Delusions of Pregnancy

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We report five cases of delusions of pregnancy of whom three were women and four had chronic schizophrenia. We draw the attention of clinicians to this symptom which is not as rare as has previously been thought.
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The literature on delusions of pregnancy is scanty (Shankar, 1991; Bitton *et al*, 1991), with the total number of cases reported in English being only 15. The first case of a delusion of pregnancy was reported by Esquirol in the 19th century (Jenkins *et al*, 1962). Delusions of pregnancy have been reported in a wide variety of organic psychiatric conditions (Jenkins *et al*, 1962; Chaturvedi, 1989) and functional psychiatric conditions (de Pauw, 1990; Milner & Hayes, 1990; Miller & Forcier, 1992; Shankar, 1991). Delusions of pregnancy have been reported more commonly in men than in women (Jenkins *et al*, 1962; Chaturvedi, 1989; Miller & Forcier, 1992). Delusions of multiple pregnancies and deliveries have also been reported (Chengappa *et al*, 1989).

Delusion of pregnancy has to be distinguished from:

(a) pseudocyesis, characterised by the conviction of a non-pregnant woman that she is pregnant, in association with the development of the signs and symptoms of pregnancy
(b) simulated pregnancy, when a person professes to be pregnant knowing he or she is not
(c) pseudopregnancy caused by a tumour creating endocrine changes suggestive of pregnancy (Hardwick & Fitzpatrick, 1981)
(d) Couvade syndrome, where a man develops symptoms of pregnancy when his wife becomes pregnant but knows that he is not pregnant.

Some authors consider that in pseudocyesis the conviction of pregnancy is not invariably associated with the somatic manifestations of the gravid state (Cohen, 1982; de Pauw, 1990), and hence some cases of pure delusional pregnancy have been reported as pseudocyesis (de Pauw, 1990; Milner & Hayes, 1990) and vice versa (Bitton *et al*, 1991).

We report five cases of delusions of pregnancy which occurred over a period of six months in a 175-bed psychiatric hospital.

Case reports

Case 1

B was a 39-year-old, single, female schizophrenic patient with treatment-resistant psychotic symptoms including delusions of pregnancy of 20 years' duration and amenorrhoea for the previous 18 years. On examination she was convinced that she had a triplet pregnancy – two boys and a girl – of four months gestational age. She reported that they moved about inside her abdomen and also talked to her. When she was 19, her dancing partner kissed her and she believed that he had been repeatedly impregnating her by means of the same kiss. Regarding her previous pregnancies she believed that their father did not want her to deliver them and hence he 'withdrew' them. She did not have any physical symptoms of pregnancy other than amenorrhoea and attributed this to the 'supernatural nature' of the pregnancy.

Case 2

C was a 52-year-old married, nulliparous, female long-stay patient with schizophrenia of 23 years' duration and amenorrhoea for many years. She presented to the antenatal clinic complaining of morning sickness and insisted that she had conceived for the second time. A year before this presentation she had claimed to be pregnant and nine months later reported that she had given birth to two babies. She had no physical symptoms other than amenorrhoea and had no evidence of morning sickness.

Case 3

D, a 65-year-old mother of four with a 17-year history of manic–depressive illness, was readmitted with a relapse of mania. She had attained menopause at age 45. The day after her admission she demanded an antenatal examination as she believed herself to be pregnant. She said she became "aware" of the pregnancy six months before admission when she had a "pregnant sensation in her tummy". She also maintained somewhat in contradiction to the above that she had been pregnant for the previous 20 years, that is since she had stopped menstruating. Her husband had died 22 years previously, and she has never had any sexual contacts since. She did not know how she became pregnant and she expected to deliver when she had labour pains. This delusion subsided along with the manic symptoms after a period of three weeks.

Case 4

E, a 41-year-old single man with schizophrenia had been persistently psychotic despite treatment. Two months after

after a homosexual contact, he developed the delusion that he was pregnant. He argued that anyone could become pregnant following sexual contact with men. This delusion disappeared after three weeks, although other psychotic symptoms including including bizarre delusions persisted.

Case 5

F, a 38-year-old single man with schizophrenia of 14 years' duration, became convinced that he was pregnant. He refused to discuss the details because he felt he had the right to withhold personal information. He also demanded an antenatal check-up. He was maintained on the same medication and when interviewed a week later he stated that no man could ever become pregnant.

Discussion

This is the largest series of cases of delusions of pregnancy reported. Most of our patients were women as opposed to the trend in the literature. One of our cases (case 1) had a delusion of pregnancy for the past 20 years: the longest durations reported previously were a case of intermittent delusions of pregnancy (de Pauw, 1990) and a case of a shared delusion of pregnancy (Milner & Hayes, 1990), both of ten years' duration. There has been only one report of retrospective delusion of pregnancy (Chengappa *et al*, 1989), where the delusion was backdated to a year. One of our patients (case 2) backdated her delusion of pregnancy to 20 years. In the two men reported here, the delusion of pregnancy constituted a short event in the course of their chronic schizophrenic illness.

The aetiology of delusion of pregnancy is likely to be heterogeneous. Contrary to earlier reports, most of our cases had chronic schizophrenia with symptoms resistant to drug treatment. Their delusions could not be attributed to factors such as psychodynamic conflicts (Jenkins *et al*, 1962) or contact with pregnant women (Miller & Forcier, 1992). None had any clinical evidence of organicity (Chaturvedi, 1989).

In the literature the suggested aetiology of delusion of pregnancy and pseudocyesis was similar. De Pauw (1990) and Milner & Hayes (1990) suggested that, in psychotic patients, neuroleptic-induced hyperprolactinaemia, galactorrhoea and intestinal dilatation may stimulate, confirm, and reinforce the desire, fear, or belief of being pregnant. The delusions in both conditions have been attributed to misinterpretation of somatic sensations (Chengappa *et al*, 1989; Bitten *et al*, 1991). Both conditions were seen as possibly being due to monosymptomatic hypochondriacal psychosis (de Pauw, 1990), loss of love or loss of a loved object (Shankar, 1991), or mental handicap (Jenkins *et al*, 1962; Chaturvedi, 1989).

Some of the aetiological factors suggested for pseudocyesis were present in our cases of delusion of pregnancy. The origins of the delusion in pseudocyesis have been traced to chronic social deprivation (Hardwick & Fitzpatrick, 1981). Four of our cases were long-stay patients, the only short-stay patient (case 3) was widowed and three of them were unmarried. Cohen (1982) suggested that pseudocyesis is found especially in societies where there is much cultural pressure on women to have children. Among the three women in our series, two were childless and hence this might have been relevant for them.

Pseudocyesis has been attributed to hysteria, wish-fulfilment, neglect by parents, projection (Hardwick & Fitzpatrick, 1981), and rebirth fantasy (Jenkins *et al*, 1962). None of these factors seemed to be important in our cases.

One should be cautious in accepting the above factors as contributing to the delusion of pregnancy: in four out of five of our cases this was only one of many delusions present.

Despite apparent overlap in aetiology and phenomenology, a clinical distinction between pseudocyesis and delusion of pregnancy based on the presence or absence of physical signs and symptoms of pregnancy is possible (Hardwick & Fitzpatrick, 1981). Only by maintaining such a distinction will we be able to further elucidate and clarify the phenomenology and aetiology of these related but different phenomena. It seems that this interesting phenomenon, though not common, is not as rare as previously thought.

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References

BITTON, G., THIBAUT, F. & LEFEVRE-LESAGE, I. (1991) Delusions of pregnancy in a man. *American Journal of Psychiatry*, **148**, 811–812.

CHATURVEDI, S. K. (1989) Delusions of pregnancy in men. *British Journal of Psychiatry*, **154**, 716–718.

CHENGAPPA, K. N. R., STEINGARD, S., BRAR, J. S., *et al* (1989) Delusions of pregnancy in men. *British Journal of Psychiatry*, **155**, 422–423.

COHEN, L. (1982) A current perspective of pseudocyesis. *American Journal of Psychiatry*, **139**, 1140–1141.

HARDWICK, P. J. & FITZPATRICK, C. (1981) Fear, folie and phantom pregnancy: pseudocyesis in a fifteen year-old girl. *British Journal of Psychiatry*, **139**, 558–562.

JENKINS, S. B., REVITA, D. M. & TOUSIGNANT, A. (1962) Delusions of childbirth and labour in a bachelor. *American Journal of Psychiatry*, **118**, 1048–1050.

MILNER, G. L. & HAYES, G. D. (1990) Pseudocyesis associated with folie á deux. *British Journal of Psychiatry*, **156**, 438–440.
MILLER, L. J. & FORCIER, K. (1992) Situational influence on development of delusions of pregnancy in a man. *American Journal of Psychiatry*, **149**, 140.
DE PAUW, K. W. (1990) Three thousand days of pregnancy: a case of monosymptomatic delusional pseudocyesis responding to pimozide. *British Journal of Psychiatry*, **157**, 924–928.
SHANKAR, R. (1991) Delusion of pregnancy in schizophrenia. *British Journal of Psychiatry*, **159**, 285–286.

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Seasonal Affective Disorder, Environmental Hypersensitivity and Somatisation

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An association between seasonal affective disorder (SAD) diagnosed according to DSM-III-R criteria and 'environmental hypersensitivity', candida hypersensitivity, and food allergies is reported in two patients. It is suggested that patients with somatisation disorder may present with symptoms of SAD and other media-popularised diagnoses in a form reminiscent of the cases of multiple media-popularised diagnoses.
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Seasonal affective disorder (SAD) is a variant of bipolar affective disorder first described by Rosenthal *et al* (1984). The syndrome is characterised by seasonal fluctuations of mood, with winter depressions and mild spring hypomania. According to DSM-III-R criteria (American Psychiatric Association, 1987), there must be three episodes of major depression occurring in the winter and two of these should have occurred in consecutive winters; in addition there should only be one episode of depression in the summer for every three years.

The depression is often associated with several atypical vegetative features, namely somnolence, fatigue, carbohydrate craving with weight gain and evening worsening of mood. Although the pathophysiology of SAD is unknown, recent hypotheses have concentrated on neuro-humoral changes (Checkley *et al*, 1989). SAD has, in recent years, attracted considerable attention in the media as a form of depression which its proponents consider common, easily treated and of predominantly organic aetiology.

Environmental hypersensitivity ('total allergy syndrome' or '20th century disease') is characterised by multiple physical symptoms, whose features often change over time. The symptoms range from mild gastrointestinal and respiratory complaints, to headache, fatigue, irritability and depression. When severe, a sufferer may be unable to lead a normal existence, believing that they are at constant risk of having life-threatening reactions to a range of common substances including foods, solvents, clothing, water and air.

Those affected may seek help from clinical ecologists who treat them with special diets, and various desensitising regimes. The entity has attracted considerable controversy in the lay and scientific literature alike, and many have questioned its validity (Brodsky, 1983; Stewart & Raskin, 1986; Stewart, 1990; Howard & Wessely, 1993).

Candida hypersensitivity syndrome is likewise associated with multiple symptoms supposedly caused by a weakening of the immune system by *Candida albicans*. Patients with this illness are generally treated with a range of antifungal medications and special diets (American Academy of Allergy and Immunology, 1986). The syndrome has likewise been criticised for its lack of scientific validity (Stewart, 1990).

Stewart & Raskin (1985) interviewed 18 patients with environmental hypersensitivity and made psychiatric diagnoses for all 18. The most common group of diagnoses were the somatoform disorders, in particular somatisation, although three patients