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Retrospective Study

A Risk Management Approach to Delusional Pregnancy and Pseudocyesis

Keirstyn A Biggans[1], Lisa M Painter[2], Richard L Simmons[3], Joseph S Sanfilippo[4]*, Kerri Brooks[5] and Chatón T Turner[6]

[1]*Project Analyst, Corporate Risk Management, UPMC, Pittsburgh, PA, United States*

[2]*Senior Director, Corporate Risk Management, UPMC, Pittsburgh, PA, United States*

[3]*UPMC, Pittsburgh, PA, United States*

[4]*University of Pittsburgh Physician, Pittsburgh, PA, United States*

[5]*Senior Manager, Corporate Risk Management, UPMC, Pittsburgh, PA, United States*

[6]*Senior Associate Counsel and Vice President, Civil Rights, Regulatory Affairs, Disability Resources, & External Relations, UPMC, Pittsburgh, PA, United States*

***Corresponding Author:** Joseph S Sanfilippo, University of Pittsburgh Physician, Pittsburgh, PA, United States.

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Abstract

Introduction: This article focuses on strategies that may be adopted by a healthcare system to improve the quality of care provided to patients diagnosed with delusional pregnancy or pseudocyesis.

Background/Objectives: The number of patients who experience delusional pregnancy or pseudocyesis may be more common than reported. This paper discusses the organizational problems inherent in managing delusional pregnancy and the need for a multidisciplinary team to coordinate care to assess patients for emotional, physical, or behavioral needs and initiate referrals as appropriate.

Methods: A retrospective review of patients who exhibited or reported signs and symptoms of pregnancy took place in a large academic center.

Results: There was a statistical difference in management of the delusional pregnancy patient post implementation of the multi-disciplinary team.

Keywords: *Delusional Pregnancy; Phantom Pregnancy; Pseudocyesis*

Introduction

Delusions of pregnancy is defined by the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders as "a somatic type of delusional disorder when it occurs independently, within the spectrum of schizophrenia or other psychotic disorders" [1]. Delusion of pregnancy is the applicable diagnosis when a woman claims that she is pregnant, but exhibits no objective physical or hormonal signs of pregnancy and when pelvic imaging studies detect no intrauterine fetus. Pseudocyesis is diagnosed when delusion of pregnancy is accompanied by some combination of somatic signs and symptoms of pregnancy such as abdominal enlargement, reduced menstrual flow, amenorrhea, subjective sensation of fetal movement, nausea, breast engorgement and galactorrhea etc.

Historically, pseudocyesis was first described by Hippocrates about 300 BC and its manifestations have been the frequent subject of medical anecdotes and fictional stories [2]. At one time 1 of every 250 pregnant patients were reported to have pseudocyesis [3].

Currently, however only one per cent of 22,000 pregnant women are reported to have pseudocyesis in developed countries [4]. Delusional pregnancy often called phantom pregnancy, is much more common but the true incidence is unknown.

The literature primarily consists of single case reports and small series; larger reviews in both obstetrical and psychiatric literature reflect the consensus that presentations are heterogeneous, treatment is ill defined and prognosis is uncertain [5]. This review of 40 articles which included 84 cases; the most common diagnoses were schizophrenia (35.7%), bipolar disorders (16.7%) and depression (9.5%) with a 64.3% favorable therapeutic outcome despite the range of underlying neuropsychiatric disorders [5]. The individual patient with phantom pregnancy, a mental disorder, presents a difficult administrative dilemma for an obstetrical service.

This paper presents the stories of fourteen patients with phantom pregnancy, including three patients with pseudocyesis, who presented to our academic obstetrical center over to 12 months [2022-2023]. During the same period, over 10,000 deliveries were performed at this hospital. The extreme rarity of phantom pregnancy, and the absence of evident obstetrical or gynecological disorders, proved that the administrative care pathways had not been organized for optimal care of behavioral disorders. Almost all patients were lost to follow up and only few were entered into behavioral health services.

During a single 12-month period, 2022-2023, our academic healthcare system risk management program became retrospectively aware of these 14 patients who fit the diagnosis of phantom pregnancy. These patients were brought to the attention of risk management because they had been referred to the hospital security services for the hypothetical fear that patients with phantom pregnancy would create an increased risk of baby abduction. Indeed, there is a solitary case in the literature of a schizophrenic phantom pregnancy patient abducting a baby, but only one [6]. This single sensational report has led some obstetrical services including our own to routinely refer such patients to hospital security services. In fact, this is the only well documented case in the literature and, furthermore, newborn abductions in developed countries are only rarely reported [7]. Despite the rarity of baby abduction, security services regularly alert the risk management department of patients with phantom pregnancy that comes to its attention.

Healthcare risk management departments are often associated with medical malpractice and claims management but, the goals of a healthcare risk management department are much broader [8]. In practice, healthcare risk management defines its role as encompassing all the "processes and procedures, and reporting structures designed to detect, monitor, assess, mitigate, and prevent risks to patients, providers, and infrastructure" [9]. Thus, the responsibility of healthcare risk management includes the collection and dissemination of any information related to the safety of patients and thereby serves as a link between patient safety and quality improvement [9]. In this academic setting, the role of risk management serves as an important recipient of reports, formal and informal, of failures to provide appropriate care. Especially difficult is the detection of rare but repetitive events which require the organization and training of disparate caregivers to mitigate latent errors and risks. The non-pregnant patient who reports to be pregnant is an example. The 14 cases studies seen in table 1 were gathered retrospectively.

Patient 1	30-year-old female emergently arrived in active labor by ambulance with no history of prenatal care and an emergency cesarean section was contemplated. Neither fetal heart sounds nor fetal movement were detectable. A fetal ultrasound revealed that the patient was not pregnant. The patient was discharged, no further medical consultations were documented, and the patient was lost to follow up.
Patient 2	An 18-year-old female reported to emergency department. She reports to be 40 3/7 weeks pregnant with complaints of spotting during pregnancy, abdominal distention, and birth labor symptoms. The patient was transferred to labor and delivery triage service where a bedside fetal ultrasound and urine pregnancy test revealed that the patient was not pregnant. At discharge without further medical referrals, the patient continued to return to the emergency department. A closer review of the patient's past medical history revealed multiple claims of phantom pregnancy at the same hospital. The patient was subsequently medically diagnosed with phantom pregnancy and discharged with a behavioral health referral. No behavioral or medical follow up was documented; patient was lost to follow up.

Patient 3	22-year-old female presented to the emergency department with nausea, abdominal pain, and was concerned she may be pregnant. Pregnancy tests indicated she was not pregnant. Patient continued to present to multiple different hospital emergency room departments with the reports of being pregnant with claims of multiple positive home pregnancy tests. The medical record documented several patient discussions regarding the negative pregnancy tests. Patient was adamant she was pregnant. Each discharge summary asked the patient to follow up with obstetrician and gynecologist or a primary care physician, but a behavioral health referral was never initiated. This patient was later diagnosed with polycystic ovary syndrome and continues to have frequent visits to acute emergency room departments.
Patient 4	A 34-year-old female presented to the emergency department on several occasions in a single week, complaining of pelvic cramping, irregular bleeding, and her suspicion that she was 30 weeks (about 7 months) pregnant. A bedside ultrasound failed to reveal signs of pregnancy. On the second emergency department visit, the patient discussed the want of a home birth, the use of a midwife, and shared her recent maternity photography session. A bedside ultrasound revealed she was not pregnant. The patient was discharged with a behavioral health referral due to her delusions and was officially diagnosed with phantom pregnancy. The severity of her delusions required an extensive engagement of multiple members of the clinical, behavioral and security team. It included multiple interventions related to social media and electronic media. Observations remain ongoing.
Patient 5	22-year-old diabetic woman with known polycystic ovarian syndrome presented to the emergency department for chronic pelvic and abdominal pain. The medical record documented persistent, reoccurring delusions of pregnancy. A urine pregnancy test and fetal ultrasound were negative. The medical record indicated the patient was well known to the emergency department due to these complaints. At discharge, it was recommended to follow up with the patient's primary care physician, but there was no behavioral health referral. The medical records indicate patient was considered a 'safety issue to the infants at the medical center and should be placed on a security watch.' A year later, the patient became pregnant and received obstetrics services at this facility.
Patient 6	23-year-old female presents at the emergency department following an altercation with her significant other. The patient complained of abdominal pain and claimed to be 5 months pregnant. Fetal ultrasound revealed the patient was not pregnant and became enraged that her fetal ultrasound was negative. She began verbally abusing the emergency physician and bedside nurse claiming she would not leave the facility until her pregnancy was evaluated further. Security was engaged to de-escalate the patient. The patient was escorted off the property. Discharge instructions recommended primary care physician follow up. On review of the medical record, it was noted the patient frequently visited multiple emergency departments with the same presenting factors: altercation with significant other, abdominal pain and five months pregnant. A behavioral health referral was not initiated.
Patient 7	36-year-old female presented to emergency department with irregular bleeding due to miscarriage. The patient was discharged with instructions to follow up with primary care physician regarding miscarriage. A month later, this patient impersonated a funeral director to access the labor and delivery department. The hospital security threat assessment team was notified, and the patient continues to be monitored by the healthcare organization as a potential baby abduction risk.
Patient 8	18-year-old female presents to emergency department for irregular vaginal bleeding, no reported menses and adamant she was not pregnant. The completed testing indicated she was pregnant and experiencing a miscarriage. An obstetrics and gynecology referral on discharge was recommended. Seven months later, the patient presented to the same emergency department with abdominal distention and birth laboring symptoms stating she is 40 weeks pregnant. The patient was transferred to labor and delivery triage service. Bedside fetal ultrasound and urine pregnancy test were performed, and the patient was not pregnant. At discharge, the treating physician discussed phantom pregnancy diagnosis with the patient and a behavioral health referral was initiated. No follow up is documented.

Patient 9	19-year-old female presented to emergency department with complaints of abdominal pain, rule out urinary tract infection and claimed to be 20 weeks pregnant. She was accompanied by her mother. Medical records documented patients having multiple negative pregnancy tests within the last month. Pregnancy was ruled out and results shared with patient and mother. The patient persisted with her belief she was pregnant because she could feel something moving in her stomach. Patient declined additional urine pregnancy test and fetal ultrasound testing. The physician documented the patient, and her mother required repetitive counseling to tell her is not pregnant. The patient was discharged and recommended to follow up with a primary care physician. A behavioral health referral was never recommended.
Patient 10	18-year-old presents to emergency department with complaints of being in active labor at 38 weeks gestation, requesting a caesarean birth. Prior to arriving at this emergency department, the patient visited multiple facilities in the same day, with the same complaint, with the same results- not pregnant and currently with an intrauterine device. Given the patient's concerns about being in active labor, a beside ultrasound was performed and revealed no intrauterine pregnancy. Further medical record documentation by the emergency physician states the patient has not had sexual intercourse in over a year, had negative urine human chorionic gonadotropin (hCG), thus doubt pregnancy. The patient was encouraged to follow up with obstetrics and gynecology, and a primary care physician, but a behavioral health referral was never encouraged.
Patient 11	The 34-year-old presented to the emergency department complaining of severe cramping and contractions for some while. The patient was escorted to labor and delivery triage, but stated she was not from the area and did not have any prenatal care. Without any medical records, the patient reported this is her third pregnancy with the first being ectopic and the second a twin pregnancy. A bedside ultrasound revealed that she was not pregnant. The physician recommended urine sample or bloodwork, but the patient refused any further testing. The patient signed out against medical advice, and the discharge instructions stated the physician could not provide a diagnosis given the limited information.
Patient 12	34-year-old presented to emergency department for evaluation of abdominal pain with unclear exacerbating symptoms at 36 weeks of pregnancy. During the medical evaluation, it was documented the patient had not been sexually active in years. Regardless, the patient had four previous other pregnancy claims within the same year. When asked about her previous presentations, in which she thought she was pregnant, the patient explained to the physicians that if she was not pregnant after examination, she must not be pregnant. The record further documents a discussion with the physician regarding her multiple presentations and the multiple negative test results. The patient was provided a behavioral health referral with comments regarding phantom pregnancy in her medical records. The patient did not follow up with behavioral health.
Patient 13	34-year-old presented to emergency department for abdominal pain and positive home pregnancy test. The patient had a tubal ligation fourteen years prior but showed videos from her cell phone of abdominal movements. A bedside ultrasound was performed, with negative pregnancy results. The patient became concerned and wanted to have the pregnancy test reevaluated. Further investigation revealed the patient had multiple pregnancy claims within the last two years, all resulting in negative pregnancy tests. Documentation in the record stated the patient is fixated on the possibility of being pregnant, although she reports a tubal ligation, she did not understand how she could be pregnant. The patient was discharged after medical evaluation and recommended to follow up with a primary care physician. There was no record of follow up.
Patient 14	27-year-old presents to emergency department at 35 weeks in active labor with complaints of cramping and bleeding. A fetal monitor was placed but fetal heart tones were not detected. The Abdomen was softly distended, but the uterine fundus could not be palpated. The urine HCG test was negative. Prior to the physician discussing negative pregnancy results with the patient, security was called to the unit. Medical history included tubal ligation, and multiple other pregnancy claims at other healthcare facilities. The medical documentation stated "the patient now wants to be tested for pregnancy" because she says that she wants to listen to the heart of the baby. Tests confirmed negative pregnancy. The patient is adamant she is pregnant. A behavioral health referral was discussed with the patient and documentation of phantom pregnancy can be found in the patient's chart. The patient was lost to follow up.

Table 1: *Case studies.*

The possibility of delusion pregnancy was considered at time of presentation but none of the patients received an initial discharge diagnosis of delusion of pregnancy. More importantly, no organized plan and training for the care or proper referral of these patients had been developed or was systematically implemented. Consequently, almost all the patients were lost to follow up and none of them received comprehensive investigation of the possible disorders associated with amenorrhea and none of them received proper referral to a behavioral health service prepared to address their underlying mental disorders. Based on our retrospective review of these 14 patients we implemented a response program for all patients with delusional pregnancy. Many studies discuss cases of phantom pregnancy, but they do not provide guidelines or structured processes for managing these patients [10].

We focused on the implementation of an approved quality improvement project with an emphasis on simplification, standardization, teamwork communication, and lastly learning from past mistakes when addressing the problems of patients presenting with phantom pregnancy in the emergency department.

Methods

A large integrated healthcare facility risk management department with a specialty hospital in obstetrics conducted a retrospective review of fourteen patients who exhibited or reported signs or symptoms of phantom pregnancy for the period February 2022-February 2023. The case summaries highlight the challenges of psychosocial assessment, diagnosis, communication and follow up care for patients who present with signs, symptoms, or beliefs of phantom pregnancy. After the study was implemented, 12 new patients were identified as having phantom pregnancies and they were reviewed to determine their discharge plan and disposition. The criteria for the 12 patients post study were compared with incidences of the 14 pre-study patients using 2-tailed Fisher Exact Probability Tests.

Results

As seen in table 2 all the phantom pregnancy patients were women, ages ranged from 18 - 37 years old. All presented to the emergency department. Ninety-three percent were single and arrived alone without a support person. In retrospect, 13/14 [93%] patients had at least one recorded presentation of unsubstantiated claims of pregnancy and 7/14 [50%] had more than one. These records were not always available or discoverable at the time of the index presentation but were discovered at subsequent emergency room encounters with recurrent complaints. At least 2/14 were not sexually active, and 8/14 [58%] were using contraceptive measures. Two patients had tubal ligations, and one had an intrauterine device in place. All patients endorsed that they had symptoms such as absent menses and abdominal pain/abdominal swelling etc. commonly encountered during pregnancy. Four of the fourteen were initially thought to be in labor and three of them were sent to the labor and delivery suite before the absence of pregnancy was ascertained. Two others were diagnosed with polycystic ovary syndrome in the medical record, one of whom later had a successful pregnancy and delivery. Abdominal pain or a sensation of fetal movement was a common complaint, but no one was convincingly diagnosed with pseudocyesis.

Attributes	Frequency Sample n = 14	Percentage
Age at first presentation		
18-21	4	29%
22-25	3	22%
26-29	1	7%
30-33	1	7%
34-37	5	35%
Gender		
Male	0	0
Female	14	100%

Marital Status		
Married	1	7%
Single	13	93%
Ethnicity		
White	7	50%
Black or African American	7	50%
Hispanic Latino	0	0
Asian	0	0
Native American/Alaska Native	0	0
Native Hawaiian or Other Pacific Islander	0	0
Point of Entry		
Emergency Department	14	100%
Primary Care Physician	0	0
Prior Behavioral Health Engagement		
Yes	8	57%
No	6	42%
Living Arrangement		
Single	10	72%
Homeless	4	28%
Clinical Presentation		
Abd Pain	6	43%
Irregular Bleeding	3	21%
Seemly Active Labor	5	36%
Phantom Pregnancy Claims		
One Claim	1	7%
Multiple, Reoccurring Claims	11	79%
Claims Unknown	2	14%

Table 2: *Characteristics of Phantom pregnancy study.*

Of considerable importance to the recognition of phantom pregnancy, at least four of the fourteen patients were documented to express profound distress and were adamant that they were pregnant despite the news that they were not. At least two insisted that they were pregnant despite admitting that the evidence was correct. One [patient #6] deliberately simulated a false identity to gain access to the hospital. All four patients who publicly expressed their dissent were considered at least on one occasion by security services that they might deserve to present a "be on the lookout" BOLO status as a baby abduction threat. This general pattern of presentation of phantom pregnancy patients is consistent with descriptions in the literature and may be helpful as a clinical description of this disorder in emergency rooms [10].

At discharge, 64% did not receive a behavioral health referral but 78% received recommendations to either follow up with their obstetrician and gynecologist or their primary care physician but were lost to follow up. See table 3.

Discharge outcome	Pre-Project Case Studies N=14	Pre- Project Percentage	Post- Project Case Studies N=12	Post- Project Percentage	p value
Behavior Health Referral at Discharge					
Yes	5	36%	12	100%	<0.001
No	9	64%	0	0%	
OB/GYN or PCP Referral at Discharge					
Yes					
No	11	78%	1	9%	<0.001
	3	22%	11	91%	
Diagnosis of Phantom Pregnancy at Discharge					
Yes	5	36%	2	17%	0.39
No	9	64%	10	83%	
Support System Identified					
Yes	1	7%	12	100%	<0.001
No	13	93%	0	0%	
Using Contraceptives					
Yes	8	58%	2	17%	0.05
No	6	42%	10	83%	
Triaged in Labor and Delivery					
Yes	4	28%	1	9%	0.33
No	10	62%	11	91%	
Referred to Threat Assessment					
Yes	4	28%	5	42%	0.68
No	10	62%	7	58%	

Table 3: *Discharge plan of phantom pregnancy patient.*

The primary objective of this quality improvement project was to establish a structured approach to the management of patients who experience phantom pregnancy. This includes a communication plan, an alert system, and a cross functional response team. The goal, an intuitively simple concept, is that when a patient demonstrates signs and symptoms of delusional pregnancy a team of care providers are engaged to provide specialized services for this complex patient. This team engages patients in future behavioral health follow up, reduce transfers to labor and delivery and minimizes patient labeling as infant abductors.

The multidisciplinary team consisted of the following: risk managers, security, behavioral health experts, obstetrics and emergency room physicians, nurses, and attorneys. They met monthly to create and understand the complex care plan of a phantom pregnancy patient. The complex care plans should first provide the phantom pregnancy patients insight on their diagnosis, although this insight may not be a realistic approach due to the denial often faced by these patients. Because of this, a healthcare provider with the strongest, positive relationship with the patient should be the one having this discussion, whether a primary care, behavioral health, or obstetrics and gynecology physician. In consideration of this, psychiatrists are often good at developing and maintaining positive relationships with both patients and their family [11]. The next appropriate response would be to reduce the physical signs and symptoms of phantom pregnancy while minimalizing unnecessary medical intervention, such as emergency caesarean section on a non-pregnant patient.

Psychological and interpersonal pressures should be addressed too, as these may create the belief of pregnancy and increase the risk of recurrence. Identifying the phantom pregnancy patient's social support is imperative due to this diagnosis. Some patients are not ready to relinquish their pregnancy beliefs and will need additional support outside of the healthcare organization. Lastly, referrals should be initiated. A framework was created and implemented. See table 4.

Healthcare Risk Management	1. Healthcare Risk Management will initiate coordination. They will validate essential members are engaged and coordinate accordingly to each respective facility. 2. Data gather information, document provider visits (timeline) 3. Report and document the event occurrence. 4. Established an email notification service.
Obstetrics and Gynecology Physicians	1. Send email to service account for pregnant phantom, pseudocyesis. 2. Report and document event occurrence. 3. Assess and evaluate patients for underlying medical conditions that may contribute to pregnancy symptoms. 4. Complete appropriate diagnostic – urine and blood screening, fetal ultrasound, manual exam. 5. Consider Endocrine, Neurology or Center for Fertility and Reproductive Endocrinology consult. 6. Complete a basic behavioral health evaluation to include screening for suicide, violence, and psychosis. 7. Determine if patient meets mental health commitment criteria or if agreeable for mental health commitment. 8. If a phantom pregnancy is diagnosed, complete a complex care plan. 9. Confirm support systems of patients. 10. Document phantom pregnancy on patient problem list.
Emergency Department	1. Complete basic medical screening 2. Complete basic screening for suicide, violence, and/or severe psychosis (pregnancy loss, further medical work up, or obvious psych overtones) 3. Determine if patient meets mental health commitment criteria or if agreeable for mental health commitment. 4. If commitment identified begin process to admit patient to the emergency psych facility 5. Engage behavioral health services by one of the following: a. ED MD to psych MD telephone consult conversation b. Engage behavior health support or social worker in real time, where available c. If not, refer to community crisis team, double check address and let them know we will reach out.
Behavioral Health Referral	1. Determine if pregnancy loss. 2. Determine if it requires rapid referral for acute psychosis. 3. Determine support services for patient. 4. Notify appropriate law enforcement agency. 5. Allow for dignified exit.

Security	1. Complete an incident event report. 2. Notify the healthcare risk manager in your facility. 3. Consider being on the lookout (BOLO) memo for internal distribution including date of incident, officer name, photo of phantom pregnancy patient, reason for infant security risk. 4. Consider BOLO dissemination to high-risk areas (registration desk, mother-baby units, front desk in the ED, local leadership, local security personnel and expand as needed per security protocol). 5. Revisited BOLO security 6 months to 1 year, criteria to be identified by security. 6. Notify threat assessment team as needed. 7. Security to determine if further notification is required. 8. In severe confirmed cases, notify all surrounding hospitals. 9. Security will provide continued follow up via social media and document concerns within 6-12 months, depending on the severity of the case, this could be done daily, weekly, monthly, or yearly.

Table 4

Discussion

The case studies are best described as examples of the organizational problems inherent in managing rare medical disorders which are not managed by care guidelines involving a variety of specialized caregivers who need to respond as a coordinated team. The result is that the patient is not rendered acute care and the referral for long-term management is not made. Recognizing the potential barriers to a comprehensive assessment may change the outcome of these patients, but currently almost uniform outcome is that the patient is lost to follow up [12].

The major reason that notification of phantom pregnancy was reported to the healthcare risk management program was the fear that these disappointed mothers might overreact, and in their grief, may abduct a newborn from the nursery. Although this outcome is rare, sensational anecdotes have been reported, and one finds pictures of women who have had phantom pregnancy are often found posted throughout the obstetrical floors so that all employees will be aware of the dreaded hypothetical potential.

The literature on phantom pregnancy distinguishes, as we have, between the much more common delusion of pregnancy and the rare case of pseudocyesis in which somatic signs of pregnancy are recognized. As noted, pseudocyesis risks the possibility that obstetrical interventions will be conducted because of the possibility that delayed delivery needs to be corrected. The pathogenesis of physical signs of pregnancy has not been determined for most patients and we have grouped the two disorders together to focus on the organizational response to the delusional pregnant patient whose possible obstetrical problem is not considered and whose behavioral disorder is not adequately addressed. The literature and the histories of our patients confirm that the finding of no pregnancy leads to inadequate social and behavioral outcomes because evidence of therapeutic success is minimal, and recurrence is common [13-15].

Our series is similar to the limited published series 1) young women who welcome their pregnancies, 2) have rarely had full term viable pregnancies, and 3) have romantic relationships [3-5]. All patients' points of entry were the emergency department and significantly half the patients had presented more than once at different healthcare facilities with the same recurring complaints.

Only five had documentation of phantom pregnancy. Meanwhile, four patients were triaged to the labor and delivery suite and caesarian delivery was contemplated in two of these, even though these patients were not pregnant. Their underlying emotional status was not explored or available, but almost all were eager to have a child. Prenatal care was virtually absent in all. Although five had documented phantom pregnancy, there is no documentation of their emotional responses. No other gynecological disorders were found such as trophoblastic diseases, persistent corpus luteum, or endocrine disorders associated with amenities were found and no search was documented. Feigned pregnancy or Couvade syndrome was not entertained.

Although referral to psychiatric or social intervention was recommended most often none was documented and a few visits were soon abandoned. Plans for pharmacological therapy were not documented or concerns for emotional support in conveying the diagnosis or counselling aside from referral for consultation was found in the medical record. Addressing infertility and restoring medication or contraception was not discussed in the medical record and the psychiatric records were not retrieved. As noted, confidentiality was not strictly practiced in that recognizable photos of the patients were sometimes posted as a security precaution. In short, the phantom pregnancy patients were most often left to fend for themselves as they were lost to follow up.

Since the implementation of this process improvement project, 12 new cases of phantom pregnancy were identified and communicated via the new, structured framework. The email notification communicated real time patient presentation and allowed for a multidisciplinary team to review the medical record. The healthcare risk manager and/or obstetric program manager took an informal lead in phantom pregnancy care coordination and communication. The care coordination consisted of the behavior health experts performing a medical records review to determine the patient's history of mental health issues, current care team, and support systems. Their assessment determined whether further interventions, including referrals to behavioral health are warranted. In certain scenarios where phantom pregnancy patients decline behavioral health services, a crisis intervention unit was mobilized to conduct wellness checks at the patient's residence providing an additional layer of support and safety. This service enhances the care provided to patients experiencing phantom pregnancies and aligns with best practices in risk management and patient centered care.

The preliminary data found in table 3 indicates a significant improvement in phantom pregnancy identification and behavioral health engagement. Despite the multiple efforts by the behavioral health team, opportunities remain in fostering long term mental health support.

Conclusion and Recommendation

In conclusion, strides have been made in the care of the phantom pregnancy patients since the implementation of this improvement project. The structured framework has increased the behavioral engagement and reduced transfers to labor and delivery suite. Since the implementation of this project, the number of patients screened and labeled an infant security risk with a BOLO were more closely scrutinized and the number of BOLOs decreased. The multi-disciplinary team is committed to continuing this successful initiative. Recommendations include adopting and refining a structured framework for these unique patients. This would include regularly scheduled multidisciplinary team meetings and an emphasis on individual assessment.

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