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PREGNANCY DELUSION IN AN ADOLESCENT GIRL – A CASE REPORT

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INTRODUCTION

Delusion of pregnancy can be described as a false and fixed belief of being pregnant despite factual evidence to the contrary. The symptom can present as a part of another disorder or can present in isolation. When present independently, a delusion of pregnancy is described as somatic type of delusional disorder according to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), within the realms of schizophrenia spectrum and other psychotic disorders

Pregnancy delusion occurs primarily in developing countries, where there is a strong familial and cultural pressure on women to be fertile. The delusion starts in a climate of apprehension and develops when sensory perceptions are interpreted as signifying pregnancy, despite evidence to the contrary.

In the literature, the most common diagnoses in patients experiencing a pregnancy delusion were schizophrenia, bipolar disorders, and depression.

Demographic data revealed that about half of the patients with pregnancy delusion were aged 20-40 years. Therefore, it is rare in adolescence.

CASE

A 16-year-old Muslim girl from Guinea-Conakry was referred to our outpatient clinic by her general physician due to fear and belief of pregnancy. She also reported symptoms she attributed to pregnancy (colic pain, breast pain, swollen abdominal veins, distended abdomen).

These manifestations started four years before her referral, during a trip to her home country, where female genital mutilation was performed, as an initiation rite in her culture. In Guinea, female genital mutilation is almost universally performed to ensure that girls are socially accepted and marriageable, and to uphold their status and honour and that of the entire family.

During that trip, she had a delay in her period.

The symptoms occurred the week before her period and remitted partially after menstruation.

Concerning her personal history, she came from Guinea with her family when she was 7. At the age of 12, she was sexually abused. She denies any sexual experiences or intimate relationships.

Regarding her family history, her 52-year-old father is very strict. Her 40-year-old mother doesn't speak Portuguese, never worked and has very little contact with people outside her family.

She currently lives with her parents and her siblings. One of her sisters had similar symptoms, which remitted without treatment.

On the first consultation, our patient came with her mother, who did not speak Portuguese. It is difficult to collect her medical history because she controls the information she translates to her mother. She says her parents are unaware of her symptoms and she refuses to ask her mother about birth and pregnancy "because it's offensive".

Concerning her mental state examination, her posture was anxious. She appeared scared, did not smile, her speech was appropriate, and she described her symptoms in detail. Her mood was depressive, and she was emotionally labile while describing her fear/belief of being pregnant. She described obsessive-like ideas around the topic of getting pregnant by touching sperm ("I believe everything has sperm" "I don't touch anything in the bathroom"), associated with compulsive-like behaviors ("I touch my cervix to see if it's high or low, I did that yesterday to see if I'm pregnant" "I wash my hands constantly with soap and toothpaste, which is acid and kills the germs I might have"). No signs of pregnancy were visible. She refused gynecological examination.

She initiated risperidone and weekly sessions of psychotherapy.

On the next appointment, she has galactorrhea due to risperidone and the anxiety related to her fear has worsened. She initiates sertraline and clonazepam.

After starting treatment with sertraline, she experienced an affective switch and maintained the same symptoms the week before her period.

On the next appointment, she said that she self-induced an abortion with sertraline pills. At this point, sertraline was stopped, and risperidone was increased.

She did multiple pregnancy tests and a pelvic ultrasound. An ovarian cyst was found in the ultrasound, and she thought the cyst might have been confused with pregnancy.

On the following appointments, the dynamism surrounding her belief of pregnancy increased, and it

remains throughout the entire menstrual cycle. She thinks she cannot control whether she gets pregnant or not, she believes she will get pregnant if she touches objects touched by the men in her house and she constantly changes her pants. Moreover, her insomnia and irritability worsened. Olanzapine was initiated.

Currently, her belief that she might be pregnant remains, but she accepts counter argumentation, she doesn't have anxiety, depressive mood or irritability related to her delusion, and her initial malaise progressively improved during follow-up.

DISCUSSION

In our differential diagnosis, we considered pseudocyesis, obsessive compulsive disorder and delusional disorder.

We deem Delusional Disorder as our main hypothesis. Delusions are false firm ideas that cannot be corrected by reasoning and are out of keeping with patient's educational and cultural background.

The phases of delusion birth described in the literature were corroborated in our case. The first stage is called "das trema" - general feeling of non-specific apprehension.

The second stage of delusion formation is a sensory perception. It may have occurred many times before but, this time around, as the person searches for what it might mean, it suddenly acquires extraordinary significance.

In the third stage, meaning is attached to an otherwise neutral sensation.

The role of socio-cultural and environmental factors in the development of delusion of pregnancy has been reported.

Chronic social deprivation, excessive societal pressure to have children and belief in the ability of spiritual deities or an evil eye to induce pregnancy have been suggested to lead to delusion of pregnancy.

Sexual abuse and Female Genital Mutilation also increase the likelihood of pregnancy delusion.

CONCLUSION

We would like to highlight the case complexity, the difficulties we felt while trying to approach the entire family due to the language and cultural barrier. We consider that there are a lot of information gaps in our appointments, since she hides important information, and her parents do not speak Portuguese. Our lack of knowledge of family dynamics, information mediation between the different family members and the mental health professionals and the secrets the family keeps prevent a multidimensional intervention.

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Contribution of individual authors:

Catarina Manuel: literature searches, manuscript writing.
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