Quadruplet pregnancy delusion in schizophrenia: A rare presentation of delusional procreation syndrome

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SUMMARY

Delusional Procreation Syndrome (DPS) encompasses delusions involving various stages of reproduction, including pregnancy, childbirth, and parenthood. Although the delusion of pregnancy (DoP) is the most commonly reported phenomenon, simultaneous delusions spanning multiple reproductive stages are rare. We describe a 39-year-old woman with chronic schizophrenia who presented with concurrent delusions of quadruplet pregnancy, miscarriage, stillbirth, childbirth, and motherhood. This case highlights the broad clinical spectrum of DPS and underscores the importance of distinguishing DoP from related conditions such as pseudocyesis and Couvade syndrome. It further illustrates the role of psychosocial adversity in shaping delusional themes.

Key words: Schizophrenia, Delusion, Pregnancy, Delivery, Delusional Procreation syndrome, Delusion of Pregnancy

INTRODUCTION

Delusional Procreation Syndrome (DPS) encompasses delusions pertaining to one or several possible stages of reproduction, such as the "delusion of having a spouse," "delusion of pregnancy (DoP)," "delusion of giving birth," and "delusion of being a parent (motherhood/fatherhood)" (Figure 1) (1). Although delusions involving various reproductive stages had been described earlier, it was Manjunatha et al. in (2010) who first unified them under a single framework and defined the syndrome as DPS. Later, they expanded the scope of the syndrome by including the delusion of surrogate polygamy (2). Among the delusions within DPS, the most frequently reported is DoP (3). While DoP is more common in women, it can also occur in men. However, an important clinical consideration is to distinguish DoP from pseudocyesis and Couvade syndrome (4).

In the Diagnostic and Statistical and Manuel of Mental Disorders, Fifth Edition (DSM-5), pseudocyesis is classified under Somatic Symptom and Related Disorders, under the subcategory "Other Specified Somatic Symptom and Related Disorder" and is defined as the false belief of being pregnant despite the presence of objective signs and reported symptoms of pregnancy (5). Couvade syndrome, on the other hand, refers to men whose partners are pregnant experiencing some pregnancy-related symptoms, such as changes in appetite, weight gain, and nausea (6).

To the best of the authors' knowledge, no previously reported case has exhibited five distinct delusions associated with DPS simultaneously. In this case report, we present a chronic schizophrenia patient who had long been deprived of treatment and demonstrated the clinical features of DPS. We believe that the coexistence of delusions of pregnancy with quadruplets, childbirth, and motherhood, together with delusions of stillbirth and miscarriage, which have not been previously discussed within the framework of DPS, will contribute to the existing literature on the syndrome.

This case presentation describes a female patient diagnosed with schizophrenia who had been untreated for a long time and simultaneously exhi-

DOI: 10.5505/kpd.2026.10270

Cite this article as: Tezcan DN, Turan A. Quadruplet Pregnancy Delusion in Schizophrenia: A rare presentation of delusional procreation syndrome. Turkish J Clin Psych 2026; 29:58-62

The arrival date of article: 11.09.2025, **Acceptance date publication:** 10.11.2025

Turkish J Clinical Psychiatry 2026;29:58-62

bited delusions of pregnancy with quadruplets, miscarriage, stillbirth, giving birth, and motherhood. This case is considered to contribute to the literature on DPS, as it encompasses four distinct delusional themes within DPS and uniquely includes the delusions of pregnancy with quadruplet, miscarriage, and stillbirth, which have not been previously reported together.

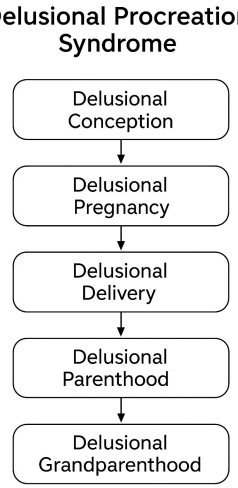
CASE REPORT

F.H., a 39-year-old widowed female patient, who had completed primary school and was unemployed at the time of admission. She resided alone in a container settlement after the 2023 Türkiye earthquakes and had limited social support. Although she had three children, she had not been in contact with them for about 3–4 years. The patient initially presented to an external obstetrics and gynecology outpatient clinic to learn about the fate of the children she believed she had given birth to. Upon evaluation, it was determined that she had no pregnancy follow-up records and no objective medical evidence of pregnancy within the reported time frame. When it became clear that she had not given birth, she was referred to the psychiatry outpatient clinic and subsequently transferred to our hospital for inpatient care.

From her sister's account, it was learned that the patient had divorced one year earlier and had three children aged 23, 20, and 17, with whom she was socially disconnected due to her illness. The children reportedly did not wish to maintain contact with her. Her first psychiatric admission had been approximately seven years earlier, presenting with paranoid, referential, and grandiose delusions. She was hospitalized for 17 days but discontinued follow-up or treatment thereafter. Her delusional symptoms persisted for seven years, with no insight into her illness. A nephew was also under psychiatric follow-up with a diagnosis of psychotic disorder.

At her initial psychiatric examination, the patient appeared to be of her stated age, had adequate self-care, was alert, and fully oriented to person, place, and time. She was cooperative, with a slightly elevated affect. Abstract thinking was intact, but judgment was partially impaired. She reported no perceptual disturbances. Her delusions included referential beliefs ("They keep calling me from the television and giving me important messages from the government"), grandiose delusions (believing she could move objects with her mind and that she was superior to others), and persecutory delusions (believing that neighbors were photographing her and that people at the hospital where she believed she had given birth wanted to harm her babies).

Figure 1.



During her psychiatric history, she stated that she had become pregnant after a relationship with a married man from the container settlement. She reported recognizing her pregnancy in the first week through symptoms such as sensitivity to odors, nausea, and abdominal pain, and that her initial blood test at a local primary care center was negative because it was too early. In the second month, she went to an obstetrics and gynecology clinic, where a blood test and ultrasound were performed. She insisted that she had seen four fetuses on the ultrasound, claiming, "The doctor told me it was just intestinal gas to surprise me, but as a mother, I immediately understood I had four babies."

When she shared the news of her pregnancy with the man she considered the father, she reported that she learned he did not want children. She claimed that in the third month she miscarried one baby. She further alleged that during subsequent hospital visits, doctors withheld the existence of her triplets from her as part of a plan. In the eighth month, she presented to the emergency depart-

ment with abdominal pain and bleeding. She reported that labor began in the emergency room toilet, where she gave birth alone: the first baby, followed by brief fainting, then the second baby. She stated she cut the umbilical cords herself, identified one infant was male and the other female, and expressed joy. According to her, a nurse then took the babies away, promising to transfer them and that she could follow later. At home, she claimed to have delivered the third baby alone, describing it as stillborn. A few days later, when she returned to the hospital to retrieve her babies, she believed the staff had been replaced to conceal them from her.

Upon referral to the gynecology clinic, it was confirmed that she had no elevated beta-hCG levels or any clinical signs of pregnancy in her medical history. She was then referred to psychiatry and admitted to our inpatient unit with family involvement.

During hospitalization, routine laboratory investigations were performed to rule out organic causes. hematological parameters (hemoglobin, white cell count, platelets), biochemical assays (liver and renal function tests, electrolytes, thyroid profile), and hormonal assays (prolactin, FSH, LH, estradiol, TSH) were all within normal reference ranges. A non-contrast brain MRI revealed no structural or ischemic abnormalities. Psychometric assessments showed a Positive and Negative Syndrome scale (PANSS) score of 98 and a Clinical Global Impression (CGI) score of 6. Medical records indicated prior irregular psychiatric consultations for schizophrenia without consistent treatment.

Her treatment was initiated with risperidone, titrated up to 6 mg/day. After four weeks, no clinical improvement was observed, PANSS(88) and CGI(5) scores showed no significant change, and hyperprolactinemia (>200 ng/mL) was detected. Risperidone was cross-tapered to aripiprazole at a dosage of 10 mg/day. After four weeks with no improvement, clozapine was introduced, titrated to 400 mg/day. Partial benefit was observed: she was able to question some of her delusional beliefs but remained convinced of giving birth and continued planning to find her supposed children. Considering treatment-resistant psychosis, electroconvulsive therapy (ECT) was initiated under anesthesia, with 12 sessions administered.

After approximately 12 weeks of treatment, the patient showed enriched thought content, improved social participation, reduced negative symptoms, and subthreshold persistence of positive symptoms. Although she did not spontaneously mention her delusional content, she occasionally expressed doubt about their validity. Psychometric assessments showed improvement, with the PANSS score decreasing to 58 and the CGI score to 4. The patient was discharged with partial remission to outpatient follow-up. At her second- and fourth-week post-discharge visits, she was reported to be adherent to treatment, receiving family support, not engaging in delusion-driven behaviors, and demonstrating partial insight.

Written informed consent was obtained from the patient for publication of this case report.

DISCUSSION

In psychiatry, many delusional syndromes have been described to date. Some examples include Cotard syndrome, Capgras syndrome, Othello syndrome, Fregoli syndrome, and Couvade syndrome. Manjunatha et al. added a new entity to this list by defining the cluster of delusions that can involve one or more stages of reproduction as Delusional Procreation Syndrome (DPS) (1).

DPS can be associated with various psychiatric or neurological disorders such as schizophrenia, schizoaffective disorder, delusional disorder, epilepsy, dementia, and organic brain syndromes (1). In a citation analysis of published cases related to Delusional Procreation Syndrome (DPS), both male and female patients were reported; however, the majority were female. Among patients with DPS, delusion of pregnancy was identified as the most frequently reported delusional theme (87.6%). The most common psychiatric diagnosis associated with DPS was schizophrenia (42%), followed by bipolar disorder (13%). A key distinction must be drawn between DoP and pseudocyesis, the main difference being that physical pregnancy symptoms are present in pseudocyesis (7). This

case also involved a female patient with a diagnosis of schizophrenia.

It has been reported that psychosocial factors play an important role in the development of DoP in schizophrenia. Pregnancy has been described as an experience that reduces feelings of loneliness and helplessness by allowing the mother to form a bond with the fetüs (4). Shankar considered the formation of delusional beliefs as an adaptive mechanism reflecting an individual's conflicts and life experiences. Loss of a valued object, profound loneliness, and the loss of a real or imagined relationship are thought to trigger DoP as a compensatory mechanism (8). Similar psychosocial factors were clearly evident in this case. Being widowed and estranged from her children, the patient lived alone. The post-earthquake container settlement environment with limited social support may have increased her feelings of loneliness and helplessness, thus contributing to the emergence of delusions themed around pregnancy and motherhood. Therefore, the patient's delusional experience appears consistent with psychosocial explanations reported in the literature.

In previously reported DPS cases, one or more stages of reproduction were often present together. A 2013 study described six cases of DPS, including delusions of fatherhood, childbirth (labor and delivery), having a spouse and motherhood, motherhood alone, and having a spouse alone (9). Similarly, the first study that introduced DPS included three cases: delusions of having a spouse and fatherhood, having a spouse and motherhood, and having a spouse, motherhood, and childbirth (1). DPS may also include delusions of multiple pregnancies. For instance, a 2014 case report described a postmenopausal woman with a delusion of giving birth to twins (10). In a case series published in 2024, a female patient with schizophrenia presenting with a delusion of quadruplet pregnancy was reported (11). In this case, delusions of stillbirth and miscarriage, which have not been previously discussed within the framework of Delusional Procreation Syndrome (DPS), coexisted with delusions of pregnancy with quadruplets, childbirth, and motherhood, representing a unique clinical constellation.

In female patients receiving antipsychotic treatment, elevated prolactin levels may be observed. Hyperprolactinemia can lead to symptoms such as amenorrhea and galactorrhea, which are also seen during pregnancy. DoP may occur in the context of antipsychotic use or other conditions that cause hyperprolactinemia, such as prolactinoma. In such cases, discontinuation of the offending antipsychotic has been reported to result in resolution of the delusional beliefs (11).

In the management of DoP, prolactin-sparing antipsychotics such as aripiprazole may be preferred. ECT has been reported to produce only limited and temporary improvement in such cases (12). In addition to pharmacotherapy, non-pharmacological interventions such as psychoeducation, cognitive, and supportive psychotherapy may positively influence treatment outcomes by enhancing insight, strengthening coping abilities, and improving overall functioning (11).

This case, the patient simultaneously exhibited delusions of pregnancy with quadruplets, miscarriage, stillbirth, childbirth (labor and delivery), and motherhood. By encompassing these multiple aspects of reproduction, this case contributes to the literature on DPS as an example of the syndrome's broader spectrum.

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