Concealed or denied pregnancy

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Review Article
Word Count 2,491
References 21

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Introduction
A 23 year old lady presented in labour with a concealed pregnancy. An ambulance was called to her home but unfortunately the baby died following complications secondary to delivery. 'Rapid Response Procedures' were set in motion and subsequent actions focused on appropriate physical and psychological care for the mother, along with multi agency safeguarding discussions.

On reflection this case posed some interesting and challenging questions including -How common is a concealed pregnancy? What are the characteristics of women who have a concealed pregnancy? What are the risks/outcomes for the mother and the baby? And perhaps the biggest dilemma, what is the appropriate response from health professionals when a concealed or denied pregnancy is suspected?

Due to the challenges we faced in managing this case we undertook a literature review to try to answer some of these questions

Literature review

Definitions
A **concealed pregnancy** is described as one in which a woman knows that she is pregnant but does not tell anyone, or those who are told collude and conceal the fact from health professionals.

A **denied pregnancy** is when a woman is unaware of, or unable to accept the fact that she is pregnant. Although the woman may be intellectually aware that she is pregnant she may continue to think, feel and behave as though she is not. Some women will deny they are pregnant until they actually deliver the baby, whereas others acknowledge the pregnancy before delivery.

Although there is an important distinction between concealed and denied pregnancy, in practise many authors use the term concealed pregnancy to describe both. Wessel (2002)[2] defines a concealed pregnancy as one which is 'unbooked for antenatal care after 20 weeks' and Sadler (2002) says it is 'where a female, through fear, ignorance or denial, does not accept or is unaware of the pregnancy in an appropriate way'.

How common is a concealed pregnancy?
A number of studies have attempted to identify the incidence of concealed or denied pregnancies. Data shows a wide variation. Thynne reported a prevalence of concealed pregnancy in Galway of 1 in 148 births and Wessel in a 1 year prospective study in Berlin, found that the incidence of denial of pregnancy is 1 in 475 at 20 weeks gestation, with 1 in 2455 still being denied at the point of delivery, that is the baby being born without the woman having realised that she was pregnant until she went into labour.[1,2]

A retrospective study of women with no history of prenatal care presenting in labour or immediately postpartum in Northfield, USA , found that 29% had a denied pregnancy and 9% had a concealed their pregnancy. 40% of those concealing and 23% of those denying their pregnancy were under 18 years of age.[4]

A study from Austria evaluated the obstetric history and pregnancy outcomes in for 27 women, who professed they did not know they were pregnant until either term or the commencement of premature contractions. In 11 women pregnancy was denied until delivery, in 9 women denial ended between 27 and 36 weeks and in 7 between 21 and 26 weeks gestation. Two of the three cases of prematurity were in the last group as were three of the four fetal deaths. Most women reported irregular bleeding in pregnancy, three had taken oral contraceptive pills while pregnant and few reported symptoms of pregnancy, such as nausea or weight gain).[5]

Nirmal and colleagues, in a population-based study of hospital deliveries in South Glamorgan over an 11 year period, found that concealed pregnancies have an incidence of 1 in 2,500 deliveries (0.04%), a figure similar to that in a study by Wessel in Berlin. 12% of women were married and 58% were

multiparous with 8% having had a previous caesarean section. 20% of women had a medical disorder during the antenatal period.[6]

What are the characteristics of women who have a concealed pregnancy?

Several studies have looked at the characteristics of women who conceal or deny that they are pregnant. The stereotype of an adolescent girl with poor social support and a history of learning difficulties, mental health problems or drug and alcohol problems, is not supported by the literature, pregnancy denial being a heterogenous condition associated with different psychological features.[7]

Wessel and colleagues conducted a 1 year prospective study in Berlin, recruiting 65 women with a denied pregnancy, with a median age of 27 years. 83% had a partner and only 21 had never been pregnant before. 3 had a psychiatric diagnosis of schizophrenia and one was abusing analgesics/tranquilizers. The authors concluded that a clear-cut typology of a 'pregnancy denier' could not be established.[8]

Spielvogel and Hohener believe that the absence of many physical symptoms of pregnancy, inattentiveness to bodily cues, inexperience, intense psychological conflicts about the pregnancy and external stresses can contribute to pregnancy denial in otherwise well-adjusted women.[9] Brezinka supports this view reporting that stressors, such as separation from a partner or interpersonal problems, play an important role as precipitating factors for the development of an adjustment disorder with maladaptive denial of pregnancy.[5] Mobilization of social support can improve the chances of successful clinical outcomes in these women.[10]

Struye, reporting on the results of retrospective studies, observes that women with pregnancy denial rarely use contraceptives and hypothesises a denial of fertility in these women, who may not associate sexual intercourse with the possibility becoming pregnant. Some adolescents may lack adequate knowledge about sexuality and fertility, some women perceive themselves as not capable of having children and some older women assume they are menopausal. Sexuality was noted to be a taboo subject in families of many of the women with denial of pregnancy, and in this group of women denial was a defence mechanism regularly used in other aspects of their lives.[11]

Denial of pregnancy may also occur in women with serious cognitive impairment or psychotic illness. Miller reports that those who denied their pregnancies often had a diagnosis of schizophrenia and may have previously lost custody of their children, and therefore they anticipated separation from their baby.[12] Spielvogel recommends assessment looking for possible contribution of painful reactivation of memories concerning either adult or childhood trauma and the effect of dissociative states on the development of denial of pregnancy.[9]

Some women may conceal their pregnancy deliberately as they fear disapproval. They may have conceived following an extramarital affair, or there may be incestuous paternity. If the pregnancy is the result of sexual abuse; women may fear that revealing the pregnancy may provoke or worsen domestic abuse and violence. They may have become pregnant before marriage and they may feel shame if pregnancy is unacceptable within their particular religious or faith group. There may be collusion with other family members to try to ensure that news of the pregnancy is not shared outside the family or wider community. A study from Galway found that 65% of those who concealed their pregnancy were from a rural background compared to 33% from a control group, with 79% fearing a negative parental reaction to the pregnancy compared to 40% in the control group.[1] Some fear removal of their newborn baby by statutory agencies. This group includes: those who abuse drugs or alcohol, those involved in a relationship featuring domestic violence, or those who have had previous children removed by social care. These women may avoid contact with health professionals during pregnancy as a way of preventing detection.

Finally, some women with a strong desire for a natural pregnancy and delivery will not seek medical advice during pregnancy

What are the risks/outcomes for the mother and the baby?

Failure to access healthcare when pregnant can have catastrophic consequences, including maternal and neonatal death.[13] Denied pregnancies have a outcome compared to other pregnancies and at least some of the outcomes are potentially avoidable.[14,15]

With an incidence of denial of about 1 in 475 at 20 weeks gestation and approximately 1 in 2500 at term, it is apparent that many women come to accept the fact that they are pregnant as their pregnancy progresses. If the pregnancy continues to be denied or concealed routine screening tests will not be performed and foetal abnormalities may not be diagnosed. Opportunities will be missed to give health promotion advice, such as information on folic acid supplements, and advice on lifestyle

choices including alcohol consumption and smoking cessation. Additionally a lack of routine antenatal care means that serious medical conditions in the mother, such as pre-eclampsia, are likely to remain undetected.

An unassisted delivery may be dangerous for both mother and baby if no qualified staff are present. Nirmal found the mode of delivery was similar for booked and concealed pregnancies for those delivering in hospital, but the prematurity rates were significantly higher in the concealed pregnancy cohort (p=0.0002). 20% of infants in the concealed cohort had depressed Apgar scores at 1 minute and 8% at 5 minutes.[6]

When the baby is born there may be poor attachment and bonding, with the mother being psychologically unprepared to look after a new baby. Miller reports that psychotic denial of pregnancy, in those with chronic mental illness, may place the women and her child at high risk of precipitous or unassisted delivery, postpartum emotional disturbance, fetal abuse and even neonaticide (murder of an infant less than 24 hours of age).[11] Platt and Vallone both state that adolescents are especially vulnerable to pregnancy denial and suggest that nurses and school nurses have a key role in prevention of neonaticide through education, early detection of pregnancy and intervention with students to help them make healthy choices.[16,17]

Tursz and Vellut emphasise that it is not only adolescents who commit neonaticide.[18,19] A retrospective study carried out in 26 courts in three regions in France looked at all cases of infants dying the day they were born, which were submitted by the state prosecutor over a 5 year period. 17 mothers were identified and 27 cases of neonaticide were analysed. The authors concluded that the rate of neonaticide was 2.1 per 100,000 births, a higher rate than suggested by the official mortality statistics (0.39 per 100,000 births). None of the deliveries took place in a medical facility and all but three of the women gave birth secretly and alone. The mother's median age was 26 years, one third had at least 3 children, two thirds were employed and over half of the women in the study lived with the child's father. The women were deemed to have low self-esteem and be immature, but did not have frank mental illness. A study of 32 cases of infanticide in Finland found that in 91% the pregnancy was concealed, 66% having previously had a concealed pregnancy. 13% of the mothers were psychotic.[20]

A review from in Lincolnshire in 2000 looked at 12 child deaths at the hands of parents or carers, over a 10 year period. Four of the children were born following a concealed pregnancy.[21]

What is the appropriate response from health professionals when a concealed or denied pregnancy is suspected?

In light of the above literature review, it is clear that the situation of concealed or denied pregnancy presents particular challenges for the multi-professional team to ensure the safety and wellbeing of both mother and child. The following suggestions for management are designed to ensure that this risk is minimised as effectively as possible.

If a health professional suspects that a woman is pregnant, and that she is concealing or denying the pregnancy, she should be encouraged to go to see her GP who will then make a referral to maternity services. It is necessary to share information irrespective of whether consent has been given, as the welfare of the unborn child will override the mother's right to confidentiality in these circumstances. A referral should also be made to Children's Social Care about the unborn child. If the woman is under 18 years then she should be considered as a child in need herself. Professionals should try to engage her but if she refuses to engage in discussion, it may be appropriate to contact her parents if she is under 18 to ensure both her welfare and that of the unborn baby. However there may be various reasons why she is concealing a pregnancy from her family and a social worker may need to talk to her without her parent's knowledge in the first instance. If she is less than 16 years it should be considered whether a criminal offence has been committed which requires investigation.

A multiagency assessment will be required to determine the risk to the baby, including a pre-birth assessment by Children's Social Care, and an unborn baby case conference to manage concerns may be deemed necessary. United Kingdom law does not legislate for the rights of unborn children and therefore a foetus has no separate rights from its mother. Although a Local Authority is unable to assume parental responsibility for an unborn baby this should not prevent plans being made for the protection of the child, both during pregnancy and after birth.

If a woman does not disclose her pregnancy prior to delivery, she may present in labour or following delivery if she gave birth outside hospital. The circumstances of the pregnancy need to be explored

and appropriate medical treatment and support given. Again a referral must be made to Children's Social Care so an initial assessment can be started and a multi-agency strategy meeting convened. A Child Protection Conference may be required and a referral to mental services for the mother should also be considered. The mother and baby should not be discharged home until relevant assessments have been undertaken and definitive plans made. If this cannot be done on a voluntary basis it may be necessary to seek an Emergency Protection Order or use Police Powers to prevent the baby being removed from the hospital.

Good communication between professionals is important and the primary care team should be directly informed if a pregnancy was concealed or denied or there was a late booking.

If the baby has been harmed or injured, or the baby has been abandoned, then an urgent referral should be made to Children's Social Care and the Police.

Women who conceal one pregnancy may conceal further pregnancies and this must be borne in mind to try to prevent harmful outcomes for children in the future.

Conclusion:
The concealment or denial of pregnancy presents a significant challenge to professionals to safeguard the welfare and well-being of both the unborn child and the mother. An effective inter-agency approach is required to ensure the best outcome for both mother and baby. Knowledge of the wider literature should enable professionals to make informed decisions. Professionals need to be aware of the circumstances around a concealed pregnancy to ensure that the correct support and care can be provided to both mother and baby.

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