type in "About a Girl, short film")

Concealed, 2009, Short Film. A Kitsch in Synch Production, MRC, Adelaide, S.A.
(Available from Birth International website at URL:
https://www.birthinternational.com/products/concealed-dvd-1
Web link to short preview - teaching pamphlet with discussion points enclosed in DVD when purchased)

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

Abbreviations

APA	American Psychiatric Association
BC	British Columbia
BPD	Borderline personality disorder
DBT	Dialectical behaviour therapy
EPDS	Edinburgh Postnatal Depression Scale
GP	General Practitioner
MBT	Mentalisation based therapy (treatment)
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIMHE	National Institute for Mental Health in England
UK	United Kingdom
URL	Uniform Resource Locator
WHO	World Health Organisation

Version control and change history

PDS reference: OCE use only

Version	Date from	Date to	Amendment
1.0	12 Apr 2011	24 Jun 2015	Original version
2.0	24 Jun 2015	Current	Reviewed

ISBN number: 978-1-74243-058-4
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 24/06/15
Contact: South Australian Perinatal Practice Guidelines workgroup at:cywhs.perinatalprotocol@health.sa.gov.au

Government of South Australia
SA Health