Pseudocyesis

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Contact Hours: 0.5 (ANCC) and 0.6 (ABN) contact hours are valid May 2, 2017 through May 1, 2019.

Target Audience: Registered Nurses, Advance Practice Nurses,

Learning Outcome: The learner should be able to assess the causative factors underlying Pseudocyesis and develop a plan of care to support the individual.

Fees: ASNA Member - $ FREE Non-Member - $6.00

Instructions for Credit: Participants should read the purpose and then study the activity on-line or printed out. After reading, complete the post-test at the end of the activity and compare your responses to the answers provided, and review any incorrect responses. Participants must complete the evaluation on line and submit the appropriate fee to receive continuing nursing education credit. The certificate of attendance will be generated after the evaluation has been completed. ASNA will report continuing nursing education hours to the ABN within 2 weeks of completion.

Evaluation: Complete at https://form.jotformpro.com/71213939118961

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Pseudocyesis

Over the centuries this diagnosis has fascinated both health care providers and non-providers. Everyone seems to know the definition of Pseudocyesis (*a non-pregnant and not psychotic woman who not only believes she is pregnant but also shows signs of pregnancy - but is not pregnant)* but not why or if there is a reason. Often the diagnosis is an interesting twist in movies, books and even television programs. However, it is real and included in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) listed under Other Specified Symptom and Related Disorders.

Pseudocyesis has been known since the days of Hippocrates and history tells that he observed and/or treated twelve different cases. Some notable women from history have also had Pseudocyesis. Perhaps the most famous was Mary Tudor. She believed that God had not given her a child because she was not harsh enough with the heretics. So, persecutions increased until she felt pregnant because of developing nausea and abdominal distension; however, she was not pregnant. Historians have named her as "Bloody Mary" because of her actions during this time. Another notable woman was Joanna Southcott, a religious prophetess. In 1814, she believed that she was pregnant by the Holy Spirit and at the time, she was 64 years old. Over one hundred thousand people were disappointed when the prophesized second coming of the Messiah did not occur at the expected date. She died 2 months later and on post -mortem it was determined that she was not pregnant.

The earliest theories of Pseudocyesis concentrated on a physical basis. For example, Hippocrates thought the cause was an accumulation excessive air in the stomach and retained menstrual fluid. In more recent times a psychological cause has gained greater prominence. An example is Sigmund Freud and his treatment of Anna O. who had Pseudocyesis. She believed that she became pregnant with the child of her previous psychoanalyst, Josef Breuer. Freud diagnosed this as transference (*strong attachment patients form with psychoanalyst).* Although this condition has been written about for centuries there is very little evaluation, testing, and/or treatment guidelines to guide practitioners. Today a physiologic basis is also being studied but the endocrinology and pathophysiology is inconclusive. Very briefly, data to support this is a defect in the dopamine level. Lowered dopamine levels are well documented as women with Pseudocyesis often have anxiety, emotional upheaval, and/or depression all of which lead to depletion of dopamine levels. The depletion of dopamine is known to inhibit the gonadotropin – releasing hormone (GnRH), leutinizing hormone pulsatility, and prolacatin levels. When these levels are depressed the luteinizing hormone (LH) elevates and this may cause symptoms of

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pregnancy such as amenorrhea or galactorrhea. Fetal movement, enlarged abdomen, and or labor pain may be attributed to increased sympathetic nervous system activity. These women may have constipation, chronic diaphragmatic contractions, increased adipose tissue in the abdomen, and lordosis posturing. It is postulated that these women experience a prolonged diaphragmatic contraction and an abdominal contraction leading to relaxation of the abdominal wall. This mechanism leads to chronic bloating and gas which gives rise to abdominal distension. Abdominal distension may spontaneously resolve under anesthesia or if a woman accepts the fact of not being pregnant. Some of these women expel flatus and other do not. In some case after the anesthesia has ceased and the women return to consciousness the abdominal distention returns.

What is the typical profile?

This is a very rare disorder affecting 6 out of 22,000 births in the Western world. However, in Africa the incidence approaches 1 out of 160 births. The incidence in the developing world has been higher in the past, an estimated 1 out of 25 births. But as trends of smaller families prevail the incidence has declined. This number (1 out of 160) is gleaned from women seeking fertility treatments and is probably artificially low. Comprehensive records are not available in the rural areas (Bush) and seeking fertility treatments involves money and poor women will not be in these clinics. 80% of the women are married and 40% have given birth before. Historically this condition has occurred in patients with an age range from 6 to 79 years old; however, most are in the 20 to 45 age range.

This condition is most often noted outside a mental health setting. Certain cultural variables are prominent and include the following: younger women where childbearing is their vital role in life, women who live in a society where children are needed for economic survival and generational continuity, pressure to have a child of a certain sex, and/or perceived prerequisite for a stable relationship or marriage itself.

Additional factors triggering somatic manifestations of pregnancy include severe distress related to any one or more of the following conditions: infant loss, recent miscarriage, history of infertility, extreme fear of pregnancy, low socioeconomic status, limited education, instability in relationships, desire to maintain partner, or being in a relationship with an abusive partner.

Although rare in the Western world, why is the topic important?

Our society is extremely mobile and although the incidence is higher in emerging economies or underdeveloped regions of the world – especially Africa, nurses from the western world interact with these individuals. Many of the women from these areas have strong cultural ties to the 'homeland' and reside in the Western world. In addition, many schools of nursing have study abroad programs in which students provide healthcare to individuals in emerging economies. Many nurses participate in Mission Trips to underserved areas of the world. Chances are good that a diagnosis of Pseudocyesis will be noted in the population.

How is the clinical presentation assessed?

The symptoms of pregnancy may continue from a few weeks to beyond nine months. In areas of the world where healthcare is readily available the diagnosis of Pseudocyesis may be addressed early if laboratory results and the ultrasound are negative. However, in areas of limited resources the "pregnancy" may be continued even through labor.

Commonly noted symptoms seen in Pseudocyesis include the following: amenorrhea or oligomenorrhea, nausea, weight gain, appetite changes, breast changes (enlargement or secretions), and perhaps labor pain. In addition, the posture may exhibit lordosis; there may be darkened pigmentation on the abdomen, around the areola, or on the face; and abdominal swelling may be noted. These symptoms are the symptoms of pregnancy. During the assessment, the nurse will note subtle differences. One of the most obvious is the abdomen. The pregnant abdomen will have contours to the shape of the fetus (or fetal lie) whereas the abdomen of a person with Pseudocyesis will be uniformly round. Percussion of an abdomen with Pseudocyesis has tympany and palpitation of the abdomen yields a tight rubbery sensation. In addition the umbilicus remains inverted in Pseudocyesis whereas in pregnancy it typically everts.

There are several probable or presumptive signs of pregnancy which are outside the realm of this paper and a number of those signs may be exhibited by individuals with Pseudocyesis as mentioned in the previous paragraph. However, the two definitive signs of pregnancy will always be negative in individuals with Pseudocyesis. They are fetal visualization with ultrasound, usually evident no later than the sixth week of gestation and fetal heart rate auscultation using the Doppler, usually 10 – 12 weeks' gestation.

There are three conditions which must be included in a differential diagnosis when determining if a woman has Pseudocyesis. They are delusions of pregnancy, factitious or deceptive pregnancy, and erroneous pseudocyesis. The person will have no physical signs pf pregnancy in delusions of pregnancy. The DSM-5 includes this diagnosis under schizophrenic spectrum and psychotic disorders. Their treatment will be that of treating a psychotic individual. The person with factitious or deceptive pregnancy acts pregnant for secondary gain such as sympathy or as an attention getting mechanism. In erroneous pseudocyesis the person develops a presumptive or probable signs of pregnancy and then believes herself to be pregnant. This can be a stable schizophrenic maintained on antipsychotic medications who experiences side effects of the medications such as amenorrhea or lactation. Other medical conditions which need to be ruled out include ascites, hydatidiform mole, ovarian cysts, uterine fibroids, or urinary retention.

How do I help these women?

The nurse is often the first contact and is in a great position to provide support. It is essential to maintain the awareness that that you cannot change culture. Individuals needing psychiatric services should be referred. At the same time, there should be a realization the many of these women are anxious, depressed, and may have numerous life stressors to be pregnant. An individual plan of care with an emphasis on open communications is essential. It stars with conveying the basic fact of not being pregnant despite having presumptive symptoms of pregnancy by presenting objective results of a lack of fetal hart rate or fetal visualization via ultrasound. The patient needs to feel that you want to continue to work with them. Often these women will accept informal counseling from a midwife or physician. And will rarely agree to formal psychotherapy. The nurse (perinatal care provider) may need to consult a mental health provider for guidance. Explore why the pregnancy is so important and determine a course which addresses the issues at hand.

Keep in mind that some women are accepting of the lack of pregnancy diagnosis without a major issue. Whereas others need ongoing support to resolve the issue. If depression or anxiety is a causative factor these issues need to also be addressed. Supportive nursing care makes a difference in these women's lives.

Selected Bibliography for Pseudocyesis

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Select the one best answer to the following questions and compare your answers to answers provided. Review article for any responses answered incorrectly.

1. Women who have Pseudocyesis have many symptoms of pregnancy EXCEPT
   a. abdominal palpitation has tight rubbery sensation
   b. round abdomen without fetal lie
   c. inverted umbilicus
   d. all of the above
2. Factors triggering Pseudocyesis include which of the following
   a. depression.
   b. extreme fear of pregnancy
   c. desire to retain partner.
   d. All of the above
3. When counseling a person with Pseudocyesis it is important to
   a. obtain a complete list of current medications.
   b. encourage psychotherapy.
   c. evaluate current life stressors.
   d. Both A and C

Answers: 1(D) 2(D) 3(D)