DOI: 10.7860/JCDR/2022/57016.17081

Case Series

Psychiatry/Mental Health Section

Erotomania: A Rare Psychiatric Condition- A Case Series

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ABSTRACT

Erotomania is a rare psychiatric condition which is characterised by the delusion that a person who is of a higher social status is in love with them. Three cases of secondary erotomania have been discussed which includes a 26-year-old female patient who had a delusion that a well-known actor was in love with her. The second patient was a 23-year-old female patient who harboured a delusion that a popular guy from her school was in love with her. Another patient was a 38-year-old female patient who was deluded that a church personnel was in love with her. All three patients shared similar features that they all developed symptoms of schizophrenia during the course of the illness following the delusion, had poor insight, had poor compliance to treatment and follow-up. Management was resorted to pharmacotherapy and psychosocial rehabilitation in all cases, which yielded improvement although there was no complete remission of the delusion in a two year follow-up in either of the cases. Since erotomania is a rare and unique phenomenon, discussion about the presentation of erotomania in association with schizophrenia, provides a knowledge regarding the condition and management.

Keywords: De Clerambault syndrome, Delusion, Female, Schizophrenia

INTRODUCTION

Delusion is defined as false, fixed, unshakeable belief not amenable to changes even with the evidences to the contrary depending on the socio-cultural educational backgrounds. Erotomania or psychoses passionelle is one such delusion, first described by G.G. De Clerambault in 1921 [1]. He made his first comment on erotomania upon a paper published in 1913. In 1920, he reported a case of a French women in love with King George V was in love with her. In 1923 he published his final papers on erotomania and accepted the term 'secondary erotomania' proposed by Truelle and Reboul-Lachaux [2]. Mostly occurs in single women and is characterised by false belief that a person of higher social status is in love with her. The subject has strong conviction and gives detailed explanation about the delusion, even-though the subject has little or no contact with the other person [3]. The subject tries to contact the other person through phone call, social media, sending gifts and even stalking. The subject interprets a new meaning to the actions done by the object that is paradoxical or contrary to the other persons behaviour [4]. De Clerambault described the core features of erotomania and since then it was called as De Clerambault syndrome [5]. De Clerambault described two forms of erotomania the pure or the primary form and the secondary form.

In the pure form, a single erotic delusion is formed and then other forms of delusion is formed with regard to the initially formed delusion. In the secondary form the erotic delusion are present with other psychotic conditions like schizophrenia, Bipolar Affective Disorder (BPAD), depressive disorder [6]. Peter Ellis and Graham Mellshop framed nine diagnostic criteria for erotomania which are as follows (a) A delusional conviction of being in amorous communication with another person. (b) This person is of much higher rank (In terms of social status and other aspects of life higher than the subject). (c) This other person had been the first to fall in love. (d) The other person has to be the first to make advances. (e) The onset is sudden. (f) The object of the amorous delusions remains unchanged. (g) The patient provides an explanation for the paradoxical behaviour of the loved one. (h) The course is chronic. (j) Hallucinations are absent [7]. This case series presents secondary form of erotomania in three different women with schizophrenia.

CASE SERIES

Case 1

A 26-year-old single woman, an engineering graduate with no known medical or psychiatric co-morbidities and good premorbid functioning presented to the psychiatry Outpatient Department (OPD) along with her parents and brother from whom history was obtained. Her father was an employee in a private firm and so was her elder brother who was two years elder to her while her mother managed the household. The symptoms surfaced soon after her parents starting seeking matrimonial profiles for her. Onset of symptoms was sudden as she claimed that a well-known Kollywood actor was in love with her as he approached her with his love proposal. Although occasional initially, the intensity of her belief grew over two months and she started stalking the actor in social media and tried to meet him in person. Her parents tried to talk her out of it but she refused to consider the contrary possibility and was inconvincible. This led to the development of persecutory ideas about her parents that they were engaging in attempts to break up her relationship.

She became increasingly persistent and managed to get herself into the actor's house and reached out to his parents a few times. They initially warned her and tried to convince her of the reality that he was already married with kids and that it was impossible for him to be having the said relationship with her. She refused to accept their response and to leave their house. She then had to be escorted to her house by the police.

A few months later her parents noticed her to be muttering to herself at home. She claimed that she was being sexually assaulted by the actor when she was asleep. She also believed to have been physically manipulated by chips inserted into her body which produced low frequency waves bringing her under an external control. She was found to be vigilant as she believed she was being watched by cameras placed around the house. Over a one-year period, there was a drop in vegetative, social and occupational functioning and hence she was brought to psychiatry OPD. Mental status examination revealed a vigilant appearance, coherent speech and anxious affect with prominent delusions of love, persecution which fulfilled all the criteria for delusion (conviction, bizareness,

extension, disorganisation, pressure, affective response, deviant behaviour) and commenting type of auditory hallucinations with impaired judgement and poor insight. Projective psychological assessment revealed paranoid ideations with immature tendencies. Blood investigations including complete haemogram, blood sugar, liver and renal function tests were normal. Neuroimaging with Computed Tomography (CT) brain was unremarkable. A diagnosis of Schizophrenia was made (with secondary erotomania) according to International Classification of Diseases (ICD-10)-10 [8]. Treatment was initiated on an OPD basis which included Tab. Risperidone 4 mg, Tab. Trihexyphenidyl 2 mg and Tab. Diazepam 5 mg and was advised follow-up after 2 weeks.

However, she was irregular to follow-up after two months and resumed attempts to stalk the actor in shooting spots and finally reached out to him in his house. He was taken by surprise and denied her accusations of ever being in a romantic relationship with her and politely asked her to leave. Offended by his attitude, she threw a tantrum and refused to leave the place unless he reciprocated his love for her, following which she was handed over to the police. She tried to lodge a police complaint against him for fraudulent behaviour which was dismissed by the authorities. She hence returned home enraged and attempted suicide by consuming 20 tablets of 2 mg Risperidone and drank phenol in the presence of her parents. She was immediately admitted in the hospital. Serial monitoring of blood parameters including complete haemogram, electrolytes, liver and renal function tests were normal. She was restarted on her previous psychiatric medications in the same dose after a week once her general condition stabilised. She showed improvement in vegetative symptoms and reduction in hallucinatory behaviour in five days. Psychotherapy sessions were initiated however did not benefit due to her lack of cooperation. She continued harbouring the delusion of love during discharge after two weeks, six months and two years and was irregular to follow-up.

Case 2

A 23-year-old woman, high school pass-out, married and separated, with no known psychiatric or medical co-morbidities and good pre-morbid functioning, was brought for psychiatric consultation by her parents from whom history was obtained. Her mother managed the household and her father was working in the field of agriculture. The history dated back six years ago, when she was in her tenth grade and claimed that a boy belonging to the twelfth grade who was popular for his good looks was in love with her. She said she was sure of it as she was convinced by the hints, he gave even though he did not personally profess his love for her for the sake of anonymity. Her father enquired around school and came to know that there existed a boy of her description who passed out years before but in no way corresponded to her claims.

Her father was informed that the boy belonged to an affluent family and never had a clue about his daughter. His whereabouts were unknown but she continued to believe that he was madly in love with her and was playing hard to get to accentuate her feelings for him. Being preoccupied with these thoughts, she struggled academically and failed in her twelth board exams which she cleared after multiple attempts. She then started going around the neighborhood and picking fights with strangers saying they were keeping her boyfriend in hiding. Mortified by her behaviour, she was put in college to keep her distracted.

Once in college, she began calling up random phone numbers enquiring about her said boyfriend. She soon was acquainted to a fraudulent person who claimed to be the boyfriend she was in search of and manipulated her. Her parents then had to take legal action against the man behind it. She however did not give up her plight of finding her boyfriend and went around the neighborhood enquiring. Her parents then decided to get her married and asked her willingness. She agreed to it and soon they found a desirable match and arranged for the wedding. On the day of the ceremony, she appeared apprehensive and suddenly refused to get married. She claimed that she agreed to the wedding in hope that her boyfriend would come to her rescue at the last moment. Her parents were taken aback but managed to keep her from stopping the ceremony. They convinced her and sent her off with her husband and in-laws. On the way home she removed her 'thaali' (mangalsutra) and threw it away and announced to her husband and in-laws that she was in love with another man and returned home to her parents.

Her belief and fantasy grew in intensity over a period of five years as she spent her time planning a wedding with her boyfriend, writing numerous pages of love letters, poems and songs for him. She was noticed to be muttering to herself gradually. She would occasionally laugh alone for no apparent reason. She would stay up all night mumbling in an inaudible voice. Her parents were worried and took her to a psychiatric hospital where she was treated as inpatient of which no details were available. Her sleep improved and she was discharged on request in a week. She discontinued medications after discharge as she developed persecutory ideas about her parents that they were attempting to kill her with some medicines. She accused them of never being her parents and that as her birth parents abandoned her, the fosters raised her for sacrifice at the right time. She blamed them for her self-claim of contracting 'blood cancer' as per their plan. She came up with seemingly diverse suspicions over her parents over the next six months. She accused her father of sexual assault and started spitting over herself, all round her house and around the neighbourhood.

She became verbally and physically assaultive and her self-care worsened hence was brought to our psychiatry OPD. Mental status examination revealed an unkempt, shabby appearance with hallucinatory behaviour. Speech was irrelevant at times and affect was restricted. Her thought was circumstantial with content of delusions of persecution, reference, grandiosity which fulfilled all the criteria for delusion (conviction, bizzareness, extension, disorganisation, pressure, affective response, deviant behaviour) and love alongside perceptual abnormalities in the form of commanding and commenting auditory hallucinations. She had impaired judgement and lacked insight. She was admitted and was investigated with routine blood investigations including haemogram profile, electrolytes, renal and liver function tests all remaining normal. CT brain was unremarkable. A diagnosis of schizophrenia (along with secondary erotomania) was made according to ICD-10 [8] which was supported by psychological projective test. She was treated with Tab. Risperidone 8 mg, Tab. Trihexyphenidyl 2 mg and Tab. Diazepam 5 mg. Her symptoms gradually improved over 4 weeks. Hallucinatory behaviour reduced; self-care improved with sleep normalising during hospital stay. Psychotherapy was initiated prior to discharge at one month. She was followed-up at two months, three months, one year and two years. She retained the delusion of love despite being fairly functional during the follow-ups.

Case 3

A 38-year-old spinster, educated up to seventh standard, living with mother, engaged in charity work in church with no known medical or psychiatric co-morbidities and good premorbid functioning presented to the psychiatry OPD. Chief informants were mother and sister. Her mother was managing the household while her sister who was recently married was working as a nursing staff.

A month prior to consultation, she was visited by her younger sister who was married recently. Seeing her sister have a partner made her long for a family of her own. The following day, she claimed there was a person in her church who was in love with her. She said she wanted to marry him and that he has been keen on drawing her attention in many possible ways over the past.

Her family members were taken by surprise as she was a person who believed in devoting her life to the needs of the church rather

than personal pleasures. Gradually she conversed more frequently about her admirer and was found preoccupied with thoughts and plans for her wedding. Her brothers inquired with the church pastor about her claims only to find out that there was a person of her description few years ago but his whereabouts were unknown and they were also informed that he was not interested in their sister in any way as he was already married and belonged to a much higher social status. When notified about the same, she refused to accept it and was stubborn in her claims.

Over two weeks, she became restless and did not sleep at night. It was noticed that she has been talking to herself and gesturing at walls. She was convinced that the church pastor was plotting to separate her from her admirer and that she had to stop them. She threw tantrums to eat food saying she would eat only if he came to visit her. She developed persecutory ideas over her family members and became defensive when they tried to persuade her to eat or change clothes. Her self-care deteriorated drastically and she refused to maintain personal hygiene. She kept chanting bible verses incessantly to evade all the bad omen trying to separate her from her admirer.

She brought out different claims every day, which included being under the control of an external force and being sexually manipulated while being asleep. In about four weeks, she was absolutely fastened to her bed refusing all food and sleep and remained awake for two days without a break.

She became hostile towards her family members as she believed they had a part to play in preventing her from uniting with her admirer. She was brought to Psychiatry OPD.

On examination, she had matted hair and wore dirty clothes. She was chanting bible verses and had a guarded attitude. Her speech was inaudible and was hesitant to answer to the examiner. Her thought had tangential thinking, delusion of love and persecution which fulfilled all the criteria for delusion (conviction, bizareness, extension, disorganisation, pressure, affective response, deviant behaviour). Perceptual abnormalities were not established. She had no insight into the illness and lacked quality judgement. She was hence admitted in the ward and was evaluated with blood investigations including complete haemogram, serum electrolytes and blood sugars all of which were normal. CT brain imaging was insignificant. She was uncooperative for psychological assessment and hence a diagnosis of Schizophrenia (with secondary form of erotomania) was made according to ICD-10 [8] based on history and clinical examination.

The patient was started on parenteral fluids and medications because of non compliance to oral drugs which included Inj. Haloperidol 10 mg and Injection (Inj.) Lorazepam 4 mg for a week. She was then switched to Tablet (Tab.) Risperidone 4 mg, Tab. Trihexyphenidyl 2 mg and Tab Diazepam 5 mg. Her sleep improved in three days and there was a gradual improvement in self-care however, she still held onto the delusion of love when she was discharged at three weeks. Psychotherapy was also initiated at the time. She was irregular to follow-up at six months, one year and two years, during which there was no remission of the symptom of delusion of love.

DISCUSSION

Psychoses passionelle or erotomania is a rare type of delusion, most commonly seen in women. It is also referred as delusional loving, phantom lover syndrome, psychotic erotic transference, melancholia erotique and amorous insanus [8,9]. De Clarambault was the first to describe the characteristic feature of erotomania and proposed that it can be superimposed with other psychiatric condition and sometimes be an independent entity. The fundamental postulate of De Clerambaults syndrome is that the subject believes that she is in an amorous relationship with the object of higher social status, who was the first to fall in love with them and first to make advances [10]. Ellis and Mellsop postulated the operational definition of erotomania and applied it to their 53 cases. They concluded that pure form of erotomania is a rare entity and according to their published data 34% of schizophrenia patients are presented with erotomania symptoms [7]. In accordance to this finding, cases discussed in the study are all secondary forms of erotomania in Schizophrenia patients.

Seeman's in 1987 proposed two groups of erotomania: the fixed group and the recurrent group. In the fixed group, the delusional love is fixed and it is not fleeting even with repeated confrontation whereas in the recurrent group, the love is short lived and it is repeated [11]. In accordance with Seeman's descriptions all three cases fall into the fixed group. Since the delusion in erotomania is strongly fixed, it is difficult to shake the delusion and the treatment usually runs a chronic course with most patients still harbouring the delusion. The women in the present study had believed that men of higher socio-cultural status as their love interest and were not convinced even when confronted. And their delusion appeared to be as a defence mechanism for their low self-esteem and sexual inexperience.

All three women were introvert, shy and had poor interpersonal relationship with others in accordance with the study 'Delusional Loving' published by Seeman MV [12]. All three patients were admitted in the ward and put on oral antipsychotics, despite adequate dosing and care, patients showed no change in the erotomanic symptoms and continue to harbour the erotomanic delusion. Prognosis is considered to be poor in patients with low or no response to antipsychotic medication and continue to have a chronic course [13]. Treatment of erotomania involves management of underlying conditions appropriately. Recommendations include pharmacotherapy with supportive therapy and challenging of delusions will aid in the recovery of the patient. All three cases were put on atypical anti-psychotics because of its milder side-effect profile than the typical anti-psychotics, successful improvement was seen in their self-care, hallucinations and they were fairly functional, but they continued to harbour the delusion. Challenging the delusion is of no benefit in the peak of the disease and when there is response to the pharmacological management, confrontation will increase the chance of recovery. In these patients, confrontation was of no benefit and all three patients held on to their belief even in the follow-up period. All diagnosis of erotomania has a separate implication in understanding the case, management, treatment and prognosis of the patient and cannot be overlooked. Also missing out the diagnosis will have legal implications as the patients can get involved in aggressive and violent behaviour whilst pursuing their lovers [5].

CONCLUSION(S)

Erotomania is rare type of delusion which is present more commonly among women. Studies have reported more secondary forms of erotomania than the primary forms. Either of the types of erotomania requires treatment with antipsychotics. It is difficult to reduce the delusional conviction even after adequate treatment with antipsychotics and so each patient should be tailored with medications which will result in the improvement in daily living and social functions. Since the symptoms are present even on treatment, patient should be closely followed-up till the reduction of the symptoms.

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PLAGIARISM CHECKING METHODS: [Jain H et al.]
- Plagiarism X-checker: Apr 14, 2022
- Manual Googling: May 20, 2022
- iThenticate Software: Sep 08, 2022 (5%)

ETYMOLOGY: Author Origin

AUTHOR DECLARATION:
- Financial or Other Competing Interests: None
- Was informed consent obtained from the subjects involved in the study? Yes
- For any images presented appropriate consent has been obtained from the subjects. No

Date of Submission: **Apr 11, 2022**
Date of Peer Review: **May 30, 2022**
Date of Acceptance: **Sep 14, 2022**
Date of Publishing: **Nov 01, 2022**