

Pseudocyesis in a non-infertile Indian woman: a case report

Abstract

Pseudocyesis, seen in non-psychotic woman without true gestation, is a common event in developing countries. Pseudocyesis results from multidimensional factors. Our case was a 46 years, Hindu, married, literate, non-infertile woman of middle socioeconomic status, from urban part of Tripura, India. She presented with amenorrhea, distended abdomen, and breast engorgement. Diagnosis of pseudocyesis was made, and further sessions with the husband and wife were carried out. She was managed with supportive psychotherapy and low dose of clonazepam.

Keywords: Pregnancy. Delusion. Gender. Psychotherapy.

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Introduction

Pseudocyesis was first described by Hippocrates.[1] John Mason Good coined the term pseudocyesis from the Greek words *pseudes* (false) and *kyesis* (pregnancy).[2] In pseudocyesis, a non-psychotic woman believes herself to be pregnant and develops objective findings of pregnancy which may include amenorrhea, abdominal enlargement, breast changes similar to those in pregnancy, apparent foetal movements, softening of the cervix with signs of congestion, nausea, vomiting, and weight gain in the absence of true gestation.[3] Pseudocyesis is quite different from 'delusions of pregnancy' found in schizophrenia and other psychotic disorders.[4] The term delusions of pregnancy, rather than pseudocyesis, should be used in cases that do not have any physical signs of pregnancy, but have a false firm unshakable belief of pregnancy.[5] The text revision of the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) categorises it into somatoform disorders not otherwise specified,[6] whereas the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) classifies it as somatoform disorder, unspecified.[7]

Case

A 46 years, Hindu, married, literate, woman of middle socioeconomic status, from urban part of Tripura, India

reported to the Gynaecology & Obstetrics Out Patient Department (OPD) of Agartala Govt Medical College, India for antenatal checkup with the complaints of amenorrhea for 34 weeks, distended abdomen, loss of appetite, nausea, vomiting, weight gain, and breast engorgement. The women felt fetal movement in last five months. Her past history showed that she was having regular menstruation and was permanently sterilised.

The woman was from a nuclear family. Her husband, a government employee remained busy most of the time in office. They had two female children and one spontaneously aborted child. She does not have any male child and was very much tensed about not having a male child for generational continuity and economic security in old age. She feared of having a third female child; for that, she had done permanent sterilisation (tubectomy) with the consent of her husband. She really had an immense desire to become pregnant to bring a male child. Gynaecological examination showed that foetal part was neither palpable nor foetal movements was felt. Breast was found to be engorged without pregnancy-related changes. Urine for pregnancy test was negative. Laboratory findings including complete haemogram, blood glucose, creatinine, urea, lipid profile, uric acid, electrolytes, liver function tests, urinary routine examination, pituitary hormones, thyroid profile, testosterone, oestrogen, and progesterone all were within normal level. Ultrasonography of whole abdomen was normal. After that, she was consulted

gastroenterologist for the frequent nausea, vomiting, and abdominal distention. She refused to believe in spite the assurance that she was not pregnant.

At that period, she was referred to Psychiatry OPD. Detailed history and mental status examination revealed that she was neatly dressed, conscious, oriented, well-communicated. Her thought content revealed a strong belief of being pregnant, but this was considered as an overvalued idea. She did not have any hallucinations and delusions. The rest of the mental state examination was within normal state. There was no past and family history of mental illness. According to DSM-IV-TR diagnostic criteria, she was thought to have pseudocyesis based on above clinical presentation.

The woman was reassured that she was experiencing a false pregnancy. She was explained that this situation aroused as a result of her strong desire to become pregnant for a male child. She was prescribed tablet clonazepam 0.5 mg twice daily for two weeks. Subsequently, a supportive confrontation was done that she was not pregnant. The negative results of urine for pregnancy test and ultrasonography of the uterus were carefully interpreted to convince the patient. The husband was advised not to blame her as her husband blamed earlier and to take care of his wife as well as their children. The patient felt well with this treatment.

Discussion

Pseudocyesis is seen in woman with longstanding infertility who desperately wants to become pregnant.[8] The intense desire for pregnancy and stress of infertility triggers the pituitary gland to secrete elevated hormones, mimicking the hormonal changes of real pregnancy.[9-11] Meza *et al.*[10] measured plasma levels of pituitary gonadotropins (follicle stimulating hormone-luteinising hormone), progesterone, oestradiol, and thyroid hormones (triiodothyronine, thyroxine, and thyroid stimulating hormone) under basal conditions through radioimmunoassay, and they observed normal hormonal trend. In India, irrespective of caste, religion, and social status, the overall status of women is lower than men and therefore, a male child is preferred over a female child.[12] A strong desire for male baby is seen among 75% Indian women after two baby girls.[13] In our society, women always have the apprehension that if they have no male child, her husband may bring a new bride for procreation of male child for social prestige, continuity of generation, and for social and economic support in their old age.[12,13] This mother of two female children and one aborted child had a

strong desire to become pregnant. The patient believed that she was pregnant at that time and would bring a male child for continuation of family name and economic insecurities. Medication and reality-based supportive psychotherapy resolved the stressful situation.

Conclusion

Pseudocyesis results from multidimensional factors. More study is needed to explore the illness.

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