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A Case of Concomitant Pseudocyesis and Couvade Syndrome Variant

By Srinagesh Mannekote Thippaiah, Vinu George, Badari Birur, Ananda Pandurangi

ABSTRACT *~ Per DSM-V, pseudocyesis is included under the category "other specified somatic symptom and related disorder" and is defined as a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy. The male counterpart of pseudocyesis is Couvade syndrome, also called "sympathetic pregnancy" where a man experiences symptoms of pregnancy when his female partner is pregnant. There are extensive reports on pseudocyesis and Couvade syndrome in psychiatric literature but none with features of both, in a single case. Here we present a unique case of a fifty-eight-year-old mother who presented with symptoms of concomitant pseudocyesis and Couvade syndrome concurrently when her daughter was pregnant. This case report discusses the epidemiology, course of symptoms and common comorbidities associated with this interesting diagnosis.* Psychopharmacology Bulletin. *2018;48(3):29–32.*

Introduction

Per DSM-V, pseudocyesis is included under the category "other specified somatic symptom and related disorder" and is defined as a false belief of being pregnant that is associated with objective signs and reported symptoms of pregnancy.[1] The male counterpart of pseudocyesis is Couvade syndrome, also called "sympathetic pregnancy" where a man experiences symptoms of pregnancy when his female partner is pregnant.[2] Flanders and Dunbar defined pseudocyesis as "a condition in which a woman firmly believes herself to be pregnant and develops objective pregnancy signs in the absence of pregnancy".[3] There are extensive reports on pseudocyesis and Couvade syndrome in psychiatric literature[4,5] but none with features of both, in a single case. Both these conditions affect individuals who are going through the process of labor, and delivery usually leads to resolution

Thippaiah, MD, Assistant Professor of Psychiatry, Zucker Hillside Hospital, NY. George, MD, Belmont Behavioral Health, Monument Road, Philadelphia, PA. Birur, MD, Assistant Professor of Psychiatry, University of Alabama, Birmingham, AL. Pandurangi, MD, Virginia Commonwealth University, Department of Psychiatry Professor and Vice Chair, Richmond, VA 23298.

To whom correspondence should be addressed: Srinagesh Mannekote Thippaiah, MD, Assistant Professor, Department of Psychiatry at Zucker Hillside Hospital, 7559, 267 Street, New Hyde Park, NY 11040. Phone: (267)-901-4139; Email: smannekote@northwell.edu

of symptoms.[5] Here we present a unique case of a fifty-eight- year old mother who presented with symptoms of pseudocyesis and Couvade syndrome concurrently when her daughter was pregnant. This case report discusses the possible etiology, epidemiology, course of symptoms, diagnostic possibilities and treatments associated with this interesting diagnosis.

Case Presentation

A 58yr old African-American female presented with a relapse of depressive symptoms for the past 4 months. Co-morbid medical conditions included hypertension, hypercholesterolemia, and obesity. Her prior psychiatric history was significant for five episodes of major depressive disorder (MDD) with good response to citalopram and duloxetine. Concurrent with depression, she had physical complaints of morning sickness, abdominal cramps, abdominal distension and backache for the previous 6 weeks. Symptoms coincided with her daughter being pregnant. The patient had experienced similar symptoms during three prior pregnancies of her older daughter. Her previous pseudo pregnancy symptoms were not associated with a categorical diagnosis of any other mental illness such as depression. She had experienced symptoms of parturition and labor pain when her daughter was in delivery. Interestingly, she had insight into not being pregnant during each of these prior episodes. A comprehensive medical evaluation and pregnancy tests did not reveal any evidence of pregnancy or any general medical or neurological disorders that could have explained her pregnancy symptoms. She was treated with supportive psychotherapy and prescribed duloxetine 60 mg once daily for depression. Physical symptoms of pregnancy spontaneously resolved after her daughter, unfortunately, had a miscarriage at the 20th week of gestation.

Discussion

Pregnancy has a psychological impact on close family members and influences psychological and possibly physiological dynamics. Pseudocyesis may occur in women who desperately want to become pregnant to maintain their identity and self-esteem. Couvade's syndrome mainly represents a somatic expression of anxiety. Psychodynamically, it is an unconscious desire to be involved in childbirth, or the expression of subjective involvement in the developmental crisis which the pregnancy represents.[6] Our patient's symptoms could be attributed to anxiety and stress derived from psychological issues and social stressors.

Her family dynamics include severe enmeshment with and dependency on her daughters.

These two syndromes are usually associated with major depression and anxiety disorder, although its association with bipolar affective disorder has been previously reported.[7] The symptoms could reflect an underlying anxiety or depressive disorder which needs to be explored. In some cases, it may represent a somatic complaint or even an overvalued idea. Abdominal distension is frequently reported. It could be due to deposition of fat, gaseous distension, bulging of abdominal viscera due to increased lumbar lordosis.[8] The frequency of symptoms displayed depends on the anxiety level.[9] Our patient's comprehensive physical examination was within normal limits. Her symptoms could not be explained by any single etiology or recognized disease entity. However, the temporal relationship between onset, course and past psychiatric history supports that; current symptoms could have been possibly predisposed by the daughter's pregnancy.

In general, the peak incidences of symptoms of these two syndromes are in the third month of pregnancy. Symptoms tend to diminish in the second trimester and rise again during the ninth month. Generally, the symptoms subside completely after delivery. However, some studies have shown that 30% had cessation of symptoms just before labor began, 35% immediately after birth, while 23% indicated their persistence into the postpartum period.[10]

There is no available evidence to support the treatment of this condition with specific medications except a referral to a psychologist for appropriate therapy based on the psychological presentation. Treating the co-morbid psychiatric conditions including anxiety and depression would be an important part of the management.

Conclusion

As treating clinicians, it is important to be aware of these two conditions and once diagnosed it is important to acknowledge the distress, reassure the patient and avoid minimizing the reality of the patient's experiences. In addition to identifying these two syndromes, mental health professionals should screen for the common comorbidities including depression and anxiety and appropriately treat them with medications and individual therapy. ✤

Conflict of Interest

None.

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