

PSEUDOCYESIS: A CASE REPORT

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SUMMARY – Pseudocyesis is a disorder that is rarely encountered in psychiatric practice. It is characterized by numerous signs and symptoms of pregnancy, except for confirmation of the presence of a fetus. The aim of this article is to present a patient with pseudocyesis. A 24-year-old woman, married, childless, was admitted to gynecology emergency clinic for metrorrhagia, after delivery that had allegedly occurred earlier that day. Gynecologic examination showed neither pregnancy nor postpartum state, therefore consultant psychiatrist was included in patient examination. Upon interview with the patient and her family, and in agreement with gynecologists, the diagnosis of pseudocyesis (undifferentiated somatoform disorder, according to ICD 10 criteria) was made, and the patient who was acutely restless, tearful, occasionally agitated, exhibiting referential ideas, was hospitalized at psychiatry department for treatment. The need of team work of gynecologists and psychiatrists in the treatment of patients suffering from pseudocyesis is emphasized.

Key words: *Pseudopregnancy – diagnosis; Pseudopregnancy – psychology; Pseudopregnancy – psychotherapy; Case report*

Introduction

Pseudocyesis (Gr. *pseudōs*, false + *kyōsis*, pregnancy) is a rare condition in which the patient has all signs and symptoms of pregnancy except for confirmation of the presence of a fetus¹. Patients with pseudocyesis exhibit abdominal distention, enlargement of the breasts, enhanced pigmentation, cessation of menses, morning sickness and vomiting, typical lordotic posture on walking, inverted umbilicus, increased appetite, and weight gain. Pseudocyesis used to be a rather frequent phenomenon in the past, when the diagnosis of pregnancy had not been developed, so that the ratio of false to true pregnancies was around 1:25. In the literature, the disorder has also been referred to as spurious pregnancy, phantom pregnancy, hysteric pregnancy, or false pregnancy¹.

Pseudocyesis was first described by Hippocrates around 300 BC. In ancient times and subsequently in the past, pseudocyesis was rather common in high so-

cial classes, e.g., Mary Tudor, queen of England, had pseudocyesis on two occasions, underlain by depression caused by her dissatisfaction with her “political” marriage to Philip II of Spain; through pseudocyesis, she tried to tie her husband to herself and to stimulate him to consider how to upgrade their relationship².

Some authors classify pseudocyesis into psychosomatic disorders, others consider it a manifestation of depressive disorder, whereas the third group refer to it as a monosymptomatic hypochondriasis (Munchausen syndrome). Modern classifications categorize it into somatoform disorders, DSM IV TR (Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revisited), code 300.82 (undifferentiated somatoform disorder), whereas ICD 10 (International Classification of Diseases, Tenth Edition) encodes it as F45.9 (somatoform disorder, undifferentiated)^{3,4}. Pseudocyesis should be distinguished from gestational psychosis characterized by the existence of pregnancy, however, these patients show no physical signs of pregnancy that are observed in patients suffering from pseudocyesis (except for the fetus)^{5,6}.

As stated above, the psychological background of pseudocyesis may be viewed through its association with

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depression⁷. The women who strongly yearn for a child while suffering problems with gestation, harbor symptoms of depression in their mental background. There is often a tendency to the phantom pregnancy purposefulness in individuals who tend to use the condition to stimulate their surrounding, seeking help to escape some traumatizing superficial events, or to activate their mechanisms of defense in trying to solve neurotic conflicts. Subconscious conflicts activate physical symptomatology as a consequence of unsolved object relationships or conflicts^{8,9}. These patients may frequently be wrongfully accused of simulation¹⁰⁻¹³.

The aim of this report is to present a patient diagnosed with pseudocyesis (somatoform disorder, undifferentiated).

Case Report

A 24-year-old patient, a designer, unemployed, married, childless, was admitted in the evening as an emergency to maternal ward of the Department of Gynecology and Obstetrics, Sestre milosrdnice University Hospital in Zagreb, having previously presented to the Department outpatient clinic, accompanied by her sister-in-law, for metrorrhagia. Her sister-in-law noted the patient had been admitted for delivery to Department of Gynecology and Obstetrics, Zagreb University Hospital Center (Petrova Hospital), on that morning, however, the newborn had died.

Ultrasonography performed upon gynecologic examination denied any pathologic hemorrhage and showed normal uterus and vagina, free from any indicators of parturition or pregnancy. Then, consultant psychiatrist joined the gynecologic team and they talked to the patient's husband, the patient, and her sister-in-law. The diagnosis of false pregnancy, pseudocyesis (somatoform disorder, undifferentiated) was made and the patient was referred to Department of Psychiatry for treatment.

The interview with the patient and her family revealed the patient had been accompanied by her husband to Petrova Hospital on the day before in the morning, for delivery, as she had been overdue by seven days and had, as her husband said, an appointment for that day. He took her by car to the hospital, and she entered the hospital alone. She stated the name of "her" gynecologist (it was a fictitious name, as no doctor of that name worked at Petrova Hospital). On the next day around noon, she phoned him to come to take her home; she said she was on Zvijezda, near Fran Mihaljević Hospi-

tal for Infectious Diseases. Her husband arrived there soon, and found her there alone, in a nightgown, telling him she had delivered a baby early in the morning, however, the baby was not well, so she and the baby had been transferred to the Hospital for Infectious Diseases, where the baby had died. She was weepy, frightened and tense, so he took her home. Then, the search for information on the event actually ensued. Her brother-in-law called Petrova Hospital, where he was told that no woman of that name had been admitted or had delivery at the hospital. The same information was also obtained from the Hospital for Infectious Diseases. Then he called police to report a suspect case of infanticide. The husband and the family as well as the patient herself had for nine months lived believing in her pregnancy, the patient had regular control visits at Petrova Hospital. During nine months he had no menstruation, gained 12 kilograms, had visible yet minor abdominal enlargement. Otherwise, she was thin, so everybody around her considered it quite normal. She had enlargement of her breasts, and enhanced pigmentation on her abdomen (linea nigra), with usual changes of the umbilicus during pregnancy. The couple arranged the baby's room, the brother- and sister-in-law gave them layette and other accessories, while the patient herself decorated the baby's room walls with motifs of Jesus' birth. The husband said they had not talked about the child's arrival very often, and then rather briefly, as the patient used to interrupt such conversation for various excuses. He noticed she had frequently isolated herself in her room over the last two months, avoiding any further conversation, always finding excuse. However, they all were convinced she carried a baby. On that day when she was found in front of the hospital, they realized that something was going on. Infanticide was what they suspected first, and they all were embarrassed learning the truth of false pregnancy in the evening.

Family history revealed the patient's father suffered from schizophrenia and committed suicide a year before the patient's current admission. The patient's uncle and her two cousins (male and female) also suffered from schizophrenia, while her mother was healthy, free from psychopathologic disorders in her family history. The patient's elder sister committed suicide jumping in front of a train, having previously been treated for depression for a short period of time.

The patient's personal history revealed her to have been born as the second child in a four-member, simply structured farmer family. The patient was mainly raised

by her mother, as her father was a psychiatric patient. The patient was an A student until sixth grade of elementary school, when her school achievements suddenly declined, yet she passed as a C student. Since age 12, she gradually turned ever more withdrawn, uncommunicative, yet exhibiting no negative behavioral patterns either at school or at home. Upon completion of elementary school, she enrolled in design high school where she showed special interest in painting. At age 17-18, she had a love affair and, according to her mother, her boy-friend left her. Her mother said: "Then I learned she got pregnant with her boy-friend, but had spontaneous abortion". As far as her mother knew, she did not go to see a doctor. Otherwise, the patient did not use to go out much, and was in a rather low spirit after breaking the affair. Her mother considered these mood changes usual for her age. However, the mother also said that her daughter, at age 14-15, had told her to have been abused by her father in childhood, which her mother did not believe then. Now, after so many years, she may have been more inclined to believe it.

At the time of admission, the patient had been married for two years. She married her husband after only three months of dating. Her husband was a field worker, therefore being frequently absent from home. He used to come home late in the evening, so that she used to be alone at home most of the time.

Medical examination and laboratory findings

Laboratory findings including erythrocyte sedimentation rate, complete blood count, blood glucose, creatinine, urea, bilirubin, cholesterol, triglycerides, uric acid, sodium, potassium, chloride, calcium, AST, ALT, GGT, creatine kinase, alkaline phosphatase, lactate dehydrogenase, and urinary sediment chemistry were within the reference values; b-chorionic gonadotropin (b-hCG) was negative; pituitary hormones: corticotropin (ACTH), prolactin (PRL), thyrotropic hormone (TSH), luteinizing hormone (LH) and follicle-stimulating hormone (FSH); thyroid hormones: triiodothyronine (T_3), thyroxine (T_4), free triiodothyronine (fT_3) and free thyroxine (fT_4); and gonadal hormones: testosterone, estrogen and progesterone were within the reference values.

Gynecologic finding: external genitalia of a nullipara, medium-space vagina, with marked signs of colpitis, the portio cylindric, epithelialized, the cervix closed. The uterus dextral positioned, of normal size, firm, elastic, insensitive; the right adnexa shortened, the left adnexa normal. Ultrasonography showed uterus of 65x35 mm in

size, empty cavum, clear endometrium, 8.2 mm. The adnexa echo free.

Physical finding: medium osteomuscular constitution, height 1.61 m, weight 62 kg, cardiorespiratory compensation. The skin and visible mucosa well perfused, the abdomen slightly above the chest level, soft and insensitive; enhanced pigmentation along the middle medial line (linea nigra). Neurologic status normal, no neurologic events.

Mental status: conscious, oriented toward herself, other persons, and in space, less well oriented in time. Verbal communication established, with some delay in response, giving short answers with projections to weariness; negativistic, depressive mood, anxious; cognitive-mnemonic functions matching the patient's age and level of education. Psychological testing was not performed because the patient declined it.

Course of disease

The patient was hospitalized at a ward with a higher level of surveillance, and was treated with anxiolytics (diazepam, 30 mg/day for five days, with a higher evening dose). On day 7, the dosage of diazepam was tapered to 15 mg/day. On day 3 of admission, she normally talked about everything, yet avoiding talking about "her pregnancy". When asked about the events preceding it, she used to answer "I don't know, I don't want to talk about it", etc. Around day 5, when talking about the issue, she just did not know how to describe it. She talked about marriage as of something she simply needed; she complained of her husband's frequent absence from home, and how she missed talking to him.

After 7-day stay at special care ward, the patient was transferred to general ward, where she took active part in the ward group activities. Her ability to accept real relations was strengthened through individual supportive psychotherapy. During conversation, she herself turned to the causes of her hospitalization, however, as she said, "I've been through all this as if light-headed, I was aware I was doing something that wasn't good, yet, something pushed me just to do it and to live like this". She emphasized again that she could hardly stand her husband's absence from home during the day. She lived in fear, wondering how she would overcome it. She criticized her husband for not talking to her, always complaining of being tired. It all came down to his providing for her financially, while she felt as if he was not interested in their marriage at all. When it came to the issue of their sex life, she was reluctant to talk about it.

She even felt her husband was not satisfied with her. Otherwise, she thought that sex “is normal in marriage but not of so great importance, although I know that my husband would not agree”.

The patient stayed at hospital for three weeks, then attended outpatient couple psychotherapy on three occasions, together with her husband, in order to settle – through target couple interventions strengthening their family roles – their disagreements and undefined roles that were rather pronounced in both the patient and her husband. The patient felt pretty well in this post-hospital system of treatment, she was communicative, with good overall mental state, reporting on much better contacts with her husband and her herself being quite satisfied. After two months of outpatient therapy, she discontinued these visits, considering she was well now, as also confirmed by her husband.

Discussion

Pseudocyesis or false pregnancy is a disorder in which the woman has all signs of pregnancy except for the existence of a fetus. In the past, it was a relatively common disorder, however, its rate has been greatly reduced with the development of prenatal care. In the past, pseudocyesis used to be classified into psychosomatic disorders, whereas nowadays it is classified into somatoform disorders, as we also did. According to ICD 10 classification, the main characteristic of somatoform disorders is persistent presentation of physical symptoms (including the existence of pregnancy) in spite of negative objective medical/laboratory findings. Indicative of the diagnosis is the existence of “true” symptoms of a condition feigned by the patient⁴. So, in case of phantom pregnancy, there is abdominal distention, enlargement of the breasts, enhanced pigmentation, cessation of menses, morning sickness and vomiting, typical lordotic posture on walking, inverted umbilicus, increased appetite, and weight gain. On differential diagnosis, psychotic disorder was taken in consideration, however, it was ruled out by the presence of objective secondary signs of pregnancy and the diagnosis of somatoform disorder was made^{4,6}. The patient exhibited accompanying depressive symptomatology which, according to some authors, is very frequently associated with this disorder. Some authors note that in some patients the presence of pseudocyesis is related to the purposefulness of the presence of psychiatric symptomatology, in some individuals in major life events. According to ICD 10 clas-

sification, somatoform disorders are characterized by attention-seeking behavior (histrionic behavior). This feature was highly pronounced in our patient, who admitted herself that it was very difficult for her to be alone at home all day long. She stayed in marriage, fearing how she would stand being alone, with her husband absent throughout the day, along with their rather unsatisfactory sex life. She criticized her husband for not talking to her, excusing himself by being tired. It all came down to his providing for her financially, while she felt he was not really interested in their marriage. She also felt her husband was not satisfied with her as his wife.

In addition to this dynamic psychological component in the development of pseudocyesis, some authors point to biological factors in the etiology of the disorder, with neuropsychoenocrinological parameters being most widely investigated to date. A number of studies suggest the role of abnormalities in the function of neurotransmitter axis, resulting in hormonal dysfunction. So, changes have been found in the production of growth hormone, prolactin, ACTH-cortisol, FSH and LH¹⁴⁻¹⁷. In our patient, all hormones were within the reference values, thus we could not confirm the results reported from these studies. The development of radiologic diagnostic procedures has also contributed to elucidation of the enigma of pseudocyesis. Namely, PET images showed enhanced activity of the temporoparietal lobe as well as an increased activity of the pituitary gland^{6,16}. Unfortunately, PET diagnosis is not available in Croatia for the time being.

In conclusion, pseudocyesis or false pregnancy is now rarely encountered in psychiatric practice, and when it occurs, a psychiatrist is usually included by liaison principle in the treatment of these patients. Team work of various specialists, gynecologists and psychiatrists in particular, also including close work with the patient's family, plays a major role in the management of this pathology. The question of pseudocyesis as a somatoform disorder remains open for further elucidation.

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Sažetak

PSEUDOCIEZA: PRIKAZ SLUČAJA

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Pseudocieza je danas rijetko stanje koje se susreće u psihijatrijskoj praksi, a obilježeno je brojnim znakovima i simptomima trudnoće osim potvrde o prisutnosti ploda. Cilj ovoga rada je prikazati slučaj bolesnice s pseudociezom. Bolesnica u dobi od 24 godine, udana, bez djece, primljena je u hitnu ginekološku ambulantu zbog metroragije, navodno nakon obavljenog poroda toga dana. Ginekološkim se pregledom nije utvrdilo postojanje eventualne trudnoće ili stanja nakon poroda, pa je konzilijarno pozvan psihijatar. Nakon razgovora s bolesnicom i njezinom obitelji, te u dogovoru s ginekolozima postavljena je dijagnoza pseudocieze (nediferencirani somatoformni poremećaj, prema ICD 10 kriterijima) te je bolesnica, koja je bila akutno uznemirena, plačljiva, na trenutke agitirana, s idejama odnosa, primljena na daljnje liječenje na psihijatrijsku kliniku. Naglašena je potreba timskog rada ginekologa i psihijatara u liječenju bolesnica koje boluju od pseudocieze.

Ključne riječi: *Umišljena trudnoća – dijagnostika; Umišljena trudnoća – psihologija; Umišljena trudnoća – psihoterapija; Prikaz slučaja*