Section: Psychiatry

Case Series

PSEUDOCYESIS AND DELUSIONAL PREGNANCY: A CONUNDRUM OF FALSE PREGNANCIES

Udbhav Tewari[1], Arun Kumar Mishra[2], Asttha Kapoor[3], Kaustav Kundu[4], Sarika Pandey[5]

[1]Senior Resident, Department of Psychiatry, U.P.U.M.S., Saifai, Etawah, Uttar Pradesh, India.
[2]Professor and Head, Department of Psychiatry, U.P.U.M.S., Saifai, Etawah, Uttar Pradesh, India.
[3]Senior Resident, Department of Pathology, U.P.U.M.S., Saifai, Etawah, Uttar Pradesh, India.
[4]Assistant Professor, Department of Psychiatry, U.P.U.M.S., Saifai, Etawah, Uttar Pradesh, India.
[5]Assistant Professor, Department of Obstetrics and gynaecology, U.P.U.M.S., Saifai, Etawah, Uttar Pradesh, India.

Received : 05/06/2025
Received in revised form : 20/07/2025
Accepted : 08/08/2025

Keywords:
Pseudocyesis, Delusion of Pregnancy, False Pregnancy, Somatic Symptom Disorder, Psychosis.

Corresponding Author:
Dr. Asttha Kapoor,
Email: docasttha@rediffmail.com

DOI: 10.47009/jamp.2025.7.4.249

Source of Support: Nil,
Conflict of Interest: None declared

Int J Acad Med Pharm
2025; 7 (4); 1313-1317

ABSTRACT

Pseudocyesis, or false pregnancy, is a rare condition with a global incidence of 1–6 cases per 22,000 births. It involves a false belief of being pregnant accompanied by objective signs and symptoms. In contrast, delusion of pregnancy is a fixed false belief of pregnancy without corresponding physical changes. Both conditions share psychosocial, cultural, and biological underpinnings. Three cases were evaluated. The first involved a 24-year-old woman presenting with amenorrhea, abdominal distension, and galactorrhea, diagnosed as pseudocyesis. The second case, a 47-year-old woman with delusional conviction of pregnancy despite negative findings and psychotic features, was diagnosed as delusion of pregnancy in schizophrenia. The third case, a 28-year-old childless woman showing classic physical signs of pregnancy but negative investigations, was diagnosed as pseudocyesis. Sociocultural pressures, marital conflict, and infertility stigma were common precipitating factors. Pseudocyesis is associated with somatic symptom disorders and often linked with affective disturbances, hyperprolactinemia, and sociocultural stressors. Delusion of pregnancy is more frequently seen in psychotic disorders and influenced by biological and cultural factors. These cases emphasize the need for multidisciplinary management, including psychiatric intervention, family education, and supportive psychotherapy. False pregnancy states highlight the complex interplay of biological, psychological, and sociocultural factors. Early recognition and culturally sensitive psychiatric management can improve outcomes and prevent chronicity.

INTRODUCTION

Spurious pregnancy or pseudocyesis is the fantasy of pregnancy. It's global incidence is approximately 1 to 6 cases per 22,000 births.[1] It is one of the oldest medical state known to history, having been documented as early as Hippocrates. Pseudocyesis, is defined as a false belief of being pregnant that is associated with reported symptoms and objective signs of pregnancy.[2]

This differentiates it from delusion of pregnancy, which is characterized by a strong, unwavering belief that one is pregnant in spite of clear evidence to the contrary, such as the lack of physical signs and symptoms of pregnancy related indicators and the results of confirmatory testing coming back negative.[3]

Other terms, such pseudopregnancy, false pregnancy, imaginary pregnancy, simulated pregnancy, spurious pregnancy, or phantom pregnancy, have been used interchangeably to characterize psychopathology of pseudocyesis.[4] Amenorrhea, morning sickness, abdominal distention, sensation of fetal movement, breast enlargement and tenderness, areolar pigmentation, galactorrhoea, softening of the cervix, lordotic posture when walking, or increase in weight are the symptoms of pseudocyesis that are most commonly observed.[4,5]

These days, cases of pseudocyesis are more common in rural parts of developing nations where women are typically not seen by doctors or midwives until they are in delivery or need medical attention. Women in developed nations see obstetricians during the first trimester of pregnancy because they have access to more precise diagnostic tools, such as ultrasound exams and pregnancy tests. These diagnostic techniques may aid pseudocytic women in convincing themselves that they are not pregnant, which typically results in resolution within minutes or even seconds. In addition, women in industrialized

ISSN (O): 2687-5365; ISSN (P): 2753-6556

nations tend to be more intelligent and sophisticated than their counterparts in developing nations, and their emotional conflicts provide a deeper, more nuanced manner of expression than pseudocyesis.[6]

Although the precise mechanisms of spurious pregnancies remain unclear, it is conjectured that psychological and endocrine factors contribute significantly. Women undergoing experience of false pregnancy often suffer from feelings of stress, fear, anxiety, excitement, and general emotional disturbance.[7]

Cases

Case-1:

A 24-year, old woman belonging to rural background and low socio-educational and economic status was brought in psychiatry OPD by her husband after referral from obstetrics out-patient department. On history taking it was found that she was married at the age of 17 years and she doesn't have a child. Her husband informed that patient had come for a regular antenatal check-up in the department of obstetrics and gynecology as she was 4 months pregnant. A urine pregnancy test was performed which came out to be negative. However she showed several symptoms and signs of pregnancy like amenorrhea, abdominal distension, occasional experience of nausea and vomiting, breast enlargement, and galactorrhoea.

She was admitted in psychiatry ward for further evaluation and management. On mental state examination her mood was found to be irritable, affect range was restricted, preoccupation with ideas of pregnancy without any abnormal flow, form and possession of thought. No abnormality was detected in perception domain. Her thinking was abstract and judgment was intact. Rest of her cognitive functions appropriate for her age, cultural background, and educational level.

She would not accept the reassurance of psychiatrist and insisted on a yet another referral to obstetrician, displaying her absolute confidence in the pregnancy. On further clarification patient's brother revealed societal and familial pressure upon the patient by the in-laws, leading to frequent frustration and altercations of the patient. She was often verbally termed as infertile by the husband and in-laws and was threatened abandonment and alienation from the main stream society. She later on developed dissociative episodes of unresponsiveness for which she was mostly taken to faith healers.

Upon repeated objective evidences in favour of absence of pregnancy and better rapport building, she started weeping inconsolably, and conveyed to the doctor that she really wanted to have this child as she has been trying a lot and has failed time and again. She felt sadness and anxious because of preoccupation with the thoughts of pregnancy. She was started on tablet escitalopram 5 mg per day, tablet clonazepam 0.5mg per day. Patient along with her partner was educated regarding the nature of mental illness and supportive and family sessions were taken. During her stay of about two weeks in the psychiatry ward, patient was taught appropriate coping strategies. On two subsequent follow-ups, the patient was found to be asymptomatic.

Case 2:

A 47-year-old female from a rural background who was illiterate and of lower socioeconomic status was brought by her partner to our tertiary care hospital's psychiatry outpatient department due to symptoms of irritability, anger outbursts, suspiciousness that someone is going to harm my baby, decreased self-care, and disturbed sleep during the previous month. But the lady stated that she was just admitted for an obstetrics consultation and refuted all of the complaints of the attendant. Upon further inspection, the findings that were reported did not align with the intended symptoms at the time of admission.

The woman revealed information that she was five months pregnant, despite several negative urine pregnancy tests. She attributed her increased appetite, need to try new foods, tightening of clothing, and six kilograms of weight gain to her pregnancy.

On detailed history taking by various attendants of the patient it was found that patient was wed approximately 31 years ago. After three months of marriage, she conceived and delivered a healthy baby at full term in her home. Then 2 years later she got pregnant for the second time but underwent miscarriage in the first trimester. She developed disturbed sleep, suspiciousness that someone is going to harm her unborn baby, she would complain often of hearing people talking about her baby behind her back, her personal self-care also declined day by day. This continued for a month and later she became aggressive towards anyone who came near her and her child. Then she was taken to nearby town for treatment where few medications were prescribed (No records or details available). Although according to family members she responded well to the treatment. Due to scarcity of money, she ceased taking medication. She was fine for several years and delivered 2 children during that period. And her mental illness resurfaced only 4 years back. She became irritable, slept much less than usual, often aggressive without provocation, muttered to self and grew suspicious towards family members and other people. She was taken to a psychiatrist in private set up in the nearby town where she was prescribed Tab. Risperidone 4 mg per day which was later increased to 6mg per day. She responded well but stopped taking medication after few months on her own accord.

Examining her mental state revealed that she was an average-built woman, dressed appropriately for the season and weather, conscious and oriented, anxious affect, and her thought content revealed delusion of persecution and pregnancy. She also had poor judgment, no insight, and cognitive functions appropriate for her age, cultural background, and educational level.

The results of the urine pregnancy test were negative, and a consultation with an obstetrician verified that

ISSN (O): 2687-5365; ISSN (P): 2753-6556

there was no pregnancy. A pelvic sonography showed that there was no gestational sac and that the uterine endometrial lining was 3 mm, which is indicative of a typical menopausal uterus. She was advised during the course of the series of interviews that her symptoms might be related to menopausal changes, and the results of her hormonal workup which revealed serum levels of LH and FSH at 38.72 micro-IU/L and 57.4 IU/L, respectively. Despite proof to the contrary, she stuck to her beliefs that she was pregnant.

She was started on tablet Olanzapine 5 mg. The patient became agitated on the first day of the regimen and refused to take any pills, claiming that they would damage her fetus. She didn't consent to taking medicine unless the psychiatrist signed a form stating that the doctor would be held accountable for any harm the medication caused to the fetus.

The patient had a shift in perspective during the course of the following week, when the dosage of the medication was increased to 10 mg of Olanzapine. At this point, she began to wonder if she was indeed not expecting. She experienced a decrease in her conviction after two more weeks of insight-oriented psychotherapy sessions and an Olanzapine dosage of 10mg. She began to wonder if her symptoms might be related to dietary and lifestyle modifications.

The patient was discharged on the same treatment with significant response and advice for regular psychiatry out-patient department follow-up.

Case 3:

An unemployed, married, childless 28-year-old female was admitted as an emergency to the maternal ward of the department of gynecology and obstetrics. The patient was in immense distress and pain per abdomen. The patient had been admitted that morning for delivery in a private nursing home, but the baby had passed away, according to her sister-in-law.

Following a gynecologic examination, ultrasound revealed a normal uterus and vagina without any signs of pregnancy or parturition, and it also ruled out any pathologic hemorrhage. After that, a psychiatrist joined the gynecology team, and they spoke with the patient, her sister-in-law, and her husband. According to the patient and her family's interview, the patient was seven days past due date and according to her husband, so he accompanied her to that private nursing home early morning that day. Here she was examined by the doctor and told that she was not pregnant. After this remark she became violent and started accusing the doctor that she had killed her baby. Her family members gathered and threatened the doctor in that nursing home. The doctor struggled to explain that their patient was not pregnant and need psychiatric help. Then she was brought to our facility later in the afternoon for further management. On further history taking it was found that she did not have a period for nine months, put on 12 kg, and developed a noticeable but slight expansion of her abdomen. In addition to the typical changes of the umbilicus during pregnancy, she noticed breast enlargement and increased pigmentation on her belly (linea nigra). The spouse claimed that because the patient would frequently cut off conversations regarding the child's coming for a variety of reasons, they had only discussed it in passing. He saw that for the previous two months, she had routinely withdrawn into her room, avoiding any more discussion and constantly coming up with an excuse. She also consistently denied the request of the husband for her antenatal checkup. But they were all certain she was carrying a child.

All routine investigation came out to be normal, b-hCG was negative; pituitary hormones: prolactin, TSH, LH and FSH; thyroid hormones: T3, T4, fT3 and fT4; and gonadal hormones: testosterone, estrogen and progesterone were within the reference values. Gynecologic findings showed a closed cervix, a medium-space vagina, and external genitalia of a nullipara. According to ultrasonography, the uterus was normal in size, the cavum was empty, and the endometrium was clear and 7.3 mm thick.

Mental state examinations revealed that she was conscious, oriented to time, place, person; low mood with pessimistic ideas and irritability. Cognitive functions showed arousable attention which could not be sustained rest all the cognitive functions were grossly normal.

She was transferred to psychiatry ward and started on anxiolytics (clonazepam 1.5mg/day). On the day of admission, she avoided discussing "her pregnancy" but otherwise talked about everything. She used to say things like, "I don't know, I don't want to talk about it," in response to questions about what had happened before it. After few days in ward and series of interview and individual supportive psychotherapy sessions later she started taking part in ward group activities. She also started accepting that she was not pregnant. She also explained that she wanted a child and her husband often stays out of station for work and it has been 8 years since marriage. Family members often accused her of being barren. She also explained that her husband is disinterested in making physical relations with her, which gave her immense stress and loneliness. Couple psychotherapy was also started and the marital issues were addressed. Patient stayed in the ward for 3 weeks during this time she showed improvement. She was discharged and lost to followup.

DISCUSSION

Although all three cases appear similar, yet some subtleties set them apart. This paper aims at a better understanding of the phenomenology, and psychology of “false” pregnancy. One by one we will discuss each case. Case 1 and Case 3 were diagnosed as “pseudocyesis” which in DSM 5 TR is classified under “other specified somatic symptom and related disorder” as both these cases showed objective signs and symptoms of pregnancy along with false but shakable belief of being pregnant.[8] These cases

ISSN (O): 2687-5365; ISSN (P): 2753-6556

brought to light the many sociocultural elements that contributed to patients developing pseudocyesis. Emotional stress brought on by psychological needs or conflicts, such as women who fear getting pregnant but simultaneously want children or women who feel pressured by society to get pregnantalso plays a pivotal role in genesis of pseudocyesis.[9,10]

According to studies, mild-to-moderate affective disorders, such as Major Depressive Disorder, may be present in the majority of females with pseudocyesis.[6] Given that pseudocyesis and depression have some comparable pathophysiological mechanisms, it has been proposed that depression plays a significant role in the genesis of both disorders.[5]

These patients have been discovered to have elevated levels of the luteinizing hormone LH and prolactin (PRL), which may be connected to the amenorrhea, abdominal adipose tissue enlargement, and galactorrhea that they have described. After the patient receives the diagnosis and gains understanding, the reversal of physical symptoms is evidence of an unquestionable psychological relationship. Research indicates that the disorder is more common in developing nations and cultures, where woman's ability to procreate elevates her status in social, psychological, and economic spheres of life. In these societies, having children continues to be a defining feature of women's social standing.[11]

Moving on to the 2nd case that was diagnosed as Schizophrenia, multiple episodes, currently in acute episode. Delusions of pregnancy was elicited in the patient as stuck to her belief of being pregnant without any obvious signs of pregnancy and all the evidence to the contrary.

A systematic review conducted by Bera and Sarkar in 2015 revealed schizophrenia (35.7%), bipolar disorder (16.7%), and depression (9.5%) as the most often diagnosed conditions associated with delusional pregnancy.[12] Like pseudocyesis both biological and psychosexual factors tend to affect the genesis and maintenance of delusion of pregnancy. Hyperprolatinemia due to various causes, physiological, drug-induced, prolactinoma etc has been linked with genesis of delusions of pregnancy.[7] Delusions of pregnancy have been linked to sociocultural issues, including social pressure to have children, social deprivation, wizardry belief, low socioeconomic level, and illiteracy, among others.[13]

These cases reiterate the importance of a multidisciplinary approach including psychiatrists, obstetricians, endocrinologists and family therapists. In pseudocyesis, supportive psychotherapy, family education and treating underlying affective or anxiety disorder are the mainstays of treatment.[8,14] Case 1 and Case 3 showed positive results of combined psychoeducation, family participation, and anxiolytics. On the other hand, delusion of pregnancy needs antipsychotic treatment at its center with the addition of psychotherapy to improve the clarity and compliance with treatment.[7,12]

It is of paramount importance that the matter does not pertain to cultural sensitivity. In rural settings fertility is socially stigmatized and thus clinicians should treat these patients with empathy, considering the dynamics of family and community factors in treatment plans.[15,16] The referral to a psychiatrist should be at the early stages to avert the unnecessary medical procedures and to prevent chronicity.

Available literature indicates that they are rare but that their clinical manifestations are difficult to diagnose and treat. Isolated studies on the neuroendocrine foundations, such as prolactin and gonadotropin regulation, can give further insights in a biological response. Also, there should be cultural adaptation of psychotherapeutic models to fit in the setting of resource-limited and a high stigma environment in order to enhance outcomes in pseudocyesis and delusion of pregnancy.[16-18]

CONCLUSION

Delusion of pregnancy and pseudocyesis are phenotypically related clinical conditions, but they are different, a tripartite interaction of mind, body, and culture. The given cases display the way reproductive desire, pressures of social environment, and psychopathology may proceed as false pregnancies with prominent mental distress. Effective management requires early recognition, precise differentiation and multidisciplinary and culturally sensitive approach. These complications cause reminders to clinicians of the potent interplay of psychological conflicts, the endocrine responses and societal demands when it comes to the development of human behavior and pathology.

REFERENCES

1. Mittal S, Lucking AN, Cunnane JG. Pseudocyesis: birth of a phantom. Prim Care Companion CNS Disord. 2017;19(6):17l02102.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Text Revision, 5th ed. Washington, DC: American Psychiatric Association; 2022.
3. Das S, Prasad S, Kumar SA, Makonyonga RD, Saadoun M, Mergler R. Delusion of pregnancy: a case report and literature review. Clin Med Insights Case Rep. 2023;16:11795476231161169.
4. Drife JO. Phantom pregnancy. Br Med J (Clin Res Ed). 1985;291(6497):687–8. doi:10.1136/bmj.291.6497.687.
5. Brown E, Barglow P. Pseudocyesis: a paradigm for psychophysiological interactions. Arch Gen Psychiatry. 1971;24(3):221–229.
6. Tarín JJ, Hermenegildo C, García-Pérez MA, Cano A. Endocrinology and physiology of pseudocyesis. ReprodBiol Endocrinol. 2013;11:39.
7. Seeman MV. Pseudocyesis, delusional pregnancy, and psychosis: the birth of a delusion. World J Clin Cases. 2014;2(8):338–344.
8. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Arlington, VA: American Psychiatric Association; 2013.
9. Whelan CI, Stewart DE. Pseudocyesis: a review and report of six cases. Int J Psychiatry Med. 1990;20(1):97–108.
10. Ouj U. Pseudocyesis in a rural southeast Nigerian community. J Obstet Gynaecol Res. 2009;35(4):660–665.

ISSN (O): 2687-5365; ISSN (P): 2753-6556

11. Sharma M, Shankar P, Kukreti P, Kataria D. A rare case report of pseudo pregnancy in a menopausal female. Indian J Psychiatry. 2023;65(7):789–792.
12. Bera SC, Sarkar S. Delusion of pregnancy: a systematic review of 84 cases in the literature. Indian J Psychol Med. 2015;37(2):131–137.
13. Mascarenhas JJ, Crasta G. Delusion of pregnancy in a patient treated with atypical antipsychotics. Int J Res Rev. 2019;6(7):313–317.
14. Bhatia MS, Choudhary S, Kaur J. Pseudocyesis and delusion of pregnancy: differential diagnosis and management. Delhi Psychiatry J. 2013;16(2):385–389.
15. Whelan CI, Stewart DE. Cultural factors in pseudocyesis. Int J Soc Psychiatry. 1990;36(4):255–263.
16. Adewuya AO, Ologun YA. Pseudocyesis in a Nigerian rural community: socio-cultural perspectives. J PsychosomObstet Gynaecol. 2006;27(2):131–134.
17. O'Grady JP, Rosenthal M, El-Mallakh RS. Pseudocyesis: an overview. Psychosomatics. 1989;30(2):252–259.
18. Yadav T, Singh S, Srivastava S. Delusional pregnancy in schizophrenia: a case series and review. Asian J Psychiatr. 2021;63:102755.

ISSN (O): 2687-5365; ISSN (P): 2753-6556