

CAN DENIAL OF PREGNANCY BE A DENIAL OF FERTILITY? A CASE DISCUSSION

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SUMMARY

Background: For many years, several cases of neonaticide resulting from a denial of pregnancy were reported in the press. Recently, a case of neonaticide made headlines in Belgium: a woman realised that she was pregnant during childbirth. A few minutes after the delivery, the baby was asphyxiated to death. In the obstetric history of the patient, we note six pregnancies, of which three births were given to anonymous adoption. Mrs D. was not able to explain why she was not using any method of contraception despite all of her pregnancies. Many questions need to be asked in order to further understand denial of pregnancy. Do these women understand the link between sexual intercourse and the potential of pregnancy? Which women are more at risk of denying their pregnancy? Is there a certain personality profile at risk?

Methods: In the following article, we report the case of Mrs D. who presented to the consultation of the clinic of CHU Mont-Godinne (Belgium). We will also discuss the literature available on the online databases (PubMed, PsycArticles, PsycInfo and Cairn.info) using the following keywords: denial of pregnancy, neonaticide, contraception.

Results: In the results of retrospective studies, we notice that indeed most women who have had a denial of pregnancy were not using any method of contraception. This observation suggests the hypothesis of a denial of fertility in these women.

In addition, it appears that a specific personality profile is very difficult to establish, due to the lack of sufficient data and due to the discrepancy of the results concerning these women, especially in the matters of age and socio-economic status. However we can note that some psychological characteristics are similar.

Conclusions: The denial of pregnancy is a complex mechanism, which still raises many questions in the clinical setting and in matters of etiopathogenesis. In these patients, we note that denial is a defense mechanism regularly used, even in other aspects of their lives. Moreover, the frequent non-use of contraceptive method might therefore be more in favor of a denial of fertility than of a denial of pregnancy.

Key words: denial of pregnancy – neonaticide - denial of fertility - contraception

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INTRODUCTION

Pregnancy denial is a woman's subjective lack of awareness of being pregnant (Beier et al. 2006). It is a mental and physical symptom where the woman has no perception of her own pregnancy and is not aware of the existence of the foetus (Gorre-Ferragu 2002). The prevalence of pregnancy denial is estimated at 0.5 to 3 per 1000 births and is comparable from one country to another (Beier et al. 2006, Wessel et al. 2007).

The denial of pregnancy is often discovered during pregnancy; in that case we call it partial denial. It is called massive or complete if it is discovered during childbirth. The risk of neonaticide (murder of a newborn within less than 24 hours after birth) is then high, especially if the delivery is illegal or practiced outside a medical structure.

This sudden confrontation to reality, equivalent to a trauma (Viaux & Combaluzier 2010) often materialized by the cries of the baby, causes an acute stress, usually accompanied by a feeling of depersonalization and derealisation.

Pregnancy denial can occur with any woman of childbearing age, regardless of her age and socio-economic status (Beier et al. 2006, Gorre-Ferragu 2002, Marinopoulos 2009). However, it is noted in some

studies that women suffering from pregnancy denial are usually young, most often single, still living with their parents, have a lower socio-educational status and are most often primiparous (Dube et al. 2003). In other recent studies, the proportion of older and multiparous women is more important (Beier et al. 2006, Pierrone et al. 2002).

Shared pregnancy denial has also been described in partners, friends, families and even health professionals of women who deny their pregnancy (Vander Borghet & De Neuter 2005).

These women usually have common psychological characteristics such as immaturity, emotional dependency, repression of emotions, poor communication with their social environment, a tendency towards passivity and an avoidance of conflicts (Seigneurie & Limosin 2012, Tursz & Cook 2011, Zagury 2011, Marinopoulos 2009). A fear of being abandoned by the spouse or parent, or even by the unborn baby is also a common finding. They are often described as women who had a strict upbringing and where communication in the family was not present. A lack of proper sexual education and a lack of understanding of the female anatomy are also noted in these women (Gorre-Ferragu 2002). In addition, several studies report that these women most often have no psychiatric history or history

of sexual abuse (Friedman et al. 2007, Wessel et al. 2007).

Women who deny their pregnancy often receive no prenatal care, and continue to act as if they were not pregnant in their daily activities (Seigneurie & Limosin 2012). The pregnancy is usually not very symptomatic, amenorrhea may even be absent. The increase in abdominal volume is also lesser, which can be explained by a different positioning of the foetus in the abdomen. Foetal movements may go unnoticed or attributed to other causes. Some authors speak of an actual psychosomatic complicity; the psychological denial being enhanced by the lack of physical symptoms of pregnancy (Dayan et al. 2003).

The term “neonaticide” was first coined by Resnick (Resnick 1970). It is a term used to describe the murder of a new-born within less than 24 hours after childbirth. It is executed almost exclusively by the mother of the child. It differs from filicide, which is the murder of a child more than 24 hours after birth. Neonaticide most often occurs after an illegal delivery. Despite better socio-economic conditions and a better access to contraception and abortion, neonaticide rate is estimated at 2.1 per 100 000 births in France (Tursz & Cook 2011). This rate is probably underestimated due to hiding and concealment of these acts. Bonnet distinguishes passive neonaticide (no initial medical care offered to the baby; the typical scenario being the baby falling into the toilet during childbirth) from active neonaticide (with violent outbursts: choking, strangulation, and drowning) (Bonnet 1993, Tronche et al. 2007). Neonaticide does not always result from a pregnancy denial (Romano 2010).

Studies on women who commit neonaticide show demographic and psychological characteristics similar to those of mothers denying their pregnancy (Friedman et al. 2007, Resnick 1970, Friedman & Resnick 2009, Simmat-Durand et al. 2012). In almost all cases, no prenatal medical care had been delivered and the child was unwanted (Tursz & Cook 2011). Despite not wanting a child, it is noted that these women rarely use a contraceptive method (Friedman et al. 2007, Vellut et al. 2012, Tursz & Cook 2011). This last finding raises several questions: do these women understand the link between sex and the risk of pregnancy? Can the pregnancy denial be explained by an actual denial of fertility? Also, very few data exist on the prevention and management of neonaticide. This article will present a case of neonaticide in Belgium along with the management of that case.

SUBJECTS AND METHODS

Patient information was collected through a series of 10 interviews conducted during several follow-up consultations between the periods of December 2012 and March 2013 with the patient who was referred by court order to the Psychopathology and Psychosomatic unit in Hospital Universitary Center Mont-Godinne

(Belgium). In addition, two interviews with the couple were also conducted. We also obtained the consent of the patient before writing this article.

For the literature review, we used the following databases: PubMed, PsycArticles, PsycInfo and Cairn.info using the following keywords: pregnancy denial, neonaticide, contraception. The initial search resulted in 45 articles of which 30 were selected for their clinical relevance.

CLINICAL CASE

In February 2012, Mrs D. aged 44, in a relationship since 2010, realized she was pregnant at the time of delivery. She gave birth to a live baby boy at full term, in the family bathroom, while her partner and children were sleeping. According to the story of the patient, she was in shock and having not realized what was happening, she pressed her child hard against her chest for a long time. When she “came back to her senses”, the baby had already died in her arms. She explains that out of fear, she did not dare to tell her companion and hid the child's body in her garden. A few days later, the baby was discovered coincidentally by the neighbour's dog. After a month of investigations, Mrs D. confessed the act to her companion and went to the police department. She was imprisoned for eight months before being granted a parole with mandatory psychiatric care. The trial is still on-going.

Mrs D. is a stay home mother; she has a diploma in social studies. She comes from a middle class family and she had no previous psychiatric history. She describes her father as very authoritarian, and her mother as very repressive and distant. The family environment was not favourable to affection or confidences, and taboo subjects were numerous according to the patient.

She has three children from a previous marriage, aged 13, 16 and 18 at the time of the incident. These three previous pregnancies were unremarkable. Mrs D. had also given birth to three children later on, which she offered for anonymous adoption. Each of these babies was from a different father. It is worth noting that upon knowledge of the pregnancy, two out of these three fathers decided to break up with Mrs D. She describes that she was aware of these three pregnancies since the beginning but decided to hide that from her friends and family. She explains that she offered those babies for adoption because she didn't believe in abortion as a solution and that she didn't want to raise these children by herself believing that she couldn't fully live up to her duties as a mother.

As for the question of contraception, Mrs D. explains that she always had a difficulty to use any contraceptive method. She states having discarded the possibility of pregnancy over the years, despite her regular sexual activity, each time thinking that pregnancy will not happen. She also explains that she never received any sex education, not even by her parents who regarded sex as a taboo subject.

Mrs D's partner is a 52 year old man, divorced, father of a 20 year-old girl. He states that he has not noticed any physical change in Mrs D. during her pregnancy and that he has not suspected anything. This was also the case for the friends and family of the patient. He states that the couple continued having regular sexual intercourse up until the moment of childbirth. As for the question of contraception, he explains that he himself had never addressed the issue simply because he thought he was too old to have children. However, he states that he would have accepted the child, and therefore he was very affected by his death.

It is worth noting that this last pregnancy happened just after the death of the patient's ex-husband, the father of her three children. She states that this event was a big trauma for her. During the entire period of pregnancy, the patient explains that she had three periods of vaginal bleeding that she took for menstruation. In fact, Mrs D's periods were irregular at the time, and therefore she was not alarmed by these episodes. She also gained very little weight during her pregnancy. She states that she did not feel any nausea or pain, or foetal movement during the 9 months preceding delivery, unlike her previous pregnancies. She therefore didn't feel the need to consult any doctor during that period.

Mrs D. describes her feelings after the incident as a constant oscillation between reality and nightmare. She explains that she didn't disclose what happened to her partner or family in an attempt to protect them for as long as possible. She also explains that she believes matters that are not discussed tend to disappear with time. She describes herself as someone who doesn't confide much in general and as someone who has a tendency towards escaping from problems by forgetting them.

The trial of Mrs D. is still on-going. The psychiatric report stated a temporary irresponsibility following an episode of acute stress at the time of birth; the context of pregnancy denial being very likely. Some experts also suggested "neurosis of abandonment" as an explanation for Mrs D's action.

The expert report could not be recovered for data collection. Therefore, we have no further information about the details of the psychiatric evaluation. The results of psychological tests would have been indeed important to clarify our interpretation, but being foremost therapists of the patient, we chose not to resubmit these tests to avoid compromising the therapeutic alliance.

DISCUSSION

Denial can be defined in psychiatry as the refusal to accept a certain external reality; a reality that cannot be metabolized psychologically (Bardou et al. 2006). It is an adaptive mechanism, which every human being can

use as a protection against a certain pain or anguish or to avoid the risk of mental collapse (Romano 2010). It is not specific to an illness or a medical condition. It can be present in other aspects of human behaviour. It is a defence mechanism often seen in patients who deny their pregnancy (Zagury 2011). In the case of Mrs D., denial seems to be an adaptive mechanism used frequently in various fields of her life. It constitutes an integral part of her overall functioning. She confirms that by saying: "what is not said does not exist". She tends to occult certain realities that might be disturbing. Her family dynamics promote that functioning as well. Some authors describe similar family patterns in these patients, the mother being most often terrifying and the father very distant (Massari 2007). They also suggest that these patients might have suffered from a lack of an adequate maternal gaze leading to a fragile constitution of a female identity preventing them from being able to project themselves in the role of a woman and consequently a mother (Mazoyer et al. 2011).

Despite her long obstetric history, Mrs D. was not using any contraception at the time of the event. In most of the studies concerning this subject, the proportion of women who experienced a pregnancy denial while not using any contraception was very high (more than 90%) (Friedman et al. 2007, Vellut et al. 2012, Tursz & Cook 2011, Friedman & Resnick 2009). These studies also showed an ambiguous rapport to contraception (Simma-Durand et al. 2012). This finding leads us to suggest that the denial is most likely a denial of fertility in some of these women (Gorre-Ferragu 2002, Seigneurie & Limosin 2012). The association between sexual intercourse and the possibility of pregnancy seems not to be established, especially among women who come from a family environment characterized by the absence of verbal communication and a very strict upbringing. They therefore ignore their anatomy and the basics of reproductive physiology and ignore their fertilizing potential. Sexuality is indeed a taboo subject in families of patients with pregnancy denial. Riley describes a fear of rejection found in these women if their active sexuality was to be discovered by the family (Riley 2006). A pregnancy denial, by denying the feeling of being pregnant, also abstracts the representation of the sexual act that led to this pregnancy (Mazoyer et al. 2011). A denial of the initial sexual act is also sometimes present in some of these women.

The denial of fertility is not exclusive to adolescents who lack adequate knowledge about sexuality and fertility. It is also seen in adult women, who are not able to conceive the idea of getting pregnant, and do not perceive themselves as women capable of having children (Gorre-Ferragu 2002, Romano 2010, Simmat-Durand et al. 2012). They often express the magical idea that they could not get pregnant and are not aware of their fertility potential (Windels 2011). Therefore, they do not use any contraception method. In this women, physical symptoms of pregnancy are often stifled.

On the other hand, a denial of fertility can be seen in older women who assume they are menopausal or after a long period of infertility (Seigneurie & Limosin 2012). Moreover, pregnancy can also occur despite the use of contraceptives. These women become aware of their pregnancy at an advanced stage. All these considerations lead us to believe that denial of fertility might be sometimes at the origin of a pregnancy denial.

In addition, some authors describe a whole spectrum of pregnancy denials: denial of the initial sexual act and the possibility of getting pregnant, which can be assimilated to a denial of fertility; denial of bodily metamorphosis; denial of otherness; denial of vital processes; denial of the inevitability of the outcome of pregnancy (Zagury 2011). All these denials concerning certain characteristics of pregnancy should be detected before delivery so that women are able to anticipate all the outcomes of their pregnancy.

Pregnancy denial and consequently the denial of fertility constitute a risk for both the mother and the child, especially on the social, legal and medical levels (Gorre-Ferragu 2002).

Prevention of denial of pregnancy and neonaticide is difficult because these women do not seek care. When they do, it is usually their general practitioner. It is advised therefore to perform a pregnancy test in any woman of childbearing age, especially when she has complaints such as severe abdominal pain, nausea, menstrual disorders, weight gain or even a more general symptom such as discomfort. If the pregnancy is confirmed, the patient should be well informed of her condition and of all the possible outcomes so that she could be prepared for childbirth. Regular follow-ups are evidently advised as well. Moreover, in the case of late abortion requests, the physician should suspect the possibility of a pregnancy denial or a hostility of the mother towards her foetus (Gorre-Ferragu 2002).

Many health professionals are concerned with this prevention: general practitioners, obstetrician-gynaecologists, emergency doctors, paediatricians, psychiatrists, and nurses along with educators and teachers in schools and social service workers.

Prevention therefore requires a medico-psycho-social care but is difficult to implement given the reluctance of these women (Gorre-Ferragu 2002). However, psychological distress is indeed present. It is therefore advised to refer these patients to mental health professionals (Friedman & Resnick 2009).

Furthermore, in the case of a denial of fertility, it is advised to work on the prevention of unwanted pregnancies during adolescence. Sex education, easy access to contraception and abortion and the possibility of a space for dialogue could reduce the number of unwanted pregnancies and thus reduce the rate of infanticide. Teens should be able to see their doctor without their parents (Friedman & Resnick 2009).

Anonymous childbirth is also an alternative for women who are expecting an unwanted baby and when abortion is not possible.

CONCLUSION

Denial of pregnancy is the lack of awareness by the woman of her pregnant state. It can occur in any woman of childbearing age, regardless of her age and socio-economic background. We note however common psychological characteristics in women who deny their pregnancy. Denial as a defence mechanism is usually common even in other aspects of these women's lives.

In most studies, we note that women with pregnancy denial rarely use contraceptives. This interesting finding could be explained by the fact that these women do not recognize the association between sexual intercourse and the possibility of getting pregnant, believing themselves unable to bear children. We can therefore suppose that a denial of fertility is actually at the origin of some pregnancy denials.

Pregnancy denial is risky for both the mother and the child. A medico-psycho-social care for these patients seems essential. In the case of a denial of fertility, prevention should target most importantly young women with childbearing age with unwanted pregnancies.

Further studies are needed to support our hypothesis and to develop an adequate prevention strategy.

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