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REVIEW ARTICLE

Foetal abuse

Paula Fernandez Arias[1,2] · Keiko Yoshida[3] · Ian F Brockington[4] · Jennifer Kernreiter[5] · Claudia M Klier[5]

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Abstract
Pregnancy and motherhood are often presented as natural and unproblematic for women. The fact that there are some women who engage in violent behaviour towards their unborn child suggests that motherhood is not as unproblematic as we are led to believe. This paper presents six previously unpublished cases of foetal abuse that is physical assaults on the foetus by the mothers themselves, and examines how the prevailing myth of the good mother might be further endangering mothers and their unborn children. So far, the research suggests there are some common, possibly co-occurring, features that might be an antecedent to foetal abuse: unplanned pregnancies, prior mental health issues in the mother, trauma, pregnancy denial up to 20 weeks or until birth, and ideation of harm correlated to in utero movements.

Keywords Foetal abuse · Pregnancy · Pregnancy denial · Motherhood · Neonaticide · Childhood abuse

Introduction

While child abuse is a concept that has been broadly recognised, and well researched, since the 1960s, the same cannot be said about foetal abuse. To many, the idea that an expectant mother would think about causing harm to their unborn child, let alone actually doing so, is an unfathomable idea (Kent et al. 1997). A concept such as foetal abuse transgresses all traditional cultural and societal norms regarding femininity, motherhood, and the 'natural order of things'. Feminist scholarship has long argued that western notions of intensive mothering are unrealistic, detrimental to women, and often used to further the surveillance of female bodies (Rich 1986). Arguably then, to examine the phenomenon of foetal abuse is to indirectly examine the prevailing cultural understanding of motherhood.

Given the limited research focusing exclusively on foetal abuse, this paper incorporates research done on anonymous birth and pregnancy denial given the similarities between them. So far, the research done has shown that there are some common features that might be an antecedent to foetal abuse: unplanned pregnancies, prior mental health issues in the mother, trauma, pregnancy denial up to 20 weeks or until birth, and ideations of harm correlated to in utero movements. These features can but need not be co-occurring.

The good mother

Motherhood, like all other social norms, is culturally constructed and perpetuated through social institutions (Feasey 2013). Sinai-Glazer (2015) identifies six dimensions that make up the 'good mother myth': idealisation vs. demonization; expectation of unconditional maternal love; motherhood as natural and instinctive to every woman; mothers as objects; the mother as an asexual woman; and exclusive responsibility for a child's welfare and mother blaming. Given the focus of this paper, we are particularly interested in the 'expectation of unconditional maternal love' and 'motherhood as natural and instinctive to every woman'.

Sinai-Glazer (2015) argues that mothers are expected to love their children always and under every circumstance, an expectation that does not extend onto any other kind of

✉ Paula Fernandez Arias
paula.fernandez@umayor.cl

1 Society & Health Research Center (CISS), Universidad Mayor, Santiago, Chile

2 Monash Deakin Filicide Research Hub, Department of Social Work, Monash University, Melbourne, Australia

3 Iris Psychiatric Clinic, 3-4-28, Sakurazaka, Cho-ku, Fukuoka, Japan

4 University of Birmingham, Lower Brockington Farm, Bredenbury, Bromyard, Herefordshire HR7 4TE, UK

5 Department of Paediatrics and Adolescent Medicine, Medical University of Vienna, Währinger Gürtel 18-20, 1090 Vienna, Austria

relationship. This idea, she notes, is rooted in the belief that motherhood is "an integral part of a woman's personality, femininity, and biological reproduction system" (Sinai-Glazer 2015, 355). Meanwhile, Feasey (2013) notes that the emergence of the good mother myth was a response to women's growing economic and social independence, increased participation in the labour force, and entry into traditionally male arenas. The ill effects of this myth have been reported in studies examining the correlation between the public discourse of motherhood and the rise in stress levels, social isolation, and anxiety disclosed by mothers (Henderson et al. 2016), particularly in the USA.

Foetal abuse

Perhaps the first mention of foetal abuse is in Oppenheim's (1919) article on Misopädie (hatred of children) where one of the mothers in his study (case five) threatened to drive a nail into the foetus. While this physical, and extreme, form of foetal abuse has not been extensively researched, considerable resources have gone into examining the impact of other female behaviours classified as foetal abuse, one such example is women's drug and alcohol consumption during pregnancy. This form of foetal abuse became well known during the 1990s when the effects of in utero exposure to drugs and alcohol were turned into a public health issue that disproportionately impacted on women's lives (Schroedel and Peretz 1994).

Likewise, as public awareness of the prevalence of domestic violence increased, a small number of publications dealing with the impact of intimate partner violence on pregnant women deployed the idea of foetal abuse to describe the outcomes of physical violence against pregnant women. Most notoriously, Pugh (1978) published a small piece inquiring why the battered foetus was not an issue comparable to the battered baby. Pugh (1978) asserted that physicians needed to pay more attention to signs, such as bruising of the abdominal wall, during antenatal visits that might indicate that the expectant mother was subjected to physical violence.

This paper, however, is concerned with assaults on an unborn child done by the mother herself. This form of foetal abuse has been most neglected by researchers as it presents considerable challenges. Condon (1987; 1986) has, perhaps, produced the most comprehensive foetal abuse research. Condon (1986) found that when 'specific inquiry' was made, the impulse to harm the foetus was not an uncommon thought among pregnant women. He described three foetal abuse cases where the women had either been victims of abuse as children or had dysfunctional relationships as adults (Condon 1986). Condon's main concern was to identify if foetal abuse was an antecedent to child abuse however, this proved difficult. To follow up, he questioned 112 pregnant women about the urge to take out their frustrations on the foetus: nine women (8%) occasionally felt that they wanted to hurt or punish the unborn child and 11 (9%) men believed their wife occasionally felt like hurting the foetus when feeling irritated (Condon 1987, 611). Further to this, he also found that 21% of women felt a mixture of tenderness and irritation towards with unborn child (Condon 1987).

Kent et al. (1997) describe five cases where women physically assaulted themselves while pregnant. They noted that the most common form of abuse was punching their abdomen as a response to foetal movements. Kent et al. (1997) also note that all five women in their sample were depressed and had comorbid anxiety. Further to this, four of the pregnancies were unplanned and the women had considered a termination and were generally ambivalent about their pregnancies throughout. None of the women had any alcohol or drug abuse issues.

Pollock and Percy (1999) found that negative preoccupied maternal antenatal emotional attachment (MAEA) was associated with increased likelihood of reported irritation with the foetus; however, none of the 40 pregnant women reported the intention to harm the foetus. However, as Brockington et al. (2006) has discussed, relying on self-reporting might underestimate the prevalence. When two postpartum bonding questionnaires were compared Wittkowski et al. (2007) found that the Postpartum Bonding Questionnaire was unlikely to identify risk for abuse in postpartum women. Brockington et al. (2006) studied over 120 mothers, all referred to mother-infant psychiatric services, from Birmingham (UK) and Christchurch (New Zealand) using the 2-hour Birmingham Interview. Two New Zealand mothers had impulses to abuse the foetus and two Birmingham mothers did. Foetal abuse predicted rejection of the child (relative risk 3.0, $p < .001$) and pathological anger towards it (relative risk 4.0, $p = .007$).

Pregnancy denial, similarly to foetal abuse, defies generalised belief however, as Sandoz (2011) points out, there might be physiological reasons women do not present as pregnant to themselves or their environment. Sandoz (2011) argues that the silhouette effect, women who are pregnant but do not have the correct shape, is due to the conscious mind not knowing about pregnancy and therefore not generating the correct physiological response, what he terms a cybernetic disorder. This persistent state of denial is also aided by the fact that the foetus is horizontal (Seigneurie and Limosin 2012). Once the woman is given proof of her pregnancy, the body almost instantly takes on the expected shape and symptomatology of pregnancy. Kenner and Nicolson (2015) conclude that trauma plays the most important role in pregnancy denial. In their review of the research, they found no substantive evidence that rejection of parenthood was the underlying motivation for denial. They did find however that most studies on pregnancy denial note the role of childhood trauma and how these were reactivated through pregnancy making denial a viable self-preservation mechanism (Kenner and Nicolson 2015).

There is only one prospective population-based epidemiological study from Germany giving an estimate of 1/475 pregnancies in which denial is present up to 20 weeks into gestation (Wessel and Buscher 2002), another study from Austria found that nearly half of those pregnancies were denied until birth (Brezinka et al. 1994). Seigneurie and Limosin (2012) estimate that the rate of denial is between 0.5 and 3 per 1000 deliveries. Friedman and Resnick (2009) studied 211 cases of women who denied pregnancy and found that psychiatric consultation was rare, which seemed striking as most mothers (90%) subsequently took responsibility for their infants. Rape was reported in two cases, but childhood abuse or neglect was not assessed in this sample. A more recent review of the media coverage of 230 neonaticidal mothers in France found that only 9 of them were acquitted due to pervasive denial of pregnancy (Simmat-Durand 2017) signalling that denial remains a complicated issue for the judiciary and the media alike.

Denial of pregnancy might even persist until after birth, as described by Bonnet (1993) in her study of women who gave birth under anonymity. She found a considerable amount of denial of pregnancy, violent fantasies, and impulses towards the foetus in this group of women. The women had a history of psychological and sexual trauma, a seemingly common trait among women who abuse the foetus. Four of the women in her sample had killed the newborn and most studies on neonaticide report high numbers of childhood trauma and denial of pregnancy in these women.

In women who give up their child under safe heaven or anonymous birth laws (Klier et al. 2013), the frequency of foetal abuse is not routinely assessed because of the requirement for anonymity. Bonnet's study remains the only source of information despite the recent dissemination of prevention measures of neonaticide in Europe and abroad (Friedman et al. 2009). Highly dysfunctional reactions after birth, such as abandonment, are rare and we do not have information on denial of pregnancy, foetal abuse, or self-abortion attempts in this group as mothers are rarely found (Sherr et al. 2009).

Unpublished cases

This paper presents six previously unpublished cases of women who disclosed foetal abuse, three of these come from Klier, two from Brockington and Birmingham, and one from Yoshida respectively.

a. A 20-year-old with a history of childhood depression and abuse, became depressed during pregnancy and blamed the foetus for her difficulties. She had suffered physical abuse in childhood and had attempted suicide as 12 years old and again during the pregnancy. She repeatedly punched her abdomen in response to foetal movements. Depression continued after the birth in 1998. The child developed feeding difficulties, to which she responded by assault, killing the child. The diagnosis of the depression in childhood and pregnancy was first made by the forensic psychiatrist evaluation of the patient after the assault, no treatment had been sought or was delivered before that. This is consistent with the high number of undiagnosed and untreated cases of depression, which is specially detrimental in the perinatal period.
b. 29-year-old German woman who had been adopted. She was sexually assaulted by her uncle but never reported the abuse. Moved to Austria and entered a violent relationship she escaped from. She began to abuse alcohol, cannabis, and cigarettes. She did not have stable work or health insurance. She entered a new relationship with an alcoholic man and realised she was pregnant from her abusive ex. She never received antenatal care despite having an appointment at a free hospital. During the initial 6 months, she tried to lose and hurt the foetus but stopped when her new partner noticed the behaviour and they decided on adoption (2010). Upon labour commencing, she decided for an anonymous birth. She never had a medical follow-up.
c. 21-year-old became pregnant as consequence of gang rape; it was impossible for her to know the identity of the father. At the time, she did not know about baby hatches and anonymous birth laws were not in place. She was directed to the only hospital in Austria that would allow her to give birth anonymously. During the pregnancy, she had homicidal and suicidal ideation up to the night prior to birth. She stated she wanted to kill the foetus throughout the pregnancy and that she had hurt herself and the foetus considerably. Considered suicide if she had not had the option of anonymous birth. Both the mother and the child were healthy and after birth (2001), she visited once. She was thankful for the help she received and the option of anonymity. She regretted not leaving a note for the child but after birth, never considered suicide again. The girl had not told anyone that she had been raped and did not see a health care provider during her whole pregnancy. She denied pregnancy until week 25 and then told her mother. This was far too late for an abortion as in Austria, the limit is 12 weeks. She did not seek any psychological help even though it was offered by the hospital.
d. A 32-year-old Afro-Caribbean woman aspired to go to college and become a dancing teacher, but instead became an unwilling housewife. She rejected her 1st child (a boy). Hoping for a daughter, she became pregnant again, but the 20-week scan showed that it was another boy. During the next week, she hit her abdomen twice. Despite desertion by her husband, and her baby's neonatal colic, she bonded with him. She developed impulses to crush his head, but these were obsessional.

e. A 32-year-old Sikh woman, unhappily married and living with her in-laws, already had three sons and wanted a daughter. A 16-week scan showed that her 4th child was another boy. After another episode of domestic violence, she punched her stomach 4–5 times. After the birth, she felt closer to this son than to her others, and was jealous of her mother-in-law's attempts to monopolise him.
f. A 23-year-old got married soon after her first unplanned pregnancy. None of her emotional relationships with her parents, colleagues, or husband had ever been good. She was brought up by her grandmother. She had little attachment with her mother, and hated her father. She might have had a personality disorder; she was a dismissive and angry person. At 31 weeks, she confessed that she did not want to keep the foetus at all. If it were born, she wanted it taken into foster care. During the third trimester, on several occasions, she punched her abdomen and took an unknown drug from a chemist shop to promote an artificial abortion. After delivery, she showed no interest or warm bonding to her son, did not even touch him. The baby was removed to her parents-in-law and she never visited. She was followed up from late pregnancy to 1 year after the birth, but no medication or treatment was prescribed, as she was coping well without the baby.

Discussion

The six cases of foetal abuse presented here are not a database from which generalizable conclusions can be drawn, but there are certain preliminary observations that can be made. The six women in this sample have similar life-stories to the women in previous foetal abuse and anonymous birth studies (Bonnet 1993; Brezinka et al. 1994; Condon 1986). Either these were unplanned pregnancies or there was a history of ambivalence towards pregnancy in the women. There was also considerable trauma and violence present in their lives. There was evidence of a continuum of abuse and bonding disturbance from pregnancy to postpartum and, in some cases, transgenerational transmission of violence and abuse. The reports of childhood abuse might be an underestimation due to the focus on the pregnancy and life situation at the time.

The women in this sample, similarly to the ones in pregnancy denial studies, present as vulnerable and having had traumatic experiences previous to pregnancy. The link between early life exposure to violence, trauma, victimisation, and a desire to harm is met within this small sample. While the data available does not provide insight into the psychological processes, the women experienced it is feasible to suggest that their newfound state of pregnancy triggered the impulse to harm the foetus—potentially perceived as a physical manifestation of their trauma—as a coping mechanism.

Women who do not comply readily with pre-established notions of motherhood can often be thought of as 'bad women'. However, given this and previous studies on foetal abuse, it is clear that even when women access services, they are not assed for potential foetal abuse even when the physical signs might be present (Pugh 1978). We can hypothesise that the transgression of foetal abuse is so abhorrent that professionals become blind to the warning signs. This in turn, increases the risk for the mother and the foetus as no appropriate interventions are put in place.

To conceive of foetal abuse, one must first accept that spontaneous motherly love and joy over pregnancy are not the default for all women. Yet, the myth of instantaneous and overpowering love for one's unborn child is one of the building blocks of our social fabric. This is in stark opposition to Condon's (1987) finding of 21% ambivalence in pregnant women or Wittkowski et al.'s finding that 8% of the women in their sample felt no? love for their newborn a week after birth. Prompt recognition of the antecedent of previous unresolved trauma and of the many difficulties and demands facing an involuntarily pregnant woman may allow clinicians to ask about this issue empathically, so that the woman can be offered psychological, social, or legal services, as need be.

Conversely, it is not possible to ignore the already coercive nature of the surveillance over the female body (Rich 1986). Suggesting blanket monitoring of pregnant women due to the potential threat of foetal abuse is a slippery slope (Schroedel and Peretz 1994), whereby there is no logical end to the surveillance and intervention of pregnant bodies. In other words, how the issue of foetal abuse is framed is a gender issue. Schroedel and Peretz (1994) notes that the creation of public policies, in the 1990s, targeting pregnant women who abused drugs and alcohol did so at the expense of both treatment facilities and the recognition of the existence of foetal abuse perpetrated predominantly by male partners as a far more prevalent issue.

Bonnet (1993) argues that women who deny pregnancy do so to protect themselves from unresolved trauma. Pugh (1978) notes that professionals ignore the physical signs of spousal abuse and, as Condon (1986) notes, foetal abuse does not happen in a social vacuum. Perhaps if women who do not adhere to the normative social constructs of motherhood are viewed with kindness and humanity, rather than being punished or ignored for their trespass, it would be possible for families and professional staff to acknowledge the warning signs they see and respond in ways that reduce harm for women and their soon to be children.

Conclusion

This paper argues that the reasons why women harm themselves and their foetuses are varied and complex. It is not possible to pinpoint a single trait or causal factor for foetal

abuse; however, it is possible to make targeted inquiries, acknowledge that foetal abuse is a possibility and that it is treatable. Bonding during pregnancy in vulnerable women, such as those with a history of abuse and especially with psychopathology, should be evaluated when women present for pregnancy health visits. The co-occurrence of depression and bonding impairment underscores the importance of addressing both in interventions for postpartum women (Muzik et al. 2013), but this might be true for pregnant women as well. The question about self-harm or suicide is part of any psychiatric evaluation, but the question about fantasies of harming their foetus, or child, or having filicidal thoughts is rarely posed (Friedman et al. 2008; Gressier et al. 2016). Services for mothers who have experienced trauma such as abuse and neglect should acknowledge the normal ambivalence surrounding seeking help, and promote hope-affirming practices in a family-centred, safe, and non-clinical setting (Muzik et al. 2013).

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interests.

Ethical standards All results were derived from studies that had full approval by the appropriate ethics committee.

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