DE CLERAMBAULT SYNDROME (EROTOMANIA): A REVIEW AND CASE PRESENTATION

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A syndrome which was first described by G.G. De Clerambault in 1885 is reviewed and a case is presented. Popularly called erotomania, the syndrome is characterized by the delusional idea, usually in a young woman, that a man whom she considers to be of higher social and/or professional standing is in love with her. She develops an elaborate delusional process about this man, his love for her, his pursuit of her, and her inability to escape his "affectionate clutches." This syndrome may persist for a period of a few weeks to a few months in the recurrent form and be replaced by a similar delusion about another man. In the fixed form, which is the example of the case being presented here, it may persist for several years. The patient presented here has experienced this syndrome for eight years; there are reports in the literature of persons maintaining the syndrome for longer than 25 years.

Patients with this syndrome may be diagnosed as having paranoid vera or other forms of paranoid disorder, or as paranoid schizophrenic. In light of the overwhelming nature of the delusional process affecting this patient's total life experience with marked delusions of persecution, grandeur, jealously, and self-deprecation as well as ideas of reference (illusions), and agitated and sometimes bizarre behavior, it seems quite appropriate that her diagnosis may be termed schizophrenic reaction, paranoid type.

The literature is surveyed in depth and the case is presented in sequential detail.

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De Clerambault, a French psychiatrist, described in 1921 a syndrome he termed "psychose passionelle."[1] It has been referred to in such exotic terms as phantom lover syndrome, psychotic erotic transference reaction, and delusional loving,[2,3] erotomania,[4] melancholie erotique,[5] and amor insanus.[6] This syndrome generally occurs in women, although it has occasionally been reported in men.[1,7,8] It consists of a specific delusion in which the patient believes that a man, who is generally of higher social status and chronologically older, is intensely in love with her.

De Clerambault believed that the delusion evolved from a fundamental assumption which he regarded as the essential basis of the whole syndrome. The assumption is that it is the patient's love object who loves the most or who alone loves. In other words, the patient imputes intense love to another person while the patient preserves a sense of innocence. De Clerambault further delineated a number of supporting delusional beliefs that the patient gradually subsumes. Secondary themes, regarded by the patient as obvious, are that the love object cannot obtain happiness without the patient, that the love object cannot be complete without the wooer, and that the love object is free or available or, if married, the marriage is considered null and void.

Secondary themes which can be demonstrated are the continual vigilance and protection of the love object, the overtures of love delivered by the love object, the indirect conversations the patient has with the love object, the phenomenal resources at the disposal of the love object to meet the insatiable demands of the patient, the almost universal sympathy aroused in others by the current "romance," and the paradoxical and contradictory conduct of the love object. De Clerambault reported that these postulates are rarely found together but that the last one, termed "paradoxical conduct" is never lacking and is of major importance. The paradoxical conduct is often rationalized by the patient as due to pride, timidity, doubt, jealously, a test of love, the love object's social or business position, etc.

De Clerambault divided the syndrome into two types: pure or prodromic and secondary or superadded. In the pure cases, he found that the erotomania existed alone. It is the whole psychosis; the origin of all ideas is passionate, the delusion is only the development of the first assumption. There are no global and absurd megalomaniac conceptions, no retrospection, no hallucinations. In the secondary cases, he found the erotomania to be associated with other psychoses and the delusion to be less intense. The defining characteristics distinguishing between the two forms are that the pure or prodromic type has a sudden, explosive onset in an otherwise state of clear consciousness. The secondary type has a gradual onset, is associated with other deliriums, is not as clearly defined, and is less intense. Most authors agree with De Clerambault that there are two clearly distinguishable types and some have altered the nomenclature and added other criteria for the differentiation. Seeman,[9] for example, divides the syndrome into "fixed" and "recurrent" types, of which the fixed is reported to be the more serious. The delusion is constant and can last the lifetime of the patient despite repeated confrontations with reality. It often occurs in poorly integrated women who are dependent, timid, and unpredictable. They tend to have little heterosexual experience, generally feel inferior to others, and often choose a "lover" who is seen as ordinary. These patients are usually diagnosed as schizophrenic. The second group Seeman describes are less psychiatrically ill and fulfill the diagnostic criteria of erotomania proper. The delusions are fairly short-lived but intense and recurrent, elicited repeatedly by individuals who fulfill certain criteria. They tend to select "lovers" who are powerful and prominent. These women are healthier, more sexually active, aggressive, and impulsive. They imagine that they are loved for several months and then finally renounce the "lover" and start again with another "lover." For the fixed group, Seeman reports that the delusion serves as a defense against low self-esteem, sexuality, and external aggression. For the recurrent group, the delusion is seen by Seeman as a defense reaction against homosexual doubts and feelings of competitiveness or resentment. It may also be an attempt to incorporate power and success into one's own self-image.

HISTORY

De Clerambault was the first to delineate features methodically and to isolate the syndrome. However, he was not the first to describe it. Rather[10] has traced its origins back to Hippocrates' diagnosis of Perdiccas, and to a case treated by Erisistratus and recorded by Plutarch. Rather[10] also mentions the Parisian physician Bartholomy Pardoux (1545-1611) who discussed the pathology of love in his book, *Disease of the Mind*, and distinguished between uterine furors (nymphomania) and insane love (erotomania). It was also referred to by Jacques Ferrand in 1623 in a treatise on maladie d'amour or melancholie erotique.[5] Kraeplin[11] described a typical case, in the same year as De Clerambault, which he regarded as a form of paranoia. De Clerambault described five cases and referred to a sixth. In 1956, the condition was again brought to psychiatric attention when Balduzzi[12] described the case of an unhappily married woman who imputed an ardent passion to the married doctor who attended her abortion. Arieti and Meth[13] briefly reported a case in 1959. Enoch, Trethowan, and Barker[6] reviewed the earlier literature and added three more cases. Haynal[14] discussed the treatment problems posed by a patient with erotomania. Pearce[15] described a case in which De Clerambault and folie a deux syndromes were combined. Sims and White[16] described a patient with both De Clerambault and Capgras syndromes in which the delusions cleared over a period of a few weeks. Raskin and Sullivan[17] presented two cases in 1974, one in which the patient thought her therapist was in love with her, and one in which the woman believed her psychiatrist was in love with her. Hollender and Callahan[18] reported four new cases and referred to another. Sims and Reddie[19] described a second case of De Clerambault associated with the Capgras syndrome and report on a ten-month follow-up that the hallucinations and delusions had cleared. In 1977, Greyson and Akthar[8] reviewed a case of erotomania in a mentally retarded patient. Seeman[3] discussed the two varieties of De Clerambault syndrome and presented eight new cases. Doust and Christie[7] also presented eight cases. Goldstein[20] reviewed the legal perspective of a patient brought to court and discussed the case briefly.

INCIDENCE

The incidence of erotomania is not known. It does not appear to be confined to any one culture, society, continent, age, sex, race, or socioeconomic status. It has been published in European, American, Canadian, Scandanavian, Russian, and Asian literature. Probably, it is often not recognized as a distinct syndrome and is consequently classified under one of the larger psychiatric categories. Nor do all of the persons with this syndrome come to the attention of mental health professionals. Typical cases have been described in court proceedings and newspaper accounts. Doust and Christie[7] report 20 recent cases, including the 15 cases discussed by Enoch et al.[6] It would probably be safe to assume that the total number of cases existing in scientific world literature is less than 100. Pearce[15] states that "with the revolutionary sociocultural changes that have taken place in the Western world over the last half-century with the far greater freedom of expression in sexual matters...it seems likely that this particular syndrome will become an even greater rarity than it is at the moment." Considering the number of cases reported since 1972, this statement appears to be, at best, doubtful. Interest appears to be rising and the number of reported cases will probably continue to increase as long as that interest is maintained.

TREATMENT

De Clerambault cases are rare, sporadic, colorful, and interesting, and have, with very few exceptions so far, eluded effective treatment. In 1883, Winslow[21] described a case of erotomania in which "the cure was, apparently, a perfect one; the mind was restored to health." Sims et al[16,19] also report satisfactory adjustment in their two patients following initial treatment with chlorpromazine 100 mg tid, and later fluphenazine decanoate 50 mg every two weeks, and administration of trifluoperazine for his other patient, both of whom were compound cases of De Clerambault and Capgras syndromes. Enoch et al[6] reported that chemotherapy, electro-convulsive treatments, and insight-oriented psychotherapy proved ineffective for one patient and temporarily effective for another, but that the delusions soon returned and thereafter remained resistant to all treatment. Pearce[15] reports that the delusions in his case of erotomania in association with folie a deux remained in spite of six weeks of intensive antipsychotic therapy. Raskin et al[17] report no major shift in their patients' delusions after three- and ten-year periods of drug and supportive psychotherapy. Hollender and Callahan[18] indicate that these patients are not suited for insight-oriented psychotherapy and that their delusions appear unmodified following treatment with various phenothiazines. Doust and Christie[7] on long-range follow-ups report no change in their patients' delusions after various prolonged treatments with ataractic drugs, phenothiazines, and electroconvulsive therapy. The outcome for these persons appears dismal as Enoch et al[6] conclude that "these patients may even be dangerous and may finish up by making an attempt on the life of their victim or members of his or her family [or their own].[7] This is particularly liable to occur when the patient reaches the stage of resentment or hatred which replaces love, after repeated advances are unrequited. They may thus require prolonged hospitalization to prevent them from acting out threats which are contained in their letters."

ETIOLOGY

The problems of effective treatment may in part reflect the inability of theorists to agree on etiology. It has been suggested[22] that "the heterosexual attachment, delusional in nature, is substituted for denied unconscious homosexual impulses." This reflects Freud's[4] belief that erotomania is one of several permutations of the core conflict of paranoia in a male. Here, through the defensive operations of denial, displacement, and projection, a formula evolves: "I do not love him; [rather] I love her because she loves me." The sex of the patient does not seem to influence the structure of the delusions essentially. One could easily substitute "she" for "he" and vice versa in Freud's formula; hence, for women this would be transformed into "I do not love her; I love him because he loves me." Enoch et al[6] agree and add that erotomania evolves out of the search for a safe and unattainable erotized father-figure and the need to ward off homosexual impulses. Feder[23] views erotomania as a "defensive facade of delusional, histrionic, romantic love, behind which lies the drama of an ontogenetically earlier phase of life elaborated in psychosis." He further relates that under conditions of regression there is an attempt at restoration of the earlier blissful union with the mother figure. Although many writers have noted homosexual tendencies in some of their patients, this impulse does not appear to be indicated in all or even most of the reported cases. The theory has little face validity and fails to explain the predominance of women. Cameron[22] views erotomania as self-love that has been denied and projected onto a man. It seems doubtful to the authors that a narcissistic individual would deny self-love and project this feeling onto another. Self-love has not been reported in most supported cases. Pearce,[15] in describing his case of De Clerambault syndrome in association with folie a deux, adds the relative contributions of heredity and environment. Raskin and Sullivan[17] view erotomania as an adaptive function, warding off depression and loneliness and providing an outside source of nurturance, protection, and control, following periods of loss or the imminent threat of loss. Hollender and Callahan[18] advance the notion brought forth by Raskin and Sullivan[17] and suggest that this type of delusional thinking is the result of an ego deficit and may be shaped mainly by an intrapsychic struggle and the individual life experiences of feeling unloved or unlovable; a narcissistic blow is overcome by a grandiose feeling of love. Hollender and Callahan[18] refer to the physical, social, and intellectual deficits of their patients and note that other authors have also casually referred to the sometimes unattractive attributes of their patients. These postulates seem plausible. Future cases may give support to the primarily unrecognized functional theory of erotomania. Finally, Doust and Christie[7] give evidence that environmental, psychological, pharmacological, and physiological factors may often trigger a predisposed person into developing De Clerambault syndrome.

CLASSIFICATION

Erotomania so far has defied precise psychiatric classification. Although De Clerambault delineated a pure form of the syndrome, most modern writers,[13,16,18,19,22-25] tend to consider this syndrome as one of the many possible ways that a paranoid process may manifest itself. Sims et al[16,19] report that their cases occur within the context of a fairly clearly defined acute paranoid schizophrenic episode. They state that the syndrome is a description of a specific type of delusional context and not a distinct entity but part of a more generalized psychotic process in which multiple misinterpretations occur. They conclude that the eponyms used are more significant historically than nosologically. Arieti and Meth[13] include it as one of the "rare, unclassifiable, collected, and exotic syndromes." Enoch et al[6] devotes a chapter to it in *Some Uncommon Psychiatric Syndromes.* Lehmann[24] states that "it would be advisable not to perpetuate the existence of this questionable syndrome in the literature," while Pearce[15] advocated that "whilst the precise status of De Clerambault syndrome as a nosological entity in its own right remains somewhat questionable, its occurrence in classical form is sufficiently distinctive to justify the retention of the eponymous term."

CASE HISTORY

When first seen, L.T., a 21-year-old, black, Baptist, single coed, was in her third year at a local college. On Good Friday 1971, the patient's mother consulted the senior author with the following complaint: "My daughter has gone crazy over a boy and has been acting strangely for the past several days." The patient had become obsessed with the idea that a young man, a student in a mutual college class, was in love with her and wanted to marry her. The senior author was able to determine that they had never dated, had had no long conversations, and had not even been formally introduced. The patient was also convinced that there were several persons on the campus, both faculty and students, plotting against them. It was first considered that this was a manifestation of the disorder, paranoid vera, but after a more prolonged follow-up and consultation with other psychiatrists, it became apparent that this was a schizophrenic disorder, paranoid type, and clearly another case of De Clerambault syndrome.

The family background revealed that the patient's parents were of average income; the father was a postal worker in his mid-40s and the mother was employed as a nurse's assistant. The patient has a twin sister, who at that time was a junior in college, and a younger sister, who was two years old at the time of the onset of this disorder. In describing L.T.'s twin sister, Mrs. T. indicated that she was outgoing, friendly, and though somewhat reserved, maintained close relationships with people of both sexes. The mother stated that the patient in contrast had always been a quiet and rather inhibited child. She was much more reserved than her popular sister and dated infrequently. She was also described as being studious, an avid reader, highly moralistic, and a loner. Moreover, she tended to be somewhat suspicious and mistrustful. Her limited heterosexual experiences were characterized as being very short-lived. According to the mother, one such relationship had just recently ended abruptly and she related that the patient appeared rather emotionally distraught by this.

The patient was neat, clean, well-groomed, well-dressed, and an attractive young woman. She was of medium height and medium build and appeared to be her stated age. She was very courteous and always behaved in a very dignified and formal fashion in both her greetings and mannerisims. Her conversation, when unrelated to her delusional process, was rational, coherent, appropriate, and relevant. One could talk with her for long periods of time without realizing that she had a disorder, if one did not broach the subject of her delusional process. When speaking of the delusional process, she went into great detail, explaining the messages she received from her fantasied lover, signs which she received on TV, from the colors of dresses, license plates on cars, and from several other sources. She saw all of this as proof of the fact that the young man was in love with her and was planning to marry her. She seemed quite sad when discussing her situation and quite disappointed that the young man had not yet rescued her from her misery. There were apparently no hallucinations, but she obviously manifested delusions of eroticism, jealousy, grandeur, and persecution, as well as the illusionary misinterpretations mentioned earlier. Her sensorium, memory, orientation, and intellect were well within normal limits. Her judgment with regard to her delusional process was greatly impaired and she had no insight into her disorder.

Initially, the senior author began seeing the patient in his office often, in an effort to engage her in the sort of therapy that would encourage her to question her delusions. It became apparent that this disorder would be chronic and, as the parents' resources were limited, the senior author began seeing her less often. During the following years, she was seen only on a quarterly basis. At times, she would become very agitated as her fantasied lover had not returned to marry her and consequently she had to be placed on fairly large dosages of tranquilizing drugs. The senior author was sometimes called upon to see her, particularly during holidays, when she was prone to be most disappointed and when her episodes of anger were more intense. Occasionally she would require an increase in medication, but generally the senior author's visit was sufficient to calm her. It also became apparent that some of the delusional fantasies which she had for her "lover" were transferred to her therapist. Throughout this whole process the senior author had been identified as a friend, although at times the patient was suspicious that he might also be involved in the plot as well.

In accordance with previously reported therapeutic efforts, the delusions remained persistent despite the repeated orientated confrontations. After nearly 2 1/2 years with the delusions unchanged, the patient's mother suggested that it might be beneficial to contact the fantasied lover by telephone. It was hoped that by allowing the patient to hear his voice and hear him state that he had no plans to return and marry her, she would then begin to question her delusional content. The young man was telephoned and the patient was allowed to listen on the extension as her mother and the senior author talked with him. The young man stated that he vagulely remembered her as a quiet, unassuming young lady in his physics class, but had long since forgotten about her. He said, however, that he was sorry she had developed the delusional process regarding him but he had not thought about her since leaving college two or three years previously and had no intentions of returning to the city and marrying her. The conversation continued for several minutes as the patient listened quite intently. After the conversation was finished, she insisted that we had not talked to him but had only gotten someone to pretend that he was her fantasied lover. She stated, "he would never have said such a thing about me." Obviously, as expected, the conversation had done no good. At a subsequent time, her mother developed the idea that we should visit the young man's hometown and make an attempt to have a face-to-face visit with him, but the senior author strongly discouraged such a plan.

During the course of her illness the patient was unable to engage in any productive activity for any period of time. She was unable, initially, to complete her junior year in college due to the debilitating nature of her delusions. However, she did finish her college career the next school year and graduated with a bachelor's degree in biology, magna cum laude. She had been a brilliant student throughout her academic training. In the fall, after her graduation, she enrolled in a local school of laboratory technology and, as usual, did well with the academic aspects but was completely unable to do the laboratory work. Consequently, she dropped out of school before the end of the first semester. About a year later, she gained employment as a clerk in a state office in which she had worked for several summers while in college. However, she terminated this work after several weeks because she became convinced that people on the job were involved in the plot as well as her former classmates, her greatly disfavored former physics teacher, and other members of her family. Finally, about four years after the senior author began seeing her, she developed the idea that someone was plotting to kill her and she became fearful of leaving her home. Consequently, for about three years subsequent to that time, she remained within the confines of her parents' home. The only exceptions to those periods of voluntary confinement were when her twin sister, who was then a public school teacher in the city and living independently from the family, would visit and take her shopping or to the beauty shop. In the fall of 1978, it became apparent that after more than seven years of follow-up that the disorder was not improving and, perhaps, was becoming more serious. Her delusional process included many members of her family including her maternal grandmother whom she was convinced was a "sinful and lustful" person and who was also a part of the plot against her. She began keeping a journal which contained many overt and detailed references to sexual relations with her young "lover." The fact that she asked the senior author to read the journal speaks for itself with regard to her transference of attachment to him.

Late in the fall of 1978 the patient was hospitalized for approximately six weeks in a private psychiatric hospital and received four weeks of electroconvulsive therapy, 12 shocks, three per week. Immediately afterward, she began to improve for the first time in 7 1/2 years. She began to question her delusions and began to say, "maybe it was all in my mind after all, maybe he is not coming anyway."

Even though this change of heart with regard to her delusional thinking has not been consistently maintained, she does not hold onto the delusional process as tenaciously now as she did before. Since being discharged from the hospital, she has been out of her home every day. She engaged in a period of job training which lasted for several months and after completing training she made several job inquiries but was not able to secure employment. The senior author encouraged her to visit a local library and read as much as possible about physiology as this is an area which she says she wishes to enter when she pursues graduate training. The young woman has spent several days per week in the library studying this subject. She has been out of the house daily either attending her pre-job training, seeking employment, or reading in the library. Moreover, she spends more time with her sister and attends a modeling class with her.

This patient at this writing is not cured. She still believes her "lover" is returning one day to marry her and she is still waiting for him. However, she is not obsessed with this and despite this delusional process she is able to lead a reasonably normal life. She is gainfully employed and is looking forward to the day when she can enter graduate school and receive a degree in physiology.

Twelve months after hospitalization and electroconvulsive therapy, the patient continues to make apparent progress.

COMMENT

The clinical case presented is consistent with the disorder first described by De Clerambault in 1921 and resembles those cases described by Enoch,[6] Seeman[2] and others. De Clerambault[1] divided the syndrome into two forms. The pure form, he stated, existed alone and remained unchanged or fixed following its sudden onset. It must not include ideas of grandeur or persecution and the erotomania must remain alone as the whole psychosis. There can never be any hallucinations and the person must exist in an otherwise clear state of consciousness. The secondary form, in contrast, exists in association with other psychiatric states—most often paranoid schizophrenia. This patient appeared to develop the syndrome rather suddenly in a reaction to the loss of a boyfriend.

Although the delusional process remained at the core of further complicating symptomatologies and was in itself a distinct entity, she does not seem to fit the strict criteria of pure or primary erotomania. In keeping within the guidelines of the original diagnostic criteria, association with other symptoms would appear to place this patient's condition as a secondary form of De Clerambault syndrome. With regard to Seeman's[2] description of the disorder, this is a fixed rather than a recurrent type of disorder; the disorder is constant and can last for many years, if not for a lifetime, despite repeated confrontations with reality. Her disorder has lasted for nearly eight years and seems to be so fixed. Seeman's[2] description of this as a fixed type is also consistent with her history as a young woman with virtually no previous history of heterosexual relationships who develops a delusional fantasy about a lover. Seeman[2] indicates that patients with a fixed disorder are persons with low self-esteem and little experience in sexuality. This is the case with regard to this patient.

This patient's response to treatment is also consistent with the literature in that her psychotic behavior has to some extent been ameliorated by phenothiazine medication and a combination of supportive and electroconvulsive therapy. Said regimens have been at least temporarily effective and have diminished the delusional process to the point that she has been able to resume functions for the first time in $7^1/_2$ years, even though the delusional process remains. This is consistent with Enoch's[6] report in 1967 that one of his patients received temporary benefit from a combination of chemotherapy, electroconvulsive therapy, and supportive therapy.

This patient represents a classical example of De Clerambault syndrome and she is a true expression of the fixed syndrome associated with delusions of persecution, grandeur, eroticism, and jealousy. There have also been ideas of reference, illusions, and agitated behavior associated with her delusional process. She has held to the syndrome for longer than seven years and has seemed to have experienced some benefit from electroconvulsive therapy and supportive psychotherapy.

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