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PSYCHOGENESIS OF PSEUDOCYESIS

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INTRODUCTION

Fifty years or more ago clinicians and medical writers gave much more attention to pseudocyesis than now. During the interim an extremely interesting subject which impressively exemplifies the influence of emotional mechanism on physiological processes has fallen into neglect. Current obstetrical and gynecological literature is almost barren of it. The condition has been known since the time of Hippocrates, but very little is known concerning the psychosomatic mechanisms involved in production of the symptom complex. In the past many physical and physiological theories have been propounded in an attempt to explain the condition. More recently with the increased acceptance and usage of a psychiatric approach to the problem, new ideas which, though inadequate in their attempts to regard pseudocyesis as a uniform entity with one explanation, are quite varied and interesting. Most authors have been satisfied to attribute the condition to wish-fulfillment, fear, or guilt, et cetera, without giving adequate reasoning for their deductions. Several cases within the last decade, although limited in number, have been studied extensively psychiatrically. The following pages contain a brief review of the literature on pseudocyesis and its discussion as an ego defense mechanism with selected cases for illustration in an attempt to show how the condition arises from one basic repressed desire, the purpose of this paper in addition being that the

author, through its preparation, as well as anyone who may subsequently read it, become familiar with pseudocyesis but, primarily, gain a better understanding of psychodynamic principles so that these principles may be utilized to greater advantage in the diagnosis and comprehension of functional medical problems, and in the promotion of better patient-physician relationships through knowledge of mental processes.

DEFINITION

The term pseudocyesis needs clarification since it has been used somewhat loosely and synonymously with such terms as false pregnancy, hysterical pregnancy, imaginary pregnancy, nervous pregnancy, phantom pregnancy, phantom tumor, pseudo-pregnancy, spurious pregnancy, and tympanites. Bivin and Klinger(2), who have made an extensive study of the subject and use the term pseudocyesis and spurious pregnancy synonymously, define it as ". . . a condition in which the signs and symptoms of true pregnancy are simulated in whole or part." The French have coined the term "Grossesse Nerveuse" which has enjoyed much usage in the American as well as in the French literature. Dunbar (4) defines grossesse nerveuse as a condition in which the patient firmly believes she is pregnant and develops objective signs and symptoms in the absence of pregnancy. In her definition she excludes (a) hallucinatory pregnancy in psychoses, or unconscious pregnancy fantasies in which the patient is not aware of the meaning of the symptoms and, (b) cases in which pregnancy is represented by tumors with endocrine

changes. The term enjoying the greatest popularity as used and defined by Bivin and Klinger is all inclusive, disregards the physical or mental condition of the patient, and excludes only those cases of simulated pregnancy in which the patient knows she is not pregnant but deliberately and consciously tries to deceive.

OBSERVATIONS

An observation of the literature shows that the incidence of pseudocyesis is decreasing in frequency. Bivin and Klinger have collected 444 cases with a bibliography dating from the early part of the 18th century to 1937. I have been able to find only 19 cases reported since 1937 in the American and British literature available in this library. These were reported by Goldberg and Schatz (6), Jacobs (7), Moulton (12), Rutherford (15), and Steinberg (16). This decrease may be due to lack of interest in reporting, dismissal of the patient as a neurotic or psychotic after confirming the diagnosis, or an actual decrease in the frequency of the cases due to better and earlier sex education of the general public.

Bivin and Klinger have compiled some interesting data in their excellent monograph which are worthy of mention. They found that amenorrhea was the most frequent symptom, ranging from scanty menses to complete amenorrhea for a nine-month duration. Amenorrhea was permanent, of course, in the menopausal patients. In 52 of the 444, menses were regular. The next most frequent symptom was abdominal enlargement. Of significance is the fact

that regardless of the size of the abdomen, the umbilicus was never reported effaced, which Rutherford considers a diagnostic criterion. The physical mechanisms for the production of the abdominal enlargement have been listed as excess fat deposition, tympanites, retention of urine or feces, and forceful contraction of the diaphragm forcing the abdominal viscera downward and outward.

The third most frequent symptom and commonly the most convincing subjective symptom was the sensation of fetal movements. Usually quickening was felt between the fourth and fifth month, but in some cases it was felt immediately after pregnancy was suspected. Increased intestinal motility could be mistaken for fetal movements by the patient and the latter simulated by violent contractions of the abdominal muscles.

Breast changes which included swelling and tenderness, secretion of milk and colostrum, pigmentation and increased size of the papillae were varied in degree and were more frequent in multiparae than in nulliparae. This suggests that previous experience or knowledge of the signs and symptoms of pregnancy were necessary for the patient to simulate them. Gastrointestinal symptoms with nausea and vomiting, pica, constipation, and occasionally impaction were observed. Some patients had severe labor pains lasting maybe for several days.

The duration of the symptoms varied. In 43% they lasted nine months. Four cases were listed in which the symptoms lasted

seven, eight, nine, and eighteen years. The ages of the patients ranged from seven to seventy-nine with the average peak incidence between the ages of thirty and thirty-five. Many had previous pregnancies and some had living children. Twenty-three had pseudocyesis more than once, and one case noted went through the symptom complex regularly every nine months from marriage until death. Most of the patients' convictions of pregnancy were shaken when nine months had passed without delivery of a child. Only a few went on to frank mental degeneration.

Twenty-two percent were menopausal and eighty-three percent were married. The social and economic status was widely varied as were their levels of intelligence. These observations are contrary to Paddock (14), who believes that most cases occur at the climacteric in women with low intelligence and poor social and economic positions. Bivin and Klinger were unable to find a characteristic or group of characteristics in these patients that could be separated out as a necessary concomitant of pseudocyesis. None of the cases reported since 1937 have been contributory in that respect either.

ETIOLOGY

Many etiological theories have been propounded in an attempt to explain the condition beginning chronologically with physical factors, such as flatus or air in the womb, with a gradual trend toward hysteria as an explanation. In recent years the emphasis has been placed on psychogenic factors, endocrine dyscrasias, and

the psychosomatic interrelationships of both. Dunbar discusses the psychosomatic mechanism in pseudocyesis and states that the endocrine changes are secondary to the emotional.

> Without endocrines, some symptoms (pigmentation, chloasma, breast changes) could not occur. The fast disappearance of the syndrome with information that there is no pregnancy indicates that the endocrine changes are psychogenic. They are only the mechanisms by way of which certain of the symptoms are produced, not the cause of the symptoms. If they were the cause, the fast disappearance of the symptoms following information given to the patient could hardly be understood. Furthermore, although endocrine disturbances as such could, of course, produce certain symptoms of pregnancy, an endocrine disturbance is hardly likely to produce precisely the series of physiologic changes which, taken singly, are meaningless, but coordinated give the picture of pregnancy.

The emotional stability of women subject to pseudocyesis is a topic that has caused much comment and aroused differences of opinion. The psychological components in these women have been noticed by most authors in their case reports, but the emphasis has been placed on signs, symptoms, progress, diagnosis, and treatment with little reference to pertinent mental and environmental factors which were undoubtedly present. Consequently, an attempt to compile a statistical analysis of psychogenic factors and personality variations seen in these cases would be difficult as the great majority of cases were not studied adequately with a psychiatric approach.

Many emotional disturbances are seen, however, which suggest various types of psychopathological conditions. Montgomery (10) cites the well-known case of Johanna Southcott, a 64-year-old vir-

gin prophetess who developed pseudocyesis, believing herself pregnant by the Holy Spirit. Another case of his was unusually happy during her period of false pregnancy but became extremely despondent when told of her condition. Another patient after learning that she was not pregnant remained in the house for almost a year. Mary Tudor, queen of England, developed pseudocyesis and, during the period of her false pregnancy, her favorite pastime other than attending mass was sitting and counting on her fingers the number of months "she was gone." Nicoll (13) had a case that threatened suicide when she learned that there was no pregnancy. Another case, reported by White (17), was distressed and wished for death. Keiser (9) had a case whose disappointment was so great that she later died in a hospital for the insane. The above cases suggest psychoses, some depressions and others schizophrenia.

Most of the writers classify the condition as conversion hysteria. Blyth (3) reports a case of simulated pregnancy in a male which was hysterical in nature and corresponded with the wife's pregnancy. This case was precipitated by an unfortunate environmental situation and was cured when the stress was removed. Hysterical substitutions are seen in some. Morton (11) reports a case in which an operation was performed in a patient for a tumor of spurious pregnancy with the return of all the symptoms after complete healing of the wound.

Paddock states that practically all patients with pseudocyesis

have mental and emotional changes, and that occasionally pseudocyesis is an outstanding delusion in a psychosis. Some patients even feign a miscarriage to prove they were pregnant. He believes that some of the cases are hysteria and that hysteria is frequently seen to simulate any condition, but that it is difficult to explain pseudocyesis on that basis. He grouped his patients into three categories: (a) the young female who, as a result of illicit intercourse or recent marriage, acquires a fear of pregnancy and develops symptoms by suggestion forced upon her by the mother, (b) older females who are desirous of pregnancy, especially after remarriage and who, he states, simulate pregnancy much better than the younger patients and are more difficult to disillusion, and (c) cases in which pseudocyesis is superimposed on an amenorrhea of organic origin such as the menopause in an attempt to prove fertility and youth. He was the first writer to discuss etiology on the basis of an emotional conflict between the inherent maternal instinct and the limiting forces of reason, past experience, and environment.

From their collection of cases in which there was suggestion of or definite reference to emotional factors, Bivin and Klinger compiled a list of what they called, for lack of a better term, psychogenic etiological factors. The list consists of wish, fear, hysteria, neurotic symptoms, suggestion and auto-suggestion, self-punishment, indifference, something to be gained, rather not have child, and delusions. They concluded that the condition was a

psychoneurosis best classified as an hysteria with the most common characteristic being the woman's own conviction of pregnancy associated with a history of organic or social factors suggestive of pregnancy. They presented no new ideas to explain how the symptom complex develops. Prior to his death, however, Bivin was working on a hypothesis that pseudo-pregnancy, a normal state in the menstrual cycle, becomes pseudocyesis, an abnormal state, due to an imbalance in the hormones which regulate the former phenomena brought about by physical or emotional changes or a combination of both.

Rutherford reported seven cases and added no new ideas but was impressed by the manner in which these patients resist a negative diagnosis and the iatrogenic factor as a powerful agent in precipitating the symptom-complex by a mistaken diagnosis confirming the patient's suspicions.

Moulton studied a case of pseudocyesis in detail with a psychoanalytical approach. The patient was an unmarried 17-year-old girl who did not know from where babies come. Unconsciously she had a strong oedipal attachment to her father, resentment toward and desire to rival her mother, fear of sexuality, and a desire to have a baby of her own. Her past life is best summed up by her own description that she had been a "Cinderella." Consciously, she felt that she could get even with her sisters and get away from home. She was diagnosed as a conversion hysteria.

Jacobs states that the authors who stress psychopathology

have been satisfied to attribute the condition to wish-fulfillment, but that there are many women who desire pregnancy but few who develop pseudocyesis. Therefore, she feels that wish-fulfillment can result in this syndrome only under certain conditions still to be defined. Two cases were studied, both patients at the climacteric. The first developed pseudocyesis on the background of involutional depression. The patient's whole life had been characterized by sexual repression and an abnormal fixation and subordination to the mother. She recovered completely with electroshock therapy. The other patient developed pseudocyesis on the background of paranoia. Her life also was characterized by sexual repression. The delusion that she was pregnant arose from a delusion that she had had sexual union with a movie star. Both patients had histories of stillbirths and miscarriages which acted as mental trauma. Jacobs concluded that there are a variety of environmental factors predisposing to the formation of the idea of pregnancy and that the completeness of the syndrome depends on the condition of the reproductive system and the extent to which the idea takes possession of the whole personality. In some cases the physical symptoms are primitive with a full psychopathological syndrome evident. In others, especially younger women, the emphasis is placed on the physical signs, while the mental components remain more latent. This last statement by Jacobs may be the reason that many of the mental symptoms in these patients have not been recognized and why these patients have not been followed up to observe

how they solved their emotional conflicts after pseudocyesis could no longer be employed.

DISCUSSION

In the beginning of my discussion, I think that it is safe to state that no one with present day medical knowledge can question the conclusion that pseudocyesis is psychogenic in origin. The general characteristics of psychoneurotic and psychotic symptoms are their irrationality, disconnectedness, and regressive nature. It is certainly irrational for a person to show signs and symptoms of pregnancy in the absence of it. Signs and symptoms of pregnancy in the presence of conscious fear of pregnancy as in the case of a young unmarried woman after illicit intercourse illustrates the disconnectedness. The neurotic temperament of many of these women illustrates the elements of regression. Alexander (1) states that the regressive nature of conversion symptoms is difficult to prove but they are the revival of early traumatic experiences which have been repressed, and this is well illustrated in the case reported by Moulton.

Psychotic symptoms, in contrast to neurotic symptoms, are not always disconnected as in delusions which Alexander defines as ". . . attempts to create imaginary situations in which the symptoms appear rational and acceptable." Delusions appear irrational to everyone except the patient because of his ego impairment or "lack of insight." This is seen in pseudocyesis by the patient's frequent offense and inability to accept a negative diagnosis of pregnancy. Pseudocyesis, then, is not a psychopathological entity, per se, but a symptom or symptom complex, depending on the number

of signs and symptoms present, and only an attempt on the part of the patient to preserve the ego regardless of the characteristics of underlying mental disease which may be present.

That pseudocyesis, the symptom, is hysterical can be illustrated easily. Hysterical symptoms have a double symbolic meaning. They express both a wish and its rejection. In more common forms of hysteria the denial of the wish is more conspicuous. In pseudocyesis, however, its fulfillment is in the foreground with the rejection appearing symbolically. A common symptom in young hysterical girls based on the widespread infantile fantasy of oral impregnation (Kisch reports a case of pseudocyesis in a young girl after being kissed by a man) is hysterical vomiting. Vomiting, however, may be rejection of any alien desire and an expression of disgust. In pseudocyesis the wish to produce offspring is obvious and the rejection of the wish is symbolized by vomiting.

Wish-fulfillment has been demonstrated in many of the patients with pseudocyesis and plays an essential part in its development. The explanation of the condition on the basis of desire has been attributed to many causes, from the desire to have offspring per se, possibly to prove fertility and youth, to the benefits of secondary gains such as special favors, attention, hold an unfaithful husband, or to have an heir. Pseudocyesis as an attempt to deny homosexuality has never been suggested. The condition might be explained on the basis of desire and secondary gains; however, it is extremely difficult to draw a sharp line between the early

dependent desires of patients and their secondary exploitation of their illness to satisfy dependency needs. This is shown in the case reported by Moulton. The nearest thing to a secondary gain in this patient was the severance of parental ties. This was only a protest of her dependency needs and an expression of her rejection of her parents' oversolicitude of which she had been the victim all her life. Her gain, then, was an essential part of the basic structure and motivations producing her neurotic illness, and pseudocyesis was only the manner in which she solved her conflict.

Fear also plays a part in the development of pseudocyesis but, in contrast to wish fulfillment, deals with secondary suffering. A distinction must be made between fear of pregnancy per se, and fear of the secondary suffering in pregnancy such as limitation of activity, discomfort, unattractive appearance, pain associated with labor and delivery, and in the unmarried, loss of social position and respect. Fenichel (5) states that no one becomes neurotic for the purpose of suffering, but that the suffering is a constituent part of the neurosis. Fears in pseudocyesis, then, since they arise from repressed memories of painful past experiences, are utilized in this neurotic illness as a mechanism for contributing to the relief of guilt, thereby making the gratification alien to the ego possible, whether they be recognized consciously by the patient as fears of pregnancy, or fears of the withheld dependency

needs secondary to pregnancy.

Secondary suffering from withheld dependency needs in the relief of guilt can be illustrated in the case of a young unmarried girl who has violated the prohibited sexuality, either in real life or in fantasy, and develops pseudocyesis. She not only expresses her unconscious desire, but also atones for her transgression. This illustrates the masochistic element. The same case serves to illustrate the sadistic element as well, since she expresses hostility toward her parents and siblings whose social position is threatened as a result of the manner in which she solves her emotional conflict, pseudocyesis.

Fears, although they are present, may not need to be expressed consciously at all by the patient as she may be entirely happy with the whole situation and appear impassive and unemotional. This illustrates what the French call "la belle indifference" in which the symptom releases the entire emotional charge of the unconscious tendencies. In these patients, the actual suffering from the withheld dependency needs serves to relieve the guilt for the expression of the unconscious wish. In either case, pseudocyesis symbolically serves to express the repressed desire and at the same time serves as the mechanism by which suffering is provoked to relieve guilt and solve the emotional conflict.

Suggestion and auto-suggestion may be one of the precipitating factors in the chain of events leading to pseudocyesis in susceptible individuals. An example is an amenorrhea from any cause

giving the woman an idea that she might be pregnant. The iatrogenic factor in precipitating any symptom is well known. Suggestion used in conjunction with hypnosis has been used successfully in the treatment for removal of the symptoms in pseudocyesis. A case of interest illustrating auto-suggestion and how the unconscious mind makes no distinction between a repressed act and a repressed desire to commit an act is reported by Wilbur (18). This was a case of a middle-aged maiden lady who developed pseudocyesis after dreaming that a man entered her room while she was asleep, gave her chloroform, and then sexually abused her while under the anesthetic. This case in addition illustrates the sleep protective function of dreams and the ego defense mechanism of projection. Her unconscious wish to have sexual relations could not be expressed simply by dreaming of having coitus since a direct expression of such an alien desire would cause conflict, arouse fear and guilt, and awaken her. Her desire was disguised in the dream by projection of a part of her personality represented by a stranger. By this mechanism the unconscious desire was expressed and the conflict with the conscience was avoided. This dream also illustrates the immaturity in this case as simple wish-fulfillment dreams are more commonly seen in children.

The nature of a neurosis or psychosis is determined by the nature of the defenses the ego chooses for its protection. Jacobs stated that in some cases the emphasis is placed on physical signs

with the mental components latent, while in others the physical symptoms are primitive with a full psychopathological syndrome present. This accounts for the fact that there is evidence to illustrate all degrees of mental degeneration in patients developing pseudocyesis.

At this point I pose the question whether a blunt statement to a woman of extremely neurotic character relative to a negative diagnosis of pregnancy immediately after its confirmation is always the procedure of choice.

In conclusion, then, into what classification in the nomenclature of mental disease the patients developing pseudocyesis fall is doubtful. It is also difficult to conclude whether or not these patients exhibit a basic personality type. It can be concluded, however, that the condition arises from the same source in all the patients. The desire to express the inherent instinct of race preservation plus the social and environmental forces inhibiting the expression of that instinct as one of the basic contributing factors to all psychopathology cannot be denied. Pseudocyesis serves as an excellent, undisguised example.

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