Asian Journal of Psychiatry 45 (2019) 72–73

Contents lists available at ScienceDirect

Asian Journal of Psychiatry

journal homepage: www.elsevier.com/locate/ajp

Letter to the Editor

Delusion of denial of pregnancy: A case report

1. Introduction

Denial of pregnancy is a rare phenomenon, which can be associated with negative maternal and fetal outcomes in the form of refusal to accept antenatal care, precipitous delivery, fetal abuse, postpartum emotional disturbances in the mother and neonaticide (Jenkins et al., 2011; Miller, 1990). Denial of pregnancy in the delusional form is rarely reported. In our literature search, we could only find few case reports reporting delusional denial of pregnancy (Kuppili et al., 2017; Miller, 1990; Slayton and Soloff, 1981; Walloch et al., 2007). In this case report, we discuss denial of pregnancy in a patient diagnosed with schizophrenia and review the existing literature on the topic.

2. Case description

A 25 years old married female, presented with acute exacerbation of symptoms during the 9th month of pregnancy. Exploration of history revealed that she has been suffering from mental illness since the age of 13 years, which was insidious in onset, with continuous course with episodic exacerbations, characterized by suspiciousness, delusion of reference, delusion of persecution, delusion of control, delusion of love, irritability with intermittent cheerfulness, agitation and aggression, hallucinatory behaviour in the form of muttering and talking to self, amotivation and disturbed biofunctions. She was treated with olanzapine and electroconvulsive therapy (ECT) in the past, with which she showed improvement in her symptoms, but would have relapse of symptoms due to poor compliance. One year prior to presentation, she got married and medications were stopped immediately after marriage, leading to relapse of symptoms. Her husband and in-laws were not supportive, when they became aware of her mental illness. About 3 months after marriage, she reported to her husband about missed periods and was found to be pregnant on urine pregnancy test. When patient came to know about her pregnancy, she refused to accept the same. However, the family decided to continue with the pregnancy. Throughout her pregnancy, she continued to be symptomatic and refused for receiving antenatal checkups. She was started on risperidone during the 2nd trimester, but with no improvement. Whenever, she would be told that she is pregnant and would be told about her abdominal distension, would refuse to accept that there was any distension or would attribute it to excessive eating. By 9th month of pregnancy, her condition worsened further, and additionally stopped eating and refused to accept the medications. At this time, she was admitted to our inpatient unit.

On examination, patient denied any fetal movements and refused per vaginal examination. A provisional diagnosis of schizophrenia with a differential diagnosis of schizoaffective disorder was considered. Her positive and negative symptom scale (PANSS) at the time of admission was 90. She was started on olanzapine and gradually increased to 20 mg/day. In view of refusal to eat and lack of cooperation for detailed evaluation for pregnancy, ECT was considered. Foetal monitoring was started and she was administered 6 effective ECTs. After receiving 6 ECTs, she started showing improvement in symptoms, but would refuse to accept her pregnancy. At 39th week of pregnancy, she developed labour pains, but had to undergo lower section caesarean section (LSCS), in view of non-progression of labour. She gave birth to a female child weighing 3040 g. Started accepting her baby and would breast feed her. However, within a week, her symptoms worsened, stopped caring for the baby and stopped feeding. As a result, she received 7 more ECTs, with which showed significant improvement in her symptoms (reduction of PANSS from 90 to 57). However, within 2 weeks of last ECT session, she again had worsening of symptoms, with refusal to accept the baby as her's, would say that she did not give birth to the child. On one occasion tried to harm the child and in view of the same the baby was separated from the mother and breast feeding was discontinued. In view of the relapse, she was started on clozapine, was not able to tolerate clozapine beyond 200 mg/day due to sedation. In view of partial response to clozapine, she was started on sodium valproate 1000 mg/day. With this combination, she showed improvement, with PANSS reducing to 50. She was discharged in an improved state. However, in the follow-up, her compliance became poor and patient dropped out of treatment.

3. Discussion

Although, denial of pregnancy is a well-known phenomenon in Obstetric practices, delusion of denial of pregnancy is rarely reported. In one of the first case reports, authors presented a case of denial of pregnancy in the 3rd trimester of pregnancy (Slayton and Soloff, 1981). In the largest series of cases, Miller (1990), presented 12 cases of psychotic denial of pregnancy and related phenomenon in the sample drawn from 26 females drawn from inpatient program for pregnant mentally ill women. Out of the 12 women with the phenomenon, in 3 patients, denial of pregnancy was the major reason for the inpatient care. In none of the patients, psychotic denial of pregnancy was associated with denial of anything else. Eleven out of the 12 females, with psychotic denial of pregnancy were diagnosed with chronic schizophrenia and many of them had past history of loss of custody of their children and were at a significant risk of facing separation from their unborn child (Miller, 1990). In some of the case reports, authors have presented denial of pregnancy as an equivalent of Cotard's syndrome in the background of a depressive episode (Walloch et al., 2007). In another case series, authors presented 2 cases, one of whom had psychotic denial of pregnancy and resultantly the child was given for adoption (Lieb et al., 2012). In a recent case report from India, authors presented a case, who denied pregnancy from 2nd month onwards and considered the fetus to be dead (nihilistic delusion) (Kuppili et al., 2017).

As one reviews all these case reports and case series, one fact which is apparent, is that delusional denial of pregnancy, is most commonly

https://doi.org/10.1016/j.ajp.2019.09.002
Received 20 July 2019

seen in patients with schizophrenia, as was also true for the index case. Further, in most of these cases, delusional denial of pregnancy was seen in young women (Kuppili et al., 2017; Miller, 1990). In the index case, patient was managed with ECT and despite best effort, LSCS could not be avoided. Available literature also supports similar outcome in patients having delusional denial of pregnancy (Kuppili et al., 2017; Miller, 1990). Studies which have evaluated the denial of pregnancy, report the same to occur more frequently in women who are young, primiparous, with poor social support, and a history of substance abuse or psychiatric disorder (Kuppili et al., 2017; Miller, 1990). Index case was also primiparous and had lack of social support.

Management of this patient was associated with frequent ethical and legal concerns. Patient lacked capacity to consent for the ECT and the baby had to be separated from her, in the immediate post-partum period, when she experienced relapse of symptoms. Available literature also highlights these issues (Jenkins et al., 2011) and suggests that clinicians managing such patients should uphold the ethical principles of medical practice and at the same time ensure the safety of the mother and the child. In the index case, consent for ECT was obtained from the mother of the patient. Mental Health Care Act (2017), suggest that children younger than 3 years of age of a women shall not be separated ordinarily during the stay of mother in the mental health establishment except that when the treating psychiatrist feel that there is risk of harm to the child from the women due to her mental illness or it is in the interest and safety of the child. In the index case, the decision to separate the child from the patient was taken in liaison with the patient's family members.

To conclude, the present case highlights a rare phenomenon of delusional denial of pregnancy in the background of schizophrenia.

Conflict of interest

None.

Financial disclosure

None.

Acknowledgement

None.

References

Jenkins, A., Millar, S., Robins, J., 2011. Denial of pregnancy—a literature review and discussion of ethical and legal issues. J. R. Soc. Med. 104, 286–291.

Kuppili, P.P., Gupta, R., Pattanayak, R.D., Khandelwal, S.K., 2017. Delusional denial of pregnancy: unique presentation of Cotard's syndrome in a patient with schizophrenia. Asian J. Psychiatry 30, 26–27.

Lieb, M., Hummel, I., Fürst, S., Baghai, T.C., Mokhtari-Nejad, R., Palm, U., 2012. Psychotic and non-psychotic denial of pregnancy. Fortschr. Neurol. Psychiatr. 80, 276–279.

Miller, L.J., 1990. Psychotic denial of pregnancy: phenomenology and clinical management. Hosp. Commun. Psychiatry 41, 1233–1237.

Slayton, R.I., Soloff, P.H., 1981. Psychotic denial of third-trimester pregnancy. J. Clin. Psychiatry 42, 471–473.

Walloch, J.E., Klauwer, C., Lanczik, M., Brockington, I.F., Kornhuber, J., 2007. Delusional denial of pregnancy as a special form of Cotard's syndrome: case report and review of the literature. Psychopathology 40, 61–64.

Devakshi Dua, Sandeep Grover*

Department of Psychiatry, Post Graduate Institute of Medical Education and Research, Chandigarh, India

E-mail address: drsandeepg2002@yahoo.com (S. Grover).

* Corresponding author.