



## **Neonaticide/Infanticide**

### **Progressive Case Conference**

#### *Trainee Guide*

#### **Contributors**

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#### **Session Structure**

After completing this module, learners should have a preliminary understanding of neonaticide risk factors, including epidemiology, phenomenology, risk factors, and treating patients at risk. This session is designed to last 60 minutes but can be modified for a longer or shorter session. This module is designed for psychiatry residents who have some clinical experience with pregnant patients. Prior to the session, residents should complete the readings listed in the pre-reading section of this module.

#### **Session Outline**

1. Review overview.
2. Case Study Part 1.
3. Case Study Part 2.

#### **Goals and Objectives**

1. Describe neonaticide epidemiology, phenomenology, and risk factors.
2. List common characteristics of women with hidden pregnancies.
3. List common characteristics of women who perpetrate neonaticide.

#### **Resources Required**

Friedman, S. H. (2018). Neonaticide. In S.H. Friedman (Ed.), *Family Murder: Pathologies of Love and Hate* (pp. 53-68). New York: Group for the Advancement of Psychiatry.

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Friedman, S.H. Child Murder by Parents: Toward Prevention. *Current Psychiatry*. 2023 June; 22(6):12

## Case Study: Part 1

You are on the Psychiatry Consult service and asked to see a woman for “delusions.” The patient, Sheree, is an 18-year-old woman who has come to the emergency department for abdominal pain. She reported to the primary team that she felt mild cramping and tightness in her abdomen earlier that afternoon and she was worried that she might be coming down with the stomach flu – several people at her work have been ill this week with gastrointestinal symptoms. Review of systems was positive for 5 pounds of weight gain over six months, swelling in her feet and ankles, heartburn, and increased urinary frequency. She didn’t recall the date of her last menstrual period. On exam, her abdomen was uniformly distended with linea nigra. On routine laboratory screening, her HCG was positive. The team suggested to the patient that her symptoms might be related to her pregnancy, to which she replied, “But I’m not pregnant. There’s no way.” When the Emergency Medicine resident calls you for the consult, she explains that further discussion was impossible. “The more we tried to talk about it, the worse it got. She wouldn’t let us do anything else and basically kicked me out of the room. She said she wanted to leave AMA.”

## Case Questions/Discussion

1. What is an important first step in the management of a patient who denies pregnancy?
2. Besides a positive HCG, does she exhibit any signs or symptoms of pregnancy?

## Case Study: Part 2

Prior to seeing the patient, you review her chart and discover that she does not seem to follow with a primary care or women's health clinician. Beginning in adolescence, she visited the Emergency Department several times for various complaints. She's tested positive for marijuana and cocaine previously. In one emergency department encounter from about six months ago, it was noted that she had bruising on her wrists and upper arms. A few months before that, she had presented for an STI check. A screening questionnaire for intimate partner violence at that time was negative, but the provider documented concern for this.

In the Emergency Department, you find Sheree putting on her shoes. Her purse is in her lap, and she seems ready to leave. After telling her your name and your role on her treatment team, she rolls her eyes. "I'm not crazy. I don't need a psychology person. You can tell everyone I'm leaving." You ask if the two of you can talk for just a moment, and she sighs. "Fine, but I've got work. So whatever you say, I'm leaving in a minute. I can't lose this job."

You ask permission to sit and to keep the door to the treatment room cracked. With reluctance, she tells you why she came to the hospital and about her conviction that she has stomach flu. You learn that she has never been diagnosed with, or treated for, psychiatric disorders. Her medical history is notable for another pregnancy when she was 15 years old. The baby was born four weeks preterm and adopted out. She lives at home with her parents, who are very strict. On weekends, she uses cocaine and marijuana with friends from work and her sometimes-boyfriend, with whom she has a strained relationship. Initially, she denies any exposure to violence, but as you build rapport together, she admits that her boyfriend "has gotten physical before." When you ask about sexual violence, she looks away and shrugs. "We're broken up now anyway."

3. What factors associated with denial of pregnancy are present in Sheree's case?

4. What are some other factors that may be associated with denial of pregnancy?

### **Case Study: Part 3**

Sheree seems more relaxed with you – she’s leaning back in her chair and has set her purse aside. You explain that you were called because the team was concerned about pregnancy complications and wanted to examine her further. Sheree again denies that she is pregnant. “That’s not it, I’m telling you. I know from last time. And my parents, they would kill me if I got pregnant again.” You acknowledge her worries and suggest that if Sheree is pregnant, you two can work together to find a good solution that would keep her and the baby safe. She is still resistant to this, but she agrees to allow the team to do some testing to rule out problems in her abdomen.

5. What test has been suggested to help patients with pregnancy denial to accept their pregnancy?

### **Case Study: Part 4**

You speak with the team and explain that Sheree should be given an ultrasound. During the test, Sheree watches the screen intently and when the fetus is pointed out to her, she begins to cry. She tells you that she is pregnant although continues to state that she didn’t know until now. She allows the team to do a vaginal exam, and she is diagnosed with Braxton Hicks contractions. You recommend follow up at the women’s mental health clinic in two days, and the emergency department sets up an outpatient prenatal visit. After discussing Sheree’s safety at home, she says she will stay with her friend from work for a few days. Sheree states that she does feel safe at home right now with her parents, but she wants to stay with a friend for a few days because she is concerned that her parents will react badly to the pregnancy and she wants to tell them when she is in another location. Social work is consulted, and Sheree is provided with information for an emergency shelter, if she feels unsafe at home.

6. What interventions could be helpful in reducing her risk for neonaticide?

## Case Study: Part 5

About six weeks later, you are moonlighting on the consult service and a request comes from the OB/GYN team. They are concerned about a patient who delivered an infant girl one day previously, when she was 36 weeks pregnant. The team says she does not appear to be interested in the infant at all and appears “flat.” She also had not engaged in prenatal care during her pregnancy. She had initially presented to the emergency department in labor and seemed “completely out of it, like she wasn’t even in the room.” She refused the team permission to contact any friends or family. Although she stated that she did not use substances while pregnant, her OB/GYN team notes some concern about possible cocaine use during the pregnancy given a history of cocaine use in the chart and the baby being small for gestational age and preterm. The patient’s name is Sheree.

In your initial interview, Sheree tells you that she did not follow up with psychiatric or prenatal care after her appointment – she was too worried about what her parents, especially her mother, would do if the baby was discovered. To hide her condition, she tried to eat less to avoid gaining too much weight and wore over-sized clothing. She does not know who the father is, but she suspects it might be her ex-boyfriend, whom she has not seen for several months. No one else knows of the pregnancy, although Sheree thinks her friend from work might have guessed. They have grown closer lately, and the friend has helped Sheree cut back on drug use. They are planning on renting an apartment together once they save enough money.

7. What is denial of pregnancy and how does it differ from concealment of pregnancy? What are the types of denial of pregnancy?

8. What common factors associated with neonaticide are present in Sheree's case?

9. What are some additional factors that may be associated with neonaticide?

10. What protective factors does Sheree have against neonaticide?

11. What steps can you recommend to decrease her risk for neonaticide?

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