CASE REPORT

Psychodynamic and Socio-Cultural Perspective of Pseudocyesis in a Non-Infertile Indian Woman: A Case Report

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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 40 years, Hindu, married, illiterate, non-infertile woman of lower socio-economic status, from rural part of Bengal, India. She presented with amenorrhea, distended abdomen and breast engorgement. Gynecological and radiological examination showed neither pregnancy nor postpartum state. The women had three female children but no male child. There was excessive pressure from husband to have a male child for generational continuity and economic security in old age. Diagnosis of pseudocyesis was made and further sessions with the husband were carried out. She was managed with supportive psychotherapy and low dose of anxiolytic. Conclusion: This psychodynamic change combined with the illiteracy, poverty, disturbed family dynamics, societal pressure and cultural belief caused amenorrhea and all other body changes may mimicking pregnancy.

Keywords: Pathogenesis, Psycho-Socio-Cultural Factor, Gender Preference

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 fetal 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\(^5\). DSM IV TR categorizes it into somatoform disorders not otherwise specified\(^6\), whereas ICD 10 classifies it as somatoform disorder, unspecified\(^7\). Pathological ambivalence of pregnancy; conflict regarding gender,
sexuality, or childbearing; a grief reaction following a miscarriage, tubal ligation, or hysterectomy; disturbed family dynamics, excessive societal pressure on women to have a large number of male children are psychodynamic and socio-cultural factors for pseudocyesis. The aim of this report is to highlight the psycho-socio-cultural context of pseudocyesis.

Case Report

A 40 years, Hindu, married, illiterate, woman of lower socio-economic status, from rural part of Bengal, India reported to the G&O (Gynecology & Obstetrics) OPD of North Bengal Medical College, India for antenatal checkup with the complaint of amenorrhea for 32 weeks, distended abdomen, loss of appetite, nausea and vomiting, weight gain and breast engorgement. The women felt foetal movement in last 2 months. Her past history showed that she was having regular menstruation and was not on any drugs or oral contraceptives.

The woman was from a nuclear family. Her husband, a priest remained busy most of time in religious activity which was their only source of income. They had three female children. Their relationship was good after marriage which was gradually deteriorating after the birth of female children that was perceived as a curse with economic and social liability. She was blamed by her husband for giving birth of all three female children and not having a male child for generational continuity and economic security in old age. The woman was overburdened with household work and leading stressful life, wanted to attract attention and sympathy of husband. She really had an immense desire to become pregnant to bring a male child.

Gynecological examination showed soft, diffusely tympanic, distended abdomen with an inverted umbilicus. Neither fetal part was palpable nor the fetal movements felt. Pelvic examination revealed a nongravid, empty, anteverted uterus with normal pelvic structures. 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, LFT, urinary routine examination, pituitary hormones, thyroid profile, testosterone, estrogen and progesterone all were within normal level. Ultra-sonography of whole abdomen was done. The scan showed a nongravid, empty, anteverted uterus with normal pelvic structures. The patient displayed an intense emotional outburst when she was informed of the negative obstetric findings regarding her being pregnant.

At that period she was made referred to psychiatry OPD. Detailed history and mental status examination revealed that she was neatly dressed, conscious, oriented, well communicated and having anxious affect. She spoke coherently. Her thought content revealed a strong belief of being pregnant, but this was considered as an overvalued idea rather than a delusion because she argued that if "confirmatory testing" showed that she was not pregnant, she would accept it. She did not have any hallucinations. The rest of the mental state examination was unremarkable. 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. We advised her to take clonazepam (0.5mg) every night for 2 weeks to reduce anxiety and also bring her husband in next visit. Subsequently, a supportive confrontation was done in which the woman and her husband were informed that she was not pregnant. The negative results of urine for pregnancy test and ultrasound of the uterus were carefully interpreted to convince the patient. Gentle exploration of her life situation was done. Reality–based, problem-solving supportive psychotherapy was given. The husband was advised not to blame her and to take extra care of his wife as well as their children. Then, the women attended for supportive psychotherapy on three occasions, together with her husband. The patient felt well with this treatment. After two months of outpatient therapy, she resumed menses.

Discussion

Pseudocyesis is seen in woman with longstanding infertility who desperately wants to become pregnant. The intense desire for pregnancy and stress of infertility triggers the pituitary gland to secrete elevated hormones, mimicking the hormonal changes of real pregnancy. The cultural attachment to childbirth and procreation among rural people of some society have been explained as emanating from the multidimensional effects of having children for generational continuity, economic security and social support in old age as well as symbols of social status and achievement of the family and mother. In India irrespective of the caste, creed, religion and social status, the overall status of women is lower than men and therefore a male child is preferred over a female child. A male child is considered a blessing and his birth is celebrated as opposed to a female child where her birth is not celebrated and is considered more of a burden. In India women are still having a very low status in their families, majority of them are illiterate and unaware of their rights. They normally fall prey to traditional practices and beliefs. A strong desire for male baby is seen among 75% Indian women after two baby girls. Birth of female child is perceived as a curse with economic and social liability. Desire for male child manifests so blatantly that parents have no qualms about repeated, closely spaced pregnancies, premature deaths and even terminating child before it is born. Even at parity four and above, woman who had no living sons did not want to terminate child bearing. 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. In these remote parts of the country the low status of women and the inability to negotiate with their family members leads to a lot of social problem. Majority of the women either go into depression or lead a stressful life.

This poor, illiterate, rural woman, mother of three female children, was having the lowest status in family. She was always criticized by her husband for not having a male child. There was economic burden but no social support. The leady was apprehensive and leading stressful life in Patriarchal Societies. She really 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.

Stress can really influence the regularity of an ovarian cycle; hence can suppress the menstruation. This woman was going through some stressful situation which
combined with other socio-cultural factors caused amenorrhea and all other body changes mimicking pregnancy. Medication and Reality-based, problem-solving supportive psychotherapy resolved the stressful situation.

**Conclusion**

Pseudocyesis results from multidimensional factors. More study is needed to explore the Psycho-socio-cultural determinants of the illness.

**References**


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