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De Clerambault Syndrome: Current Perspective

Tulika Ghosh and Minkesh Chowdhary

Abstract

De Clerambault syndrome is a psychological condition named after Gaetan Gatian De Clerambault in which the sufferer is under the delusion that a certain person is in love with him or her. This is a condition in which the patient, often a single woman, believes that an exalted person is in love with her although the alleged lover may never have spoken to them. Occasionally, isolated delusions of this kind are found in abnormal personality states. Erotomania may also be a feature of paranoid schizophrenia. Sometimes, schizophrenia may begin with a circumscribed delusion of a fantasy lover, and subsequently delusions may become more diffuse, and hallucinations may develop. This chapter will focus on the role of technological advancements in the origin of this syndrome in various age groups.

Keywords: De Clerambault syndrome, erotomania, delusion, paranoid schizophrenia

1. Introduction

De Clerambault syndrome, more commonly known as erotomania or fantasy lover's syndrome, is a psychological condition which was named after **Gaetan Gatian De Clerambault** who was a French psychiatrist. He was the first person to describe it as a distinct disorder in 1921. This disorder is one such condition in which the sufferer, who is very often a single woman, holds that a person of high repute is in love with her even though the claimed person may have never met or interacted with them [1]. Here, in this particular disorder, the sufferer's belief reaches to a delusional level with gradual passage of time in spite of having strong proofs against it.

De Clerambault, to his credit, distinguished a "pure" or "primary" erotomania (more or less approximating to Kraepelin's paranoia) from symptomatic erotomanias which could occur as part of other psychiatric disorders. Because of paranoia's virtual demise as a recognized diagnostic entity in the middle of the twentieth century and because, until recently, very few cases of erotomania were described in the literature, a great deal of confusion arose about the nature of the disorder, with some authorities insisting that it was always symptomatic of other conditions and denying that erotomania could exist as a primary illness [2, 3].

Erotomania as it is commonly known can originate instantaneously, and the manifestations are often enduring. The core of the delusions is frequently a renowned person, usually an elderly, or hardly accessible individual with a higher social position. This individual may have had little or no previous contact with the patient. The object of his or her obsession can be any fictional or deceased individual or it can be someone with whom the patient has never met. The sufferer of

this condition may also believe that this particular person is interacting with them and are professing their love, by means of secret messages.

Occasionally, atypical delusions of this type are found in abnormal personality states. This particular condition may also be present in paranoid schizophrenia. Sometimes, it may begin with a restricted delusion of a fantasy lover. Later, the delusions may become more scattered gradually resulting in the development of hallucinations. A comparatively uncommon condition, this syndrome is most commonly seen in females who are having a demure personality, who get dependent quickly on others and who are sexually naive. It can be related to other psychiatric disorders, but sometimes it may also originate on its own.

Referential delusions are very common, as the sufferer very frequently perceives that the object of their love or the person whom they believe to be infatuated with them is sending them secret messages and are confessing about their love for them through some harmless cues like the green light at the traffic signal.

In secondary erotomania, the delusions can arise because of some other mental disorders such as bipolar I disorder or schizophrenia. The symptoms of this disorder may also get triggered by various substances like alcohol. It can also get accelerated by the use of antidepressants.

In this syndrome, there is a possible genetic element present as first-degree relatives of people with this particular syndrome had a family with history of psychiatric disorders. The famous psychoanalyst of Vienna, Sigmund Freud, made a commendable attempt to explain this atypical syndrome. As per Freud, this disorder is a defence mechanism which is employed by the sufferer to avert homosexual urges or instincts which in turn results in enduring feelings of paranoia, denial, displacement and projection.

Likewise, this particular atypical phenomenon was explained by some major theorists as having an instrumental role in coping with severe level of loneliness or a certain level of ego deficit which occurs after a major loss. This particular syndrome can be also associated with unfulfilled desires, wishes or urges. Sigmund Freud was of the notion that ungratified wishes or desires lead the sufferer towards homosexuality or narcissism. Some particular researches conducted in this area have found brain abnormalities to be present in patients with erotomania such as heightened temporal lobe asymmetry and greater volumes of lateral ventricles than those with no mental disorders.

2. Historical perspective

Initial references to this condition can be found in the work of Hippocrates, Freud (1911), De Clerambault (1942), Erasistratus, Plutarch and Galen. Bartholomy Pardoux (1545–1611), who was a Parisian physician, studied the concepts of nymphomania and erotomania. Jacques Ferrand referred to this syndrome as “erotic paranoia” in 1623 in a treatise known as “*Maladie d’amour ou Mélancolie érotique*”. He also termed this condition as “erotic self-referent delusion” until the terms erotomania and De Clerambault syndrome came into common usage.

It was during the seventeenth century that this disorder which was known as “*amor insanus*” at that time was differentiated from nymphomania. Until recently, this disorder was thought to occur almost always in females, but now researches have proved that it is also found to affect males.

In the early eighteenth century, this disorder was conceptualized as a general disease, the causal factor of which was taken to be unrequited love. Later in the early eighteenth century to the beginning of the nineteenth century, this disorder was defined as showing excess of physical love. Gradually as the early nineteenth century came to an end and the twentieth century began, this syndrome was

explained as an unrequited love which later gradually developed into a certain form of mental disease. The period of the early twentieth century introduced this definition of having a delusional belief of “being loved by someone else” which is continuing till date.

Later in the year 1971 and 1977, M.V. Seeman gave various terminologies for this syndrome such as “phantom lover syndrome”, “psychotic erotic transference reaction” and “delusional loving”. Emil Kraepelin and Bernhard have also contributed significantly in the development of this disorder; they wrote about erotomania. And more recently, Winokur, Kendler and Munro contributed to the knowledge available on this disorder. Berrios and Kennedy [4] described in *Erotomania: A Conceptual History* several periods of history in relation to this syndrome which resulted in significant changes in the definition of erotomania.

Thus, it is evident from the various definitions described above that this disorder had different connotations at different times.

3. Symptoms of erotomania

The chief feature of erotomania is a fixed, false and delusional belief that another person is deeply or obsessively in love with them. The other person may not even be aware of the existence of the person with erotomania. Often, there is no evidence of the other person's love. A person with this disorder might talk about the other person incessantly. They may also be obsessed with trying to meet with or communicate with this person so that they can be together. The behaviour associated to this disorder includes persistent efforts to make contact through stalking, written communication and other harassing behaviours.

The sufferer can also have this belief that their object of affection is sending secret, personal and affirming messages back. This belief can be precipitated by the targeted person making it known that the attention is unwanted. Individuals with erotomania can also act like a threat to their object of affection. Often, this threat is underestimated as a risk factor when the severity of this condition is evaluated. The following are the characteristics generally demonstrated by patients with erotomania [2, 5]:

1. The sufferer has this unshakeable belief that he/she is loved by a specific individual who is often of higher social status and sometimes is a well-known figure or even a celebrity.
2. Although the other person has had little (or absolutely no) previous contact with the patient, the latter usually believes that the other initiated the relationship.
3. The patient usually has strong erotic feelings towards the other person, although sometimes the “relationship” is regarded as platonic.
4. The other person is usually unattainable in some way, for example, because of marital status or high social visibility. In many cases the patient never makes any attempt to contact the love object, often writing letters but not mailing them or buying presents but never sending them. Even when given a chance to make real contact, the patient will frequently avoid doing so and will devise spurious explanations to account for this.
5. In those individuals who do make contact with the other person, reasons are found to explain the “paradoxical” (i.e. rejecting) behaviour which is naturally shown by the latter.

In some instances, there can be anger about this perceived rejection associated with acting out behaviour.

6. Sometimes the other person is believed to protect, watch over or follow the patient, and all kinds of behaviours are misinterpreted as evidence of passionate interest.
7. The onset of erotomania may be sudden or gradual.
8. Hallucinations may be present, and some individuals with tactile hallucinations may believe that they have been visited by a lover during the night, a phenomenon sometimes known as the “incubus syndrome” [6].
9. When the case is one of “pure” or “primary” erotomania, the accompanying features are those of delusional disorder. That is, it is a monodelusional disorder with relative preservation of normal personality features and often some capacity to remain functional in society. In these cases the patient not infrequently is able to conceal the abnormal belief from other people [7]. Thought disorder is virtually absent outside the delusional system.

Psychotic breaks: One more interesting aspect related to this disorder is that the course of erotomania is of two types. One is that it may happen over a long period of time and second, only in short episodes. These short episodes also come to be known as “psychotic breaks”. Psychotic breaks are a common symptom of other mental health conditions. They involve an abrupt worsening of delusions or other psychotic features. They may occur in disorders such as schizophrenia, schizoaffective disorder, major depressive disorder with psychotic features, bipolar disorder or Alzheimer’s disease.

Aetiology: Though the real cause behind this disorder is largely unknown, some studies have suggested that delusions may develop as a way of managing extreme stress or trauma. Genetics and personality patterns may also contribute to the development of this disorder.

One major factor which has been emphasized is the role of psychodynamic factors in the emergence of this disorder. Many authors have written about the psychodynamic aetiology of fantasy lover’s syndrome and have said that this delusion acts as a gratification to the individuals’ narcissistic needs. Every individual has this basic need to be loved. But when an individual is rejected by the society, he has to go through that perceived sense of rejection.

This, in turn, develops the fantasy that some other human being is in love with them. By developing such kind of a belief, they tend to feel important in their own eyes and are able to cope with the societal rejection. Kraepelin was of the view that it develops as a compensation for the disappointments of life. De Clerambault highlighted the idea of sexual pride. He elaborated this idea as when there is an absence of affective and sexual approval in an individual’s life, this stimulates the development of erotomania in order to satisfy the individual’s pride.

Another psychodynamic explanation which was given by Hollender and Callahan [8] says that this disorder develops as a result of an ego deficit. The sufferer feels that he/she is not attractive enough. Segal says that erotomanic delusion results from the patient’s need for love. The sufferer relates his need for love as a way to gain approval. Taylor highlighted the idea that the individual’s loneliness, isolation and extreme dependence on others also leads to the development of erotomanic disorder.

Diagnosis: Erotomania has flouted easy categorization for several years. De Clerambault syndrome or erotomaniac delusion is a rare delusional disorder which makes the diagnosis of erotomania very challenging. Though Kraepelin and De Clerambault had discussed this syndrome in detail, it appeared officially as a diagnosis for the first time in DSM-III R as a subtype of delusional disorder. Erotomaniac delusions may be a part of schizophrenia, schizoaffective disorders or mood disorders. Thus, much care should be taken before reaching to a confirm diagnosis because the treatment and management of the disorder is planned as per the diagnosis. Rudden et al. [9] conducted a study on 28 patients with erotomaniac delusions and compared them to 80 patients with other delusions and found that erotomaniac patients had significantly more manic symptoms than the comparison group and more affective diagnosis. The following conditions must be met before a stand-alone diagnosis of erotomania can be made:

1. Delusions should involve possible events, even if they are highly unlikely.
2. The delusion should be only applied to the relevant issue, with all other domains of the sufferer's life being functional and normal.
3. If depressive moods or manic episodes are present along with delusional disorder, then the duration of the delusional period should be longer than the depressive or manic episode.
4. Schizophrenia, mood disorders and substance use disorders should be excluded.

4. Differential diagnosis of erotomania

When an individual is recognized as having erotomaniac delusions, the following disorders must be considered:

1. Delusional disorder, erotomaniac subtype.
2. Schizophrenia, especially of the paranoid type. Here, there will usually be other delusions with a variety of themes, hallucinations and relatively wide-spread thought disorder. The personality is less well preserved, and obvious abnormalities of behaviour may occur [10–12].
3. Major mood disorders. Erotomania has been noted in association with unipolar and bipolar affective disorders [9, 13, 14], and there is a description based on one case which suggests that it can appear as a variant of pathological mourning [15].
4. Various organic brain disorders. There have been descriptions of erotomania occurring in epilepsy, as part of the after-effects of head injury and amongst the late effects of substance abuse [16, 17]. It has also been observed in senile dementia [18, 19] and apparently as a side effect of certain therapeutic drugs including oral contraceptives and steroids [16]. Signer and Cummings [20] have suggested that abnormalities of the left temporal lobe may be particularly likely to cause symptoms of erotomania.

5. Mental handicap. Callacott [21] and Ghaziuddin and Tsai [22] have reported erotomaniac delusions in mentally retarded individuals. There is no reason why such persons cannot have delusions associated with a superimposed psychiatric illness, but it is possible that part of their erotomania may be due to a simple person's misunderstanding of another individual's intentions. However, in this context, one must be aware that mentally handicapped patients can sometimes be taken advantage of sexually by helpers or relatives and that sexually laden remarks made by the patient about others may have had a basis in fact.
6. Delusional misidentification syndrome (DMS). Erotomania has been described in association with DMS in a small number of cases [23, 24].
7. Shared psychotic disorder (folie à deux). A sharing of the erotomaniac beliefs with another individual (not the victim), and acceptance of these as truth by that individual, has been described [25]. This is hardly surprising since folie à deux has been shown to be relatively common in delusional disorder [26].
8. Non-delusional erotomaniac beliefs. These have already been touched upon, and it does appear that certain people may have very powerful erotomaniac emotions which are in the nature of over-valued ideas rather than delusions [15, 27]. It is important to make this distinction because, in such cases, psychotherapy rather than medication may be indicated.

5. Course and prognosis

The "pure" or monosymptomatic form of erotomania is the one which usually corresponds with the diagnosis of paranoia/delusional disorder. In the past this has been regarded as unremitting and associated with a poor prognosis, but there is no early evidence that, analogous to other subtypes of delusional disorder, the condition may respond well to neuroleptic treatment. When erotomania is a symptom of another psychiatric illness such as major mood disorder, schizophrenia or some form of dementia, the course of the phenomenon is that of the parent illness and the prognosis depends on the natural history and adequate treatment of that illness. It is also important to take into account the possible presence of mental handicap, and to consider that, at least in some cases, erotomania may be non-delusional in nature. All of this emphasizes, as always, the need for complete and detailed history-taking and mental status examination as well as careful physical examination. Unfortunately, as we already know, patients with delusional disorder are not always prepared to be cooperative in such investigations. In special circumstances, as, for example, in the forensic psychiatric field, where repeated harassment of one person by another, assault of a female by a male or statements about alleged sexual feelings or behaviours have occurred, great care must be taken with assessment. If the perpetrator has a subtle delusional illness, the facts may be very difficult to tease out, and his certainty may, as has been noted, in some ways seem more convincing than the victim's bewilderment and denial. Good collateral information is of the essence here, and the person doing the assessment should be aware that professionals in the past have themselves been drawn into a kind of folie à deux situation when they have come to believe uncritically in the statements of a highly persuasive paranoiac, as well as being influenced by implied or overt threats of litigation.

Complications of erotomania and comorbid conditions: Erotomania can make the patients show risky and aggressive behaviour. Sometimes, this behaviour can also result in the person getting arrested for stalking or harassment. Very rarely,

erotomania can also result in the death of either person. Erotomaniac delusions may be a single symptom which is also known as primary or pure erotomania and classified as a delusional disorder as per the DSM-IV. It may also occur as a secondary or symptomatic erotomania as a part of an extensive psychopathology. It can occur in various mental disorders such as schizophrenia, mood disorder or organic brain disorder.

This syndrome has been described in both heterosexual and homosexual forms. Comorbidity with other rare psychotic conditions has been reported, particularly with the delusional misidentification syndromes, including Fregoli's syndrome. More cases of secondary in comparison to primary erotomania have been reported usually in the context of a schizophrenic illness. This disorder has been often associated with bipolar disorder. It has been found to be associated with other conditions like anxiety disorder, drug or alcohol dependence, eating disorders and attention deficit hyperactivity disorder.

6. Treatment and management

The prognostic factors vary from person to person, and the ideal treatment is not completely understood. Though it has been seen that those patients who are having this syndrome along with some major psychiatric disorder like schizophrenia show poor prognosis as the complexity of the symptoms of both the disorders makes it difficult for the patient to get treated. Simultaneously, the patients become drug resistant also as they have to take the medicines for a very long period of time. This results in the body getting adjusted to the drug, and very less improvement is noticed as a result. Researches have proved that treatment for this disorder gives the best results when they are tailored specifically as per the requirements of each individual. The most common modes of treatments are medication and therapy. Till recently, the mainline pharmacological treatments have been pimozide, which is a typical antipsychotic approved for treating Tourette's syndrome, and atypical antipsychotics like risperidone and clozapine.

Treating this disorder can be tough because those individuals who are affected are not likely, or even able, to see that their beliefs are tenuous. Comparatively, few of the affected people seek treatment by their own will, and they may find it difficult to engage successfully in therapy. Non-pharmacological treatments that have shown some degree of efficacy are electroconvulsive therapy (ECT), supportive psychotherapy, family and environment therapy, rehousing, risk management and treating underlying disorders in cases of secondary erotomania. ECT may help in the temporary remission of delusional beliefs; antipsychotics help attenuate delusions and reduce agitation or associated dangerous behaviours, and SSRIs may be used to treat secondary depression.

In this disorder, there is some evidence that pimozide has superior efficacy as compared to other antipsychotics. Psychosocial psychiatric interventions can help enhance the quality of life by allowing some social functioning, and treating comorbid disorders occupies a very important place during the treatment of secondary erotomania.

Other than pharmacological treatments, some non-pharmacological treatment methods are also there which prove to be important in the treatment of this syndrome. Amongst them, family therapy, adjustment of socio-environmental factors and replacing delusions with something positive may be beneficial to all. In maximum cases, harsh confrontation should be avoided. Structured risk assessment helps to manage risky behaviours in those individuals more likely to engage in actions that include violence, stalking and crime. For particularly troublesome cases, neuroleptics and enforced separation may be moderately effective. Priorities

should focus on maintaining social function, minimizing the risk of problematic behaviour and improving the affected person's quality of life. It may also be helpful to provide social skills training and to provide practical help in dealing with any problems stemming from erotomania.

Apart from the classic modes of treatment, as the situations are changing and exposure to social networking sites is unavoidable, thus the treatment mechanisms should also employ the strategies needed to help people decrease their social media use. Clinicians should enquire about the pattern of social media use when taking the clinical history of the client, and immediate action should be taken to reduce the chances of such behaviour. Similarly, people should be made aware of the information which they should avoid revealing on social media. In addition, more research should be conducted in this area in order to explore the interplay between social media and erotomaniac delusions.

Successful symptom management will focus on treating the underlying disorder and may include medications, therapy and hospitalization. Any or all of these approaches can be applied, depending on the person concerned and the underlying causes. Therapy should help the affected person to comply with an agreed treatment plan and to educate them about their illness.

Hospitalization may be needed if the affected person becomes a danger to themselves, to the object of their affection or to anyone else. Antipsychotic medication may control symptoms effectively and can be prescribed for the underlying disorder. Medication and psychotherapy can be used together. The role that social media plays in any problematic behaviour should be considered when developing a treatment plan.

Current perspective: Erotomania is a type of delusional disorder. Other types include delusions of persecution, grandiosity or jealousy. Recent researches have concluded that an extensive use of social media may potentially cause or exacerbate erotomania. Social media eliminates some of the barriers between unacquainted people and can easily be used to observe, contact, stalk and otherwise harass people who would previously have been completely inaccessible. Social media platforms can also reduce the level of privacy of individuals, which can make stalking behaviour much easier. A case study was reported by Faden et al. [28] of a 24-year-old male college student who used social media to stalk a female college student which resulted in his suspension from school and hospitalization. He was diagnosed with delusional disorder, erotomaniac type. This case demonstrates that social media can act as a triggering factor of this disorder. Social networking has become a necessity nowadays; thus communication with the object of attention has become easier.

Many a times, girls in the adolescent phase go through different kinds of psychological and physiological changes. They experience attraction towards the opposite gender and want to experience affection from them. Nowadays, access to the Internet and social media has become very easy. Thus, it has led the teens to get information about the celebrity individuals, especially the movie stars very conveniently. When the teens are going through this tumultuous phase of change, the easy access to celebrity's lives can create a feeling of being in love with some celebrity very easily. Some adolescents tend to accept this as an infatuation and forget everything. But some are unable to pass through this phase and start believing that their love is real and mutual. Gradually, it reaches to the delusional level and ultimately ends up in erotomania.

Forensic aspects of erotomania: In general, women do not flamboyantly act out their erotomaniac delusions, although a well-known American film of the 1970s, *Play Misty for Me*, describes in fictional terms the dangerous outcome of erotomania occurring in a female. Less dramatic but nonetheless disturbing instances do sometimes occur in real life, to the annoyance, alarm and distress of the object

of the deluded individual's attention; nowadays, when male professionals are under so much moral pressure to guard against inappropriate sexual behaviour towards clients, it can be devastating if a deluded woman publicly declares that a doctor, a counsellor, a university teacher or someone else has been demonstrating strong erotic feelings towards her. If the deluded individual has a non-deteriorated personality, totally believes her own story and presents her claims as vehemently and persistently as such people do, it may be almost impossible to get the public to believe that what she is saying is untrue. Real unrequited love is bad enough: delusional unrequited love can be impossible. Taylor et al. [5] studied a group of males charged with antisocial behaviour, including persistent unwelcomed importuning of women, and were able to identify cases of erotomania amongst these. Often, they were initially diagnosed as schizophrenic, but closer examination sometimes suggested the presence of paranoia/delusional disorder. The same researchers noted that several patients exhibited quite grandiose behaviours, a common feature of delusional disorder which makes it especially difficult to engage in logical discussion with the person about his false belief or to persuade him to change his behaviour. None of these particular cases had behaved violently towards their victims, but their unremitting harassment often caused the women involved to feel threatened. Goldstein [29] has described cases of severely aggressive, erotomanic behaviour in males, some of whom gained widespread public notoriety. One of these was the young man who attempted to assassinate Ronald Reagan when the latter was President of the United States, apparently believing that this would gain the attention of a well-known female film star, towards whom he entertained erotic delusional feelings. Amongst the other cases Goldstein describes, murder, serious assault, kidnapping and severe harassment occurred. In these individuals the underlying diagnoses were varied but mostly fell within the categories of delusional disorder or paranoid schizophrenia. Goldstein proposes that the changing role of women in society and their higher public profile may act as a stimulus to male erotomania, possibly making the phenomenon more common, but that is hypothetical.

Although the origins of erotomania can be traced to the time of Hippocrates, and from that time onwards, many efforts have been done by different people to explain the nature and root cause of this disorder, but there is limited information about how this disorder, which was first described by De Clerambault, began its course and treatment.

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