South Australian Perinatal Practice Guideline

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

Note: The words woman/women/mother/she/her have been used throughout this guideline as most pregnant and birthing people identify with their birth sex. However, for the purpose of this guideline, these terms include people who do not identify as women or mothers, including those with a non-binary identity. All clinicians should ask the pregnant person what their preferred term is and ensure this is communicated to the healthcare team.

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 horseshoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horseshoe shape depicts a pregnant woman. The smaller horseshoe 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 Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2–5 times more likely to die in childbirth and their babies are 2–3 times more likely to be of low birth weight. The accumulative effects of stress, low socio-economic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services, and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics, the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation, and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectfully manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.

Purpose and Scope of PPG

To guide the care of women with a concealed or denied pregnancy to minimise harm to the woman and her fetus or newborn.

Table of Contents

Summary of Practice Recommendations

Whether concealed, denied, or undetected; lack of antenatal care places women and their unborn baby at risk of complications. Incidences in Australia is unknown but is thought to be rare.

When determining the gestation at which the woman seeks medical support, consider hospital admission to enable a comprehensive assessment, physical examination, history, screening, ultrasounds, and pathology tests.

Develop a detailed management and partnership plan for the remainder of the pregnancy, including community liaison and support.

Assessment of social situation and screening for domestic or family violence is warranted for any pregnancy, but particularly for those with a concealed or denied pregnancy.

Mental health assessment is recommended as a priority, as the cause in some cases is psychosis or severe dissociation.

The pregnancy should be treated as high risk, with appropriate monitoring if the woman presents in labour.

Screening for substance use is warranted with appropriate referrals for drug, alcohol, and tobacco services (such as Drug and Alcohol Services SA (DASSA)). See *Substance use in pregnancy PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal.

Staff need to be ready for a range of reactions from the woman upon learning about the pregnancy or newborn. Recognise that this situation may also be distressing for clinicians, seek support as needed.

Appropriate postpartum follow up with support services is required, including mental health care, reproductive health, and contraception education.

Discussing this topic with Aboriginal women is sensitive. Practices need to be extremely culturally safe, appropriate, and sensitive. Women should be offered cultural support in the first instance from a female Aboriginal healthcare provider. Aboriginal women should be referred to an Aboriginal Health Professional as soon as practicable.

Abbreviations

>	Greater than
≥	Equal to or greater than
<	Less than
≤	Equal to or less than
ANRQ	Antenatal risk questionnaire
CARL	Child Abuse Report Line
DCP	Department of Child Protection
EPDS	Edinburgh Postnatal Depression Scale
GTT	Glucose tolerance test
GP	General Practitioner
HIV	Human immunodeficiency virus
MSSU	Mid-Stream Specimen of Urine
STI	Sexually transmitted infection

Definitions

Concealment of Pregnancy	A woman knows she is pregnant but actively conceals it from her partner, family, friends, or community.[1]
Affective Denial	There is an intellectual awareness of the pregnancy, but no emotional or physical preparations are made for the infant's arrival.[1]
Pervasive Denial	Existence of pregnancy is kept from the woman's own awareness (i.e., the woman not allowing the existence of the pregnancy to enter her consciousness).[1]
Psychotic Denial	The woman is suffering from a psychotic illness and tends to deny her pregnancy in delusional ways.[1]
Undetected pregnancy	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.
Neonaticide	The killing of a newborn infant within the first 24 hours of life.
Infanticide	The killing of an infant in their first year of life.
Filicide	The deliberate act of a parent killing their own child, regardless of age.

Introduction

Pregnancy denial (or cryptic pregnancy), is when a woman is unaware of their pregnancy, often discovering it in late gestation (20+ weeks), in labour or following the birth (may be unassisted and carry additional risks for the newborn). Concealed pregnancy, on the other hand, refers to the woman being aware of their pregnancy but chooses to hide it.[2]

There are a variety of underlying factors (psychiatric and sociological) leading to concealment or denial of pregnancy.[3, 4] Although a concealed pregnancy involves a more active psychological process than a denied pregnancy, the backdrop of psychosocial and psychological indicators is often similar, including the woman's symptoms and behavioural patterns, and birth outcomes when infanticide has occurred.[1, 5]

Concealed or denied pregnancy can occur in women of all age groups and parity, regardless of their relationship status (i.e., single or partnered). These phenomenon raises significant concerns due to the potential risks to the fetus, the newborn, and mother, particularly when there is delayed or absent antenatal care. In some cases, it can result in the abandonment of the infant and in extreme circumstances, neonatal death.[1, 6]

Incidence

There is limited data on Australian incidences of concealed or denied pregnancies. A study conducted across four hospitals in NSW, Australia over a period of 7 years found that 1 in 1420 women did not recognise their pregnancy until giving birth. In contrast, statistics from Germany and the United Kingdom indicate lower incidences, with approximately 1 in 2455 cases of denied/concealed pregnancy until birth. On the other hand, rates of denied/concealed pregnancy beyond 20 weeks gestation (but before birth) vary substantially, with Germany and France reporting 1 in 475 and 1 in 300 pregnancies, respectively, are not recognised until 20+ weeks gestation.[7]

Risk Factors

Pregnancy denial is a multifaceted issue, influenced by complex, psychological, social, and individual factors. However, under specific conditions all women are at risk of concealing/denying their pregnancy.[3, 6, 8] Factors that increase the risk of concealed or denied pregnancy include:

- Fear of ostracism or cultural repercussions
- Domestic violence/sexual abuse
- Social isolation
- Low socio-economic status (linked with most known cases of pervasive denial).
- Intellectual disability
- Immaturity
- History of psychiatric disorder (e.g., schizophrenia or poorly managed/treated conditions)
- Substance abuse.[9]

In some Aboriginal cultures and communities, women may conceal their pregnancy if they have conceived a baby outside of acceptable social clans, 'wrong skin' relationships may be one example. She may choose to keep the pregnancy quiet for fear of causing unhappiness or fighting among families, communities, and groups. Reproductive coercion may be a factor influencing concealment of pregnancy in some Aboriginal communities, particularly if the pregnancy is a result of domestic or family violence. In such cases, the woman may be worried that her baby will be removed from her care.

Women who have experienced neonatal loss may be risk of affective denial, where they emotionally distance themselves from the pregnancy. Similarly, women with a history of infants being removed from their care may conceal their pregnancy to prevent a recurrence of their child being taken.

Aboriginal Women may be reluctant to access services that are culturally unsafe. There is an over-representation of Aboriginal babies in out of home care, and there is a need for culturally appropriate care and support. In the experience of rural and remote clinicians in South Australia, and the stories of women in communities, Aboriginal women living in remote areas may conceal their pregnancy to avoid have to travel from their communities to access care.

Misdiagnosed Pregnancy Symptoms

Undetected pregnancies may occur in women experiencing perimenopause, irregular menstrual cycles, using contraception, obesity, or absence of pregnancy symptoms. These women may seek medical advice for symptoms that may not be linked to the pregnancy and therefore often misdiagnosed (see table 1).[3]

Women with pervasive denial (i.e., the woman is not allowing the existence of the pregnancy to enter her consciousness) may not to experience any, or have less obvious, pregnancy symptoms, such as weigh gain, nausea/vomiting, and in some cases continue to experience menstrual like bleeding.[3] In these cases, labour often takes women by surprise, leading them to present to hospitals experiencing intense abdominal/back pain, or increased urge to empty their bowels. Women in pervasive denial often experience feelings of dissociation with their infant at birth.

Table 1: Alternative explanations given to 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 • Perimenopause or obesity may cause irregular cycles
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

Outcomes of Concealed or Denied Pregnancy

Concealing or denying a pregnancy has the potential to cause serious adverse maternal and neonatal outcomes as a result of inadequate antenatal care. These include, low birth weight, prematurity, higher rates of admission to neonatal intensive care units.[6] Furthermore, poor maternal-fetal attachment during pregnancy serves as a predictive factor for subsequent maternal-infant interactions including decisions to abandon their newborn. Amidst these concerns also lies the alarming potential for neonaticide or infanticide, underscoring the urgency of addressing and managing concealed and denied pregnancies effectively.[5, 10, 11] For more information on assessing maternal/infant relationships see *Assessing Parent Infant Relationship PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal

Potential Harm to the Fetus and/or Newborn

Concealment or denial of pregnancy is a risk factor for attempting to harm the fetus, abandonment of the newborn and in rare instances neonaticide (see *Intent to Harm Fetus* PPG found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal). Incidence of neonaticide in Australia are difficult to attain due to records not being easily accessible or reported accurately.[12]

Neonaticide refers to the killing of a newborn in the first 24 hours of life, often by a parent and in most cases the mother.[8] Neonaticide is marked by a complete denial of the pregnancy and birth by the mother, rather than a deliberate motivation to harm the infant.[13] The severity of the denial correlates to an increased risk of infanticide.[14] Women who experience profound denial often exhibit state of shock and emotional dissociation during birth. Among these cases, drowning of the newborn is the most prevalent cause of death. Additionally, fractures to the neonate's head may occur if the mother births in a crouching or unassisted standing position.[1] Women who play an active role in the demise of their newborn often exhibit dissociative or near dissociative states, often struggling to recollect details of the event and/or displaying minimal efforts to conceal their actions.

Management

The underlying reason for concealing a pregnancy often determines the level of risk to the fetus/newborn. The reasons may become apparent through a comprehensive risk assessment. The risk to the unborn child and newborn is often heightened in cases involving alcohol or substance abuse.

Women with concealed or denied pregnancies often do not present for antenatal care until later in the pregnancy or at birth. Therefore, the approach to care is often an opportunistic one.

Antepartum

- Based on an approximate gestation of the pregnancy and presenting symptoms, consider expediting care for women presenting for antenatal care after 20 weeks gestation and/or possible admission to hospital for "catch up" care.
- With consent, perform all possible **screening, pathology tests and monitoring**, including:
  - booking bloods
  - MSSU
  - STI screening
  - glucose tolerance test (GTT), if fasting
    - HbA1c is not fasting, with a plan to have a GTT as soon as possible.
  - obstetric ultrasound.
- See *Antenatal Care PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal for a comprehensive list of screening, pathology tests, ultrasounds, and referral services.
- Undertake a **full maternal history** as per the **South Australian pregnancy record** (SAPR).
- Where possible, explore reasons for late or no antenatal care with the woman including:
  - any prior child protection orders
  - major stressors
  - accommodation arrangements
  - financial stability
  - relationship dynamics
  - provide woman with referral options to social work and/or mental health services to support psychosocial concerns. If so, mark this as urgent and follow up with relevant departments.

Note: *intimate partner violence is an associated risk for concealed or denied pregnancy and therefore prompt screening needs to be considered.*

- 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, Aboriginal family birthing programs, whichever is most appropriate.

For Aboriginal women consider referral to an Aboriginal Health Professional or Aboriginal Community Controlled Health Service/Organisation as soon as practicable.

Perinatal Mental Health Assessment

- All women should be encouraged to complete the **Edinburgh Postnatal Depression Scale (EPDS), and Antenatal Risk Questionnaire (ANRQ)**, and supported by an appropriately trained staff.
  - Complete the questionnaires in the immediate post-partum period if woman presents in labour.
  - Use the iCOPE digital screening platform if available at your LHN otherwise, the questionnaires can be found under *Screening and Assessment Tools for Health Professionals* at https://www.cope.org.au/health-professionals/clinical-tools-health-professionals/

- For more information on perinatal mental health assessment and referral pathways for metropolitan and regional South Australia see the *Anxiety and Depression in the Perinatal Period PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal.

- Staff need to be aware of the normal emotional reactions to pregnancy versus those that are compromised.

Perinatal service providers need cultural sensitivity within a non-judgemental environment when planning care for the Aboriginal woman. Aboriginal women should be consulted about any decisions in the first instance. If requested, an Aboriginal Health Professional should be consulted.

Intrapartum

- Treat the pregnancy as **high risk** if the first hospital presentation is in labour.
- Consider possible intrapartum risks such as precipitous labour, undiagnosed pregnancy complications and unknown fetal gestation.
- The woman may present with little or no antenatal care of medical history, therefore, obtaining as much information about their pregnancy history from the woman (or family/support person present) is essential.
- Use a calm, sensitive and non-judgemental approach. There is a risk of psychological trauma for the mother from unexpected birth if she is denial.
- Identify risk of:
  - blood borne disease (HIV, Hepatitis B and C)
  - infectious diseases including sexually transmitted infection
  - fetal abnormalities
  - substance use
  - intra-uterine growth restriction
  - poorly controlled diabetes
  - intra-uterine infection
  - pre-eclampsia.
- Estimate fetal gestation and presentation (abdominal palpation and portable or formal ultrasound).
- Rule out low-lying placenta as soon as practicable via ultrasound, before performing any vaginal examination.
- Ensure continuous fetal monitoring in labour.
  - **Do not** use fetal scalp monitoring until gestation, HIV, Hepatitis B and C, STI status is established.
- If the timing of the presentation allows, consider routine antenatal screening, such as:
  - booking bloods
  - high and low vaginal swabs (including Group B streptococcus)
  - MSSU and urine toxicology.
- Assess need for psychiatric advice, +/- review, depending on mental state and if any known mental health history.
  - Look for any indication of delusional thinking and enquire about current mood and suicidal or infanticidal thoughts.
- Ensure neonatologist is present at time of birth.

Consider contacting an Aboriginal Liaison Officer for cultural support and emergency needs. May require support to notify family. Aboriginal women should be consulted about any decisions in the first instance.

Neonatal Considerations

- The gestational age of the baby should be estimated based on Ballard or Dubowitz scoring.
- A careful clinical examination is required after birth by a medical officer or neonatal nurse practitioner.
- Where the baby appears to be > 37 weeks gestation and is over 2500 grams, has a normal examination, and there are no risk factors for sepsis, the baby can stay with the mother to establish bonding and facilitate breast-feeding where this is maternal preference, with provision of lactation support.
- The baby should not be separated from the mother unless:
  - a Section 41 order is in place
  - there is a medical reason for transfer to a nursery,
  - the mother has indicated that adoption is their preference and they do not want the baby to remain with them while awaiting this process.
- Where there has not been a maternal glucose tolerance test, or if the baby appears preterm, growth restricted or large for gestation, there should be screening for hypoglycaemia at 1 and 4 hours.
- Vitamin K and hepatitis B vaccine are given with parental consent as routine.
- Where hepatitis B serology is not immediately available, then hepatitis B immunoglobulin and hepatitis B vaccine are given.
- A social work assessment is required:
  - if the pregnancy was concealed/denied, then CARL is notified immediately detailing concerns of staff
  - if the pregnancy was 'undetected' then CARL is only notified if staff hold concerns.
- Babies at risk of sepsis or with other medical concerns are admitted to a nursery for management.
- Where there is a history of opioid use in pregnancy, the baby should be monitored for neonatal abstinence (see *Neonatal Abstinence Syndrome PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal).
- Ideally, social work (and DCP if relevant) should be consulted in discharge planning of the baby and unless a *Children and Young People (Safety) Act 2017 – Section 41* order is in place, then the child remains under the guardianship of the birth parents.
  - If DCP are involved, then they should be consulted in discharge planning, which may include a Safety Plan Document, however they do not have legal authority unless a Section 41 has been invoked.
- The family's GP should be informed prior to discharge of the baby.

Assessing Potential Risk of Harm to the Unborn Child and/or Neonate

The following recommendations have been taken directly from section *7.2.2: Risk to the infant* found in the *Mental Health Care in the Perinatal Period Australian Practice Guideline (2023 edition)* produced by Centre of Perinatal Excellence (COPE).[15]

- Risk of harm to the infant can be related to suicide risk in the mother but can also be a separate issue. It should be noted that expressions of fear of harming the baby may be a sign of anxiety rather than intent but should always be assessed further.
- Assessment of risk to the infant needs to be conducted with sensitivity to avoid implicitly blaming or stigmatising the mother for having negative thoughts about her infant which could impact the therapeutic relationship and reduce open/honest discussions.
- Cultural consultation should be sought by clinicians undertaking a risk assessment involving children and their birth families.
- The nature of the enquiry will depend on a range of factors, including the setting and the extent of the therapeutic relationship (see table 2).

Table 2: Example questions for assessing risk of harm to the unborn child and/or neonate.

The following are **examples of questions** that could be asked, taken from the Postpartum Bonding Questionnaire, and adapted to the perinatal context:
• Have you felt irritated by being pregnant or by your baby? • Have you had significant regrets about becoming pregnant or having the baby? • Does the baby feel like it's not yours at times? • Have you wanted to harm your unborn child or shake or slap your baby? • Have you ever harmed your baby?

- Action will depend on the answers to these questions.
- It is best practice that the mother and infant remain together, but if it is assessed that there is risk of harm to the infant from the mother, then alternative arrangements for the infant should be explored (i.e., co-parent, family member, CARL notification).
- Consider the need for a high-risk infant notification.
- All health professionals should be familiar with the legislation concerning reporting of concerns about children at risk of harm from abuse or neglect in their State or Territory. Health services and child and maternal agencies will generally have internal policies setting out these requirements.
- For more information see 2023 National Perinatal Mental Health Guideline - COPE

Infant and Unborn Child at Risk Notification

- All SA Health employees are mandated by Section 30 of the *Children and Young People (Safety) Act 2017* to report to the Department for Child Protection any suspicion on reasonable grounds that a child or young person is or may be at risk of harm, including risk to the unborn child where:
  - a lack of antenatal care or preparations for birth including addressing any child protection risk factors or
  - expectant parent with a recent history of threatening, planning or attempting suicide or who is at serious risk of suicide.
- All serious concerns **must only** be reported via:

Child Abuse Report Line (CARL) on **131478**

***Note**: **Do not** use the online eCARL form to report high-risk/serious infant and unborn child concerns. These must be done directly via phone on the number listed above.*

- For more information see Report suspected harm of children and young people | Department for Child Protection

Postpartum

- Consider extended stay to ensure adequate support, observation, and education prior to discharge.
- Perform ANRQ and EPDS if not completed antenatally.
- Liaise with community health services and primary care, including General Practitioner (GP), or Aboriginal Controlled Health Services to ensure that the woman has timely follow up upon discharge from the birthing hospital.
- If assessment and patient presentation require a mental health review, offer and refer to your relevant Perinatal Mental Health team for postnatal assessment.[16]
- Social Work involvement is likely to be beneficial with the mother's consent 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.

- 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.
- At metropolitan hospitals seek advice for referral pathways from the perinatal mental health team.
- At other locations such advice can be sought from the Perinatal and Infant Mental Health Education and Consultation (PIMHEC) team at **Helen Mayo House** on **0481 057 744.** For more information see Women's and Children's Health Network • Helen Mayo House – Referral Information (wchn.sa.gov.au).
- Priority referral to CAFHS is recommended if mother and baby are going home together. For more information see *Assessing Parent Infant Relationship PPG* found in the A-to-Z index at www.sahealth.sa.gov.au/perinatal.

Family Planning

It is highly recommended that women presenting with concealed or denied pregnancy are offered education or reproductive health and contraception as part of pre-discharge planning that these women, with appropriate referrals for follow up.

For Aboriginal women, all follow up plans and/or referrals should be referred to the nominated or appropriate Aboriginal health professional.

Resources

SAPPGs Web-based App:
Practice Guidelines (sahealth.sa.gov.au)

Medicines Information: (sahealthlibrary.sa.gov.au)
https://sahealthlibrary.sa.gov.au/friendly.php?s=SAPharmacy

SA Health Pregnancy:
Pregnancy | SA Health

Australian Government Pregnancy, Birth and Baby: (www.pregnancybirthbaby.org.au)
Pregnancy, Birth and Baby | Pregnancy Birth and Baby (pregnancybirthbaby.org.au)

Pathology Tests Explained: (https://pathologytestsexplained.org.au/)
Pathology Tests Explained

Centre of Perinatal Excellence (COPE): (www.cope.org.au)
COPE: Centre of Perinatal Excellence

Australian Birth Stories – Undiagnosed Pregnancy
(www.australianbirthstories.com/podcasts/undiagnosed-pregnancy)
Podcast: Undiagnosed Pregnancy Birth Stories | Australian Birth Stories

References

1. Barnes DL. Towards a new understanding of pregnancy denial: the misunderstood dissociative disorder. Archives of Women's Mental Health. 2022;25(1):51-9.
2. Duckitt K. Cryptic pregnancy. Case Reports in Women's Health. 2023;38.
3. Chechko N, Losse E, Nehls S. Pregnancy Denial: Toward a New Understanding of the Underlying Mechanisms. Current Psychiatry Reports. 2023;25(10):493-500.
4. Buist A. Understanding the Mysteries of Pregnancy Denial. Infanticide and Filicide: Foundations in Maternal Mental Health Forensics. 2020:153.
5. Stenton S, Cohen MC. Assessment of neonaticide in the setting of concealed and denied pregnancies. Forensic Sci Med Pathol. 2020;16(2):226-33.
6. Murphy-Tighe S, Lalor JG. Regaining agency and autonomy: A grounded typology of concealed pregnancy. J Adv Nurs. 2019;75(3):603-15.
7. Watson K, Angelotta C. The frequency of pregnancy recognition across the gestational spectrum and its consequences in the United States. Perspectives on Sexual and Reproductive Health. 2022;54(2):32.
8. Milia G, Noonan M. Experiences and perspectives of women who have committed neonaticide, infanticide and filicide: A systematic review and qualitative evidence synthesis. Journal of Psychiatric and Mental Health Nursing. 2022;29(6):813-28.
9. Sablone S, Margari A, Introna F, Catanesi R, Mandarelli G. Denial of pregnancy and neonaticide: A historical overview and case report. Journal of Forensic Sciences. 2023;68(2):688-95.
10. Stokes J, Forster, P, Geary, M.,. Concealed pregnancy in the 21st Century. Irish Medical Journal. 2020;113(10).
11. Wessel J, Gauruder-Burmester A, Gerlinger C. Denial of pregnancy - characteristics of women at risk. Acta Obstet Gynecol Scand. 2007;86(5):542-6.
12. Brown T, Lyneham S, Bryant W, Bricknell S, Tomison A, Tyson D, et al. Fillicide in Australia, 2000-2012: A national study. online: Criminology Research Advisory Council; 2019.
13. Landoni M, Silverio SA, Ionio C, Ciuffo G, Toscano C, Lega I, et al. Mothers who kill their children: A systematic review of perinatal risk factors. Maltrattamento e Abuso All'Infanzia. 2022(2022/2).
14. Lattanzi GM, Provini L, Williams R, Aceti F, Giacchetti N. Personality structure and attachment models of women who kill their children. A systematic review on maternal filicide. Child abuse & neglect. 2020;106:104532.
15. NJ H. Mental Health Care in the Perinatal Period: Australian Clinica Practice Guideline. Melbourne: Centre of Perinatal Excellence (COPE); 2023. Available from: https://www.cope.org.au/health-professionals/review-of-new-perinatal-mental-health-guidelines/.
16. Nanjundaswamy Madhuri H, Gaddapati S, Thippeswamy H, Thampy M, Vaiphei K, Kashyap H, et al. Denial of Pregnancy: Psychopathology and Clinical Management. Psychopathology. 2019;52(4):271-4.

Acknowledgements

The South Australian Perinatal Practice Guidelines gratefully acknowledge the contribution of clinicians and other stakeholders who participated throughout the guideline development process particularly:

Write Group Lead

Dr Ros Powrie
Dr Anne Sved Williams

Write Group Members

Dr Rebecca Hill
Dr Elizabeth Coventry
Dr Kate Jarvis
Dr Elsa Jureidini
Victoria Sutton
Marnie Aldred

Other Major Contributors

Letitia Waite
Keely Taylor
Deb Clissitt
Michele Northey
Dr Jordana Scharnberg

SAPPG Management Group Members

Dr Michael McEvoy (Chair)
Monica Diaz (SAPPG EO)
Marnie Aldred
Dr Elizabeth Allen
Elise Bell
Elizabeth Bennett
Dr Angela Brown
Marnie Campbell
John Coomblas
Dr Danielle Crosby
Kate Greenlees
Catherine Leggett
Dr Linda McKendrick
Dr Scott Morris
Dr Anupam Parange
Dr Amanda Poprzeczny
Dr Charlotte Taylor
Dr Shruti Tiwari
Allison Waldron

Suggested citation:

Powrie R, Williams A. Concealed or Denied Pregnancy PPG035 [Internet]. South Australian Perinatal Practice Guideline. SA Health, Government of South Australia. 2024 [updated 29 August 2024, version 3.0). Available from: http://www.sahealth.sa.gov.au/perinatal.

OFFICE USE ONLY

Document Ownership & History

Developed by: Maternal, Neonatal and Gynaecology Strategic Executive Leadership Committee
Contact: HealthCYWHSPerinatalProtocol@sa.gov.au
Endorsed by: Clinical Guideline Domain Custodian
Next review due: 29/08/2029
CGSQ reference: PPG035
Guideline history: Is this a new guideline (V1)? **N**
Does this guideline amend or update and existing guideline? **Y**
If so, which version? **V2.0**
Does this guideline replace another guideline with a different title? **N**
If so, which guideline (title)?

Approval Date	Version	Who approved New/Revised Version	Reason for Change
29/08/2024	V3	Clinical Guideline Domain Custodian	Formally reviewed in line with 5 yearly scheduled timeline for review.
24/06/2015	V2	South Australian Maternal & Neonatal Clinical Network	Formally review in line with scheduled timeline
12/04/2011	V1	South Australian Maternal & Neonatal Clinical Network	Original approved version.