DENIED PREGNANCY

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SUMMARY – Two cases of non-psychotic denied pregnancy are presented and discussed.

Following obstetric expertise, the forensic-criminal evaluation should investigate the reported crimes of denied pregnancy associated infanticide or criminal abortion as well as the potential involvement of other persons in these crimes. All this would require close collaboration between obstetricians, psychiatrists and crime investigation experts in the forensic expertise of these criminal offences.

Key words: *Pregnancy – psychology; Pregnancy – complications; Pregnancy – outcome; Denial – psychology; Life change events; Adaptation; Infanticide – psychology*

Introduction

Denied pregnancy is defined as deliberate negation of the existing pregnancy. The term 'denied pregnancy' was introduced by M. Klein in 1946, based on the then psychodynamic concepts, distinguishing psychotic and non-psychotic denied pregnancy. The phenomenon is mostly found in minors, single, frequently psychoemotionally immature females, those with unwanted conception, or in patients with treated or untreated psychosis.

Pregnancy is denied for various reasons, including fear, shame, fear from losing job, fear from parents, friends, coworkers, preparing for abortion or delivery in secret, for abandoning or substituting a changeling, intended infanticide, blackmail, etc. Denied pregnancy may also be motivated by pregnancy resulting from rape or incestuous relations. Pregnancy is concealed by abdominal tightening and wearing loose or very tight clothes[1-6]. In denied pregnancy cases, aid from another person helping the woman to keep pregnancy unrecognized until abortion or delivery is quite frequently present. This person may also assist at abortion or delivery, and take an active part in the subsequent crime of illegal abortion or infanticide. Such persons may even induce denied pregnancy in minor, immature individuals. The phenomenon is frequently associated with primitive settings and poor socioeconomic conditions[6,7].

Two cases of non-psychotic denied pregnancies are reported and discussed.

Case Reports

Case 1

A 28-year-old graduate economist was transferred by ambulance to obstetric emergency room, having delivered a live eutrophic newborn (3200/50) into the toilet after denied pregnancy; the newborn died from aspiration. The woman failed to call an ambulance and left the newborn in the toilet to suffocate. She called an ambulance after more than one hour, because of massive vaginal bleeding and failure of the placenta to cast off. On admission, she was frightened; more than one hour had elapsed from the delivery, the placenta did not cast off and was delivered by cord traction. The birth canal was free from lesions. The newborn's body was brought one hour after birth, livid, with overt signs of death, without reflexes at attempted resuscita-

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tion by ambulance personnel. The interview revealed the woman to be unmarried, from a respectable urban family with good family relations; she had concealed pregnancy which proceeded uncontrolled. Her parents disliked her boyfriend but did not interfere with her affair. She had no serious illnesses and her psychiatric history was normal. The woman was discharged after two-day hospital stay. The judiciary authorities and the police filed criminal charges against the woman for infanticide. Psychiatric interview failed to demonstrate mental incompetence or other psychopathology. She was prescribed a benzodiazepine sedative and obligatory psychotherapeutic treatment. Autopsy of the child's body indicated death from aspiration, without any other abnormalities.

Case 2

A 16-year-old high-school student, of middle-class socioeconomic conditions and family relations, concealed pregnancy from her parents and schoolmates by wearing very tight clothes, because the parents disapproved the affair with her boyfriend. Their first intercourse resulted in conception, and the girl imitated menstrual bleeding every month by dropping several drops of blood from a finger cut upon the napkin for her mother not to observe amenorrhea. Her weight gain during pregnancy was only 4 kg. The labor began at home, following amniotic membrane rupture. She told her father she had to go to the hospital because of uterine hemorrhage, and her father took her in panic to the department of gynecology. In front of the hospital, precipitated labor terminated by her delivering a live male term newborn (2900/47). On admission to the ward, the newborn showed normal Apgar score; the young parturient was free from lesions of the birth canal, normal labor stage III and IV, and was discharged from the hospital on day three postpartum. The interview with a psychiatrist and social worker indicated no psychopathology except for some signs of emotional immaturity. The parents were advised accordingly, and they accepted the newborn readily and willing to provide all necessary support.

Discussion

Denied pregnancy is a heterogeneous condition with different meanings and different psychiatric diagnoses in different women. Stress factors such as interpersonal problems or separation of partners may serve as denied pregnancy triggers also in non-psychotic patients. Psychopathology frequently reveals a history of trauma experienced in childhood or adolescence, associated with dissociative reactions. In their prospective study performed in Berlin, Wessel *et al.*[8] found some 1600 cases of denied pregnancy, yielding a rate of 1 *per* 475 deliveries at 20 weeks of gestation, indicating that denied pregnancy is by no means an infrequent obstetric, social and forensic issue that requires closer attention. Denied pregnancy results in uncontrolled pregnancies, frequently precipitated deliveries and deliveries without professional assistance, intrauterine fetal death (IUFD) or infanticide, while the children born from denied pregnancy are at a significantly higher risk of unfavorable neonatal outcome due to the lack of antenatal care. The Berlin study demonstrated a significantly poorer neonatal outcome in denied pregnancy group *versus* control group, with a higher incidence of premature deliveries, intrauterine growth retardation and IUFD[9].

Neifert and Bourgeois[10] report on a healthy woman with non-psychotic denied pregnancy that gave birth to a live, healthy and term newborn by precipitated delivery. She concealed pregnancy for socioeconomic reasons. Brezinka *et al.*[11] present 27 women with denied pregnancy: 11 until delivery, nine from 27-36 weeks, and seven from 21-26 weeks of gestation. There were four cases of IUFD and no infanticide. These women believed they were not pregnant because they had irregular menstrual cycles, and three of them "conceived while on oral contraceptives". The grade of criminal offence is significantly more severe in psychotic patients with denied pregnancy, including infanticide and postpartum psychotic reactions[2,3], and in those with schizophrenia who require intensive psychiatric-obstetric treatment with antipsychotic pharmacotherapy, supportive psychotherapy and social-family support. In their study, Friedman *et al.* recorded 29% of denied pregnancy and identified subtypes of denied pregnancy: pervasive denial, affective denial and concealment of pregnancy[6].

Kaplan and Grotowski[12] describe a woman with denied pregnancy terminated with stillbirth and panic. Postpartum, the patient was treated by a psychiatrist because these events were underlain by a psychiatric

disorder. Driever *et al*.[13] report on two cases of denied pregnancy: one that resulted in twin IUFD, where severe placental dysfunction was forensically proved in the mother who did not believe she was pregnant. She was adipose, with continuous bleeding during pregnancy, living in intact social and family conditions. The other case of denied pregnancy resulted in live birth and was intentionally associated with the mother's private and occupational stress. The method of choice to treat denied pregnancy is psychotherapy with social support, especially in primiparae to prevent denied pregnancy in future pregnancies and for social reasons[1,14]. Psychiatric surveillance and management are required in case of psychotic patients[15].

Conclusion

Although denied pregnancy is more frequently described in psychotic patients, both of our patients were emotionally immature individuals without psychotic elements, motivated to conceal pregnancy exclusively for social reasons. In the first case, criminal charges were filed for infanticide because the woman deliberately left the live child in the toilet, not even trying to provide due care and call an ambulance. The second case refers to an emotionally immature high-school student, motivated to denied pregnancy for fear from her parents, which fortunately ended favorably, without forensic and criminal consequences. Social service should be actively engaged in schools and in the community to prevent denied pregnancy, with special reference to non-psychotic denied pregnancy caused by poor socioeconomic conditions or stress-induced maladjustment. These preventive actions should include large-scale social and health education of the young.

Following obstetric expertise, the forensic-criminal evaluation should investigate the reported crimes of denied pregnancy associated infanticide or criminal abortion as well as the potential involvement of other persons in these crimes. All this would require close collaboration between obstetricians and crime investigation experts in the forensic expertise of these criminal offences.

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Sažetak

PRIKRIVENA TRUDNOĆA

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Prikazana su dva slučaja nepsihotične prikrivene trudnoće uz raspravu. Forenzičko-kriminalističkom procjenom treba nakon opstetričkog vještačenja istražiti prijavljena kaznena djela čedomorstva ili kriminalnih pobačaja iz skrivene trudnoće, kao i moguće uplitanje drugih osoba u izvršenje ovih kaznenih djela. Potrebna je uska suradnja opstetričara, psihijatara i kriminalističke službe u forenzičkoj ekspertizi.

Ključne riječi: *Trudnoća – psihologija; Trudnoća – komplikacije; Trudnoća – ishod; Poricanje – psihologija; Životne promjene; Adaptacija; Čedomorstvo – psihologija*