

PARTIAL DENIAL OF PREGNANCY AT 32 WEEKS IN A DIABETIC AND SUICIDAL PATIENT: A CASE REPORT. What Are the Treatment Recommendations?

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SUMMARY

Background: Denial of pregnancy is an issue that is often discovered a posteriori with sometimes dramatic complications. Denial of pregnancy is considered partial when the woman becomes aware of the pregnancy after the fifth month before delivery. The populations studied were heterogeneous, which made it impossible to establish a standard algorithm of the treatment and support of a discovery of partial denial of pregnancy.

Subjects and methods: Based on a literature review and a discussion of partial denial of pregnancy case and the consequential treatment with a five-year follow-up, the global management recommendations need consideration in the case of partial denial of pregnancy.

Results: The reported case confirmed the significance of the trauma caused by the discovery of pregnancy in a patient in denial, but also showed that this trauma can extend to caregivers concerned by the treatment.

Conclusion: Continuous training of all caregivers for denial of pregnancy is essential even if the issue may be considered infrequent. Contraception, prevention of sexually transmitted diseases and the importance of gynecological follow-up must be systematically addressed in a medical consultation. A standard algorithm for the treatment of partial denial is difficult to establish, but the rapid mobilization of a multidisciplinary team or hospitalization is recommended for the announcement of the diagnosis as well as personalized support during ultrasounds. The establishment of a relationship of trust remains the major issue.

Key words: pregnancy – denial – partial – diabetes - avoidant personality- psychotherapy

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INTRODUCTION

The issue of denial of pregnancy remains a complex subject that generates a particular emotional context for both patients, their families and their caregivers. Denial of pregnancy complicated by infanticide has given rise to several legal and psychiatric debates due to the different legislations from one country to another (Dayan et al. 2013). The definition of denial of pregnancy is "in a woman, a lack of subjective awareness of being pregnant, beyond the third trimester" (Beier et al. 2006). Denial is complete if it lasts until the birth and partial if the woman becomes aware of the pregnancy from the fifth month. It is estimated that this concerns 0.5-3/1000 births (Chaulet et al. 2013, Wessel et al. 2007). From a theoretical point of view, many authors tend to classify denial of pregnancy as a particular entity (Zaguri 2013, Oliveira 2013). This type of denial cannot be simply assimilated to anosognosia phenomena, psychotic denial, or reaction denial with dissociative components. Although it remains in the spectrum of these different processes, our team has already considered the link between denial of pregnancy and denial of fertility (Struye et al. 2013); the latter is probably linked to a lack of knowledge and education about sexual life in the family system. A typology of these women who have experienced complete denial of pregnancy is young, single women living with their parents, with a low socioeconomic and primiparous

living standard (Dubé et al. 2003). Other authors have suggested that for partial denial, there is no correlation with age or socio-economic status (Rott 2016). Some authors have also underlined the frequent presence in these patients of immaturity, dependency, repression of emotions, passivity or avoidance in the face of conflicts, poor communication with family and the social environment (Vellut et al. 2012), and a lack of sexual education and understanding of the female anatomy (Gorre-Feragu 2002). Overall, these women do not have a notable psychiatric history (Jacob Alby et al. 2014). In the literature, the concepts of prevention and screening are regularly mentioned as indispensable (Pansarasa 2004). When considering a treatment algorithm for partial denial of pregnancy, the population heterogeneity (Seguin et al. 2013, Friedman et al. 2004) makes it impossible to reach a common and systematic consensus. Nevertheless, based on a case report and a literature review, the purpose of our observations and reflections is to try to draw general recommendations in the context of the discovery of a denial of partial pregnancy.

SUBJECTS AND METHODS

Based on a literature review and a discussion of partial denial of pregnancy case and the consequential treatment with a five-year follow-up, the global management recommendations need consideration in the case of partial denial of pregnancy.

Information concerning the patient studied was collected from 11 psychiatric interviews prior to the discovery of the denial of pregnancy from December 2010 to December 2011, five endocrinology consultations since December 2010 where the diagnosis of pregnancy was made in December 2011, monitoring in psychiatric hospitalization in December 2011, and 30 psychiatric interviews from January 2012 to June 2017. Consultations and hospitalization took place at the Catholic University of Louvain, UCL Namur UHC, Psychosomatic Dpt, avenue Dr G. Therasse n°1, 5530 Yvoir, Belgium.

The literature review was conducted using the databases, PsycArticles, PsycInfo, and Pubmed with the following keywords: partial-denial-pregnancy and treatment.

A total of 154 articles were found in the search and 21 were selected for their clinical relevance.

RESULTS

The patient was 23 years old when she began psychiatric follow-up in December 2010.

She was single, pursuing vocational studies, and lived with her parents. She had type I diabetes diagnosed in childhood and Hashimoto's thyroiditis.

She was treated with insulin and thyroid hormones. She was also overweight. She regularly followed-up by an endocrinology consultation. In 2008, she presented a coma on ketoacidosis that required hospitalization in intensive care.

The patient was referred to a psychiatric consultation for impulsive behavior and poor management of diabetes.

In the first 10 psychiatric interviews from December 2010 to November 2011, the Mini International Neuropsychiatric Interview diagnosis and DSM IV criteria showed moderate major depressive disorder, impulse control disorder. Psychodynamically, the patient presented typical traits of avoidant personalities. Psychiatric follow-up shifted from psychoeducation to impulsivity management and better adherence to diabetes monitoring. The patient reported family tension dominated by an apparent lack of communication that seemed to reinforce the avoidant features of her behavior. Moments of impulsiveness seemed to be closely related to frustrations related to lack of communication or family affective disorders.

In March 2011, in this context, the patient experienced drug abuse (excessive intake of benzodiazepines), which required emergency room monitoring and hospitalization in the psychiatric unit. The patient worked on the issue of impulsivity and better expression of her emotions, and then continued outpatient psychiatric follow-up. At that moment, the family refused to undergo family follow-up.

The therapeutic alliance with her attending psychiatrist consolidated well with the follow-up. Contact with social services allowed her to begin living in apartment in order to become autonomous.

In mid-December 2012, in an endocrinology consultation, although the diabetic management had improved, a weight gain of 8 kg as well as a secondary amenorrhea triggered a blood test to exclude pregnancy. The patient refuted that she could be pregnant. The beta HCG dosage came back positive and confirmed the pregnancy.

The patient had no prior gynecological follow-up. The patient's attending physician ensured that she saw an emergency gynecologist, who assessed the pregnancy at 32 weeks. The patient was seen again four days later in a psychiatric consultation where she expressed that she did not want this child as well as suicidal ideation. Further hospitalization for psychiatric care was organized the same day. Having no maternity and neonatal services at the hospitalization site for psychiatric care, contact was made with the Maternal Intensive Care (MIC) service; however, an immediate transfer was impossible since the patient had suicidal thoughts and continued follow-up with her attending psychiatrist and the psychiatric team with whom a relationship of trust was well established. While remaining hospitalized in psychiatry care, consultations with the MIC were organized in order to assess the 32-week pregnancy in a diabetic patient, which had not been followed-up, and gradually established a link with the gynecology team that would accompany her during childbirth. In particular, a nurse from the psychiatric department accompanied the patient during the first ultrasound exams, where confrontation with the reality of pregnancy was the most difficult.

Psychiatric interviews during hospitalization made it possible to appease the suicidal ideation. Support of the patient, as voluntary interruption of pregnancy is illegal beyond 12 weeks in Belgium, tended toward a process of legal abandonment of her child with a proposal of adoption. The patient, although seemingly determined about this solution, remained open to the fact that she could always change her mind and the social service also explained the help that could be put in place if she decided to keep her child.

A family interview was also organized. The patient spoke very little and the interview remained focused on practical and medical questions about the risks associated with this unmet pregnancy in terms of potential complications.

After three weeks of hospitalization in psychiatry care, the patient agreed to be hospitalized for a week at the MIC for further assessment and then returned for one week in the psychiatric ward. The patient gave birth at the end of January 2012 to a boy in good health and no significant complications were reported. The patient decided to keep her child and with the help of the social service, set up home support.

Psychiatric follow-up continued with a monthly interview, alone or with her son, at the beginning. In December 2012, the patient no longer presented any suicidal ideas or behaviors and the mother-son relationship was established harmoniously. The report was

similar in December 2013 with more time between each follow-up. In December 2014, the situation remained stable. In December 2015, her son integrated into the nursery school very well. In December 2016, the patient resumed and passed vocational training and the mother-son relationship was still harmonious, based on the consultations and the social management team. The correct integration of the child in school continued.

During psychiatric interviews, compliance with oral contraception was well consolidated. The patient continued her endocrinology follow-up.

The time between psychiatric follow-up became more spaced out, but the patient regularly updated the team. The family refused to carry out other family interviews.

DISCUSSION

In our case report presents a frequent typology of women who present denial of pregnancy (Dubé et al. 2003): young, single, living with parents, and with a low level of education and knowledge about sexuality. The avoidant personality context in this case report also goes hand in hand with poor communication with the entourage and passivity/avoidance in the face of conflict (Gorre-Ferragu 2002, Friedman et al. 2007); confirmed by the observation of the family interview and the subsequent refusal to carry out family follow-up (Desaunay et al. 2016).

A decisive factor in this case report, but which is very different from what is observed in general, is the presence of moderate psychiatric disorders associated with type 1 diabetes with the implementation of psychiatric follow-up prior to the discovery of denial of pregnancy. This dimension of an existing psychotherapeutic trust relationship was a decisive factor that treatment was possible. In the case of neonaticide phenomena (murder of the newborn within 24 hours of birth), one hypothesis retained is that the brutal trauma of confrontation with the reality of childbirth leads to a dissociative state of derealization or depersonalization (Viaux et al. 2010) in a patient who has no gynecological or psychiatric medical follow-up to support her.

Nevertheless, it seems important to emphasize that although the conditions for prior follow-up appeared optimal, the emotional reactions of the caregivers directly involved in the follow-up were intense, regardless of years of experience. Being overweight probably contributed to the difficulty of perception of pregnancy; nevertheless, the retrospective experience of having met this patient in consultation several times without perceiving the pregnancy remained disturbing for the caregivers as well. Therefore, in our opinion, decision-making algorithms concerning the denial of pregnancy were not implemented in caregivers and the confrontation with the reality of a denied pregnancy was also a difficulty for caregivers (Janati Idrissi et al.

2014). In the reported case, the decision-making priorities process was very difficult when the patient, confronted with the reality of her pregnancy, developed intense suicidal thoughts, but accepted and asked for care in a hospital where trusted caregivers work. Intensive gynecological monitoring, with all the risk management of a 32-week pregnancy not followed-up in a diabetic patient, required a transfer to a maternity unit with an associated neonatal unit. In this case, the priority given to the relationship of trust established with caregivers helped to sustain suicidal thoughts to give the patient time to consider the various options available to her and to create a progressive link with the maternity team. The limiting factor remains the pregnancy progress, which does not allow in all cases to have enough time to establish psychotherapeutic and psychosocial treatment.

Another pivotal moment in the treatment was the referent nurse's accompaniment of the patient to the ultrasounds. These ultrasounds were confrontational for the patient who, with the real-time support of the psychiatric nurse, was able to gradually look at the images and develop an awareness of the presence of her child.

The importance of the social worker has already been noted (Berns 1982), and in this case it has proved to be indispensable for the mobilization of support or the administrative procedures concerning the final decision of the patient. Meetings with social services also participated in working the patient's ambivalence.

Lastly, the continuation of multidisciplinary medico-psycho-social postpartum follow-up is an important stabilizing factor. Addressing the issue of prevention in terms of contraception or risky sexual behavior should also be systematic.

CONCLUSION

Coordinated multidisciplinary work allowed a patient, in partial denial of pregnancy discovered at 32 weeks who want to leave her child for adoption, to agree finally to keep her child with the development of a harmonious relationship mother-son in a follow-up at five years.

This case discussion concerning a partial denial of pregnancy led us to consider that initial prevention lies in the context of continuing education for caregivers in general (general practitioners, medical specialists, nursing teams, and social workers), awareness of denial of pregnancy, although uncommon, is important because it is destabilizing when the caregiver is confronted. In general, and systematically, including in psychiatric follow-up, the importance of addressing the issue of regular gynecological follow-up, possible contraception, and measures to protect sexually transmitted diseases are important factors of prevention already well accepted in the literature.

In case of discovery of a partial denial of pregnancy, we would recommend the rapid mobilization of a multi-disciplinary team (attending physician, gynecologist, psychiatrist, psychologist, nurses, and social worker) and, in view of the trauma that can constitute the announcement of the diagnosis, consideration of making this announcement in the presence of the patient's trusted persons and if necessary announcing it during hospitalization to allow monitoring and mobilization of more comprehensive support.

We would also recommend a sustained and personalized accompaniment when the patient had routine ultrasounds.

The remaining limiting and unpredictable parameters are the possibility of establishing a professional and trusting therapeutic relationship and the pregnancy progress at the time of the discovery of a partial denial.

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Contribution of individual authors:

All authors made a substantial contribution to the design of the study, and/or data acquisition, and/or the data analysis and its interpretation

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