PSI LOGOS

Caso Clínico / *Case Report*

open-access

Conceptualizing Primary and Secondary Erotomania: A Brief Review about Two Clinical Cases

Conceptualizando Erotomania Primária e Secundária: Uma Breve Revisão a propósito de Dois Casos Clínicos

Eduardo Gomes Pereira*, Francisco Coutinho*, Constança Reis*, Cátia Guerra*

ABSTRACT

Erotomania is a rare condition in which an individual has the delusional belief that the other person is in love with him/her. Some authors suggest the distinction of a primary and secondary form, depending on etiology, with possible implications on the management of the disorder. In the latter form, treatment should be focused on the underlying disease, while in the former, besides antipsychotic medication, attention should be paid to certain specific characteristics of these patients. There is little data published on the subject, with most of the available information coming from case-reports or small collections of cases. Here, we describe and discuss two clinical cases of primary and secondary erotomania and perform a short review about the subject. We believe that this paper provides a global view about erotomania, showing its distinct forms of clinical presentation and association with different conditions, as well as implications for its therapeutic approach.

Key-Words: Delusional Disorder; Psychosis; Clerambault Syndrome.

RESUMO

A erotomania é uma condição rara em que um indivíduo tem a crença delirante de que outra pessoa está apaixonada por si. Alguns autores sugerem a distinção de uma forma primária e secundária, dependendo da sua etiologia, com possíveis implicações na abordagem e tratamento desta patologia. Na sua forma secundária, o tratamento deve ser focado na doença de base, enquanto na primária, além da medicação antipsicótica, deve ser prestada atenção a algumas características específicas desses doentes. Há poucos dados publicados sobre o tema, com a maioria das informações disponíveis provenientes de relatos de casos ou pequenas séries de casos. Neste trabalho, descrevemos e discutimos dois casos clínicos de erotomania primária e secundária e fazemos uma breve revisão sobre o tema. Acreditamos que este artigo proporciona uma visão global da erotomania, ilustrando as suas diferentes formas de apresentação clínica e associação com condições distintas, com implicações para a abordagem terapêutica.

* Serviço de Psiquiatria, Clínica de Psiquiatria e Saúde Mental, Centro Hospitalar Universitário de São João; eduardomgpereira@gmail.com.
https://orcid.org/0000-0001-7559-5924

Recebido / *Received:* 02/10/2019 - Aceite / *Accepted:* 20/09/2020.

Palavras-Chave: *Perturbação Delirante; Psicose; Síndrome de Clérambault.*

BACKGROUND

Erotomania is defined as the delusional belief that one is loved by another person[1]. This condition was described by French psychiatrist Gatian de Clérambault in 1921, becoming known as De Clérambault's Syndrome. In the same period, other authors, such as Emil Kraepelin or Bernard Hart, also described erotomania[2]. Although De Clérambault had already made reference to a "pure" and a "secondary" form of erotomania[3], it was Hollender and Callahan[4] that defined the classification of the syndrome as "primary erotomania" and "secondary erotomania". They stated that the former arises in the absence of another significant organic or psychiatric disorder, while the latter occurs as part of another condition. Nowadays, DSM-5 includes erotomania as a subtype of delusional disorder[5], a monosymptomatic delusion that can be understood as the classical view of "primary erotomania". Erotomania due to another psychiatric or organic disorder is not recognized in the contemporary classification systems[5, 6].

The epidemiology of "primary erotomania" is not known, although generally recognized as one of the rarest type of delusional disorder[7]. There is even less epidemiological data on its secondary form, probably because of its lack of recognition in the most commonly used classification systems. One study found an incidence of 15 cases of primary and secondary erotomania in an area of 400000 people over a calendar year, although stating several study limitations[8].

Erotomania has been described as a secondary delusion in the setting of various psychiatric and non-psychiatric situations. In the psychiatric field, mood disorders with psychotic features, schizophrenia or borderline personality disorder may occur with erotomanic delusions. Considering organic pathology, erotomania is mainly associated with neuropsychiatric syndromes, such as dementia, head trauma, cerebrovascular disease, epilepsy or neurodevelopmental disorders. Secondary erotomania may also appear as a side effect of psychoactive drugs such as corticosteroids, methylphenidate or venlafaxine[7].

In this paper, we aim to review the etiology, clinical presentation and management of erotomania, while describing two clinical cases of primary and secondary erotomania.

Case 1

We describe the case of a 46-year old woman, single with no children, living with her older sister. She grew up in a poor socio-economic environment and at the time was unemployed and experiencing serious financial difficulties. She was taken to the psychiatry emergency department by her sister because of behavioral changes related to the firm belief that a famous TV news-anchor was in love with her. She claimed that they had met in a restaurant about 30 years ago and now he was talking to her and sending her signs of his love through the TV. She had no previous personal or family history of psychiatric pathology. Concerning her pre-morbid personality, she was described by her sister as very shy and mistrustful, including with her family members and work colleagues, with no friends. Re-

garding her sexual history, she had never had any known affective or sexual relationships, what was seen by her sister as an uncomfortable topic for the patient. She was admitted to the psychiatry acute ward. Initially, she would spend most of her time staring in front of the TV, watching the news in order to be in contact with the referred news-anchor. She also confirmed that she had never had any other previous boyfriends, nor did she intended to, because she was "saving herself" for this man. According to DMS-5, a diagnosis of delusional disorder, erotomanic subtype was established, and she was treated with risperidone 2mg daily. During the first days of admission, she presented with anxiety, insomnia and psychomotor restlessness, related to the fact that she was admitted to the inpatient ward against her will, whereby she was also prescribed valproic acid 1000mg daily in order to stabilize her behavior. After two weeks of treatment, the only abnormality at her mental state examination was the erotomanic delusion, which persisted, although interfering less with her behavior. After discharge from the acute ward, she was admitted in Day Hospital and engaged in socio-occupational activities, while also receiving counseling from social services. After this, she kept regular psychiatric appointments. Since her behavior remained adequate, therapeutic with valproic acid was stopped, without worsening of her clinical state. She kept taking risperidone 1mg daily, with gradual diminishing of the intensity of her erotomanic delusion, which, however, she maintained. During this period, she had no other symptoms or changes in her mental state.

Case 2

We describe the case of a 49 year-old woman, single with no children, retired (previously a History teacher). She had a diagnosis of schizoaffective disorder, with history of five inpatient ward admissions, and regular psychiatric appointments since 1999. She had been stabilized for some time with haloperidol decanoate, 100mg every 4 weeks, risperidone 4mg daily and oxcarbazepine 600mg daily. She started a clinical picture of elevated mood, restlessness, increased thought speed and decreased need for sleep, followed by the arising of the unwavering belief that King Philip of Spain was in love with her, that she married him 18 years ago and was now pregnant with their two children. She also presented cenesthesic hallucinations, feeling the supposed children moving in her belly. A diagnosis of manic episode with psychotic features in the context of schizoaffective disorder was made. Haloperidol decanoate dose was increased to 150mg every 4 weeks, risperidone was switched to 10mg of haloperidol daily and oxcarbazepine was kept at 600mg daily. Her mood improved towards euthimia and the erotomanic delusion and hallucinations completely subsided. She maintained regular follow-up at psychiatric consultation. It was observed that in periods when she didn't take her medication, she presented with manic symptoms and the erotomanic delusion recurred.

CLINICAL PRESENTATION

Erotomania has a consistent clinical presentation across all cultural settings[7]. It is characterized by the presence of a delusion in which

the patient (the subject) believes he or she is loved from afar by another person (the object)[1]. Patients are often single, middle-aged men or women, with a medium-low socio-economic status, poor social skills and little or no history of affective relationships. The object is generally perceived as physically attractive, with superior social standing, which often leads to him/her being unattainable to the subject[7, 9].

The subject and the object may have established some kind of personal contact between them, but, if they did, it was often casual, although perceived by the subject as with deep meaning and importance. Frequently, the subject enthusiastically accepts the supposed love from the object, developing an intense feeling of passion for him or her. The object's acts of rejection or indifference are paradoxically interpreted by the subject as secret love declarations or ways of testing their relationship[1,7]. Hallucinations are rare but may be present, namely tactile hallucinations, usually with a sexual connotation[8].

Social isolation is characteristic of these patients, who do not seek medical attention, leading to perpetuation of the disease. It is possible that many patients with erotomania never receive medical care, making it an underdiagnosed disorder. However, they may come to the attention of forensic psychiatry services when they commit socially disruptive acts, such as harassment or stalking[7].

ETIOLOGY

The imagiological and neurobiological data on delusional disorders, including primary erotomania, are scarce[7]. Neurochemical factors may have a role, namely imbalances in dopaminergic and serotoninergic pathways[3]. Studies focusing on families state that a family history of psychiatric illness is more frequent in patients with the disease than in the general population and that erotomania and pathological jealousy tend to appear in successive generations[8].

Regarding secondary erotomania, etiology is extremely variable, ranging from psychiatric disorders like schizophrenia or bipolar disorder to organic syndromes such as dementia[7].

On other field, numerous authors put focus on psychodynamic factors, particularly regarding primary erotomania. In fact, Kraepelin considered the erotomanic delusion a "compensation for the disappointments of life"[1] and De Clérambault emphasized the concept of "sexual pride": stimulated by the absence of affective approval, the erotomanic delusion arises as a mean of satisfying the individual's pride[9]. Hollender and Callahan[4] described erotomania as the result of an ego deficit, shaped by an intrapsychic struggle of feeling unlovable following a narcissistic blow. Various authors highlighted the patients' general profile of isolation, solitude, lack of affective/sexual experience, perceived unattractiveness and rejection by society[9]. With this in mind, some authors hypothesize that the erotomanic delusion solves an intrapsychic conflict, delivering gratification to the patient's narcissistic needs, enhancing his/her self-esteem and providing a support figure[9, 10].

MANAGEMENT

Treatment of erotomania will depend if it is primary or secondary in its origin. In the latter, attention should be given to the treatment

of the underlying disease, either organic or psychiatric. On the other hand, the treatment of primary erotomania may be more complex, requiring a broader approach with both pharmacological and non-pharmacological measures[7].

There is limited data on the treatment of primary delusional disorder, especially erotomania, as it is a rare condition. Most of the existing information consists of case-reports or small collections of cases. The major body of evidence on this topic was published in the 1990s and, therefore, mainly focuses on typical antipsychotics [(11)]. However, pharmacological approach of delusion disorders, including primary erotomania, is generally extrapolated from other psychotic disorders and both typical and atypical antipsychotics have been the treatment of choice over the years[7], a practice supported by a 2015 review[12].

Having in mind the characteristics of the majority of patients with erotomania, various non-pharmacologic measures are also important. Social skills training, investing on enhancing self-esteem and occupational orientation, could be of major importance in the rehabilitation of these patients. Cognitive-behavioral therapy has been studied on delusional disorders, helping disrupt cognitive biases[10].

DISCUSSION

Erotomania can be conceptualized as a primary or secondary disorder, with implications on clinical presentation and management, as shown by our case description. The first case illustrates a previously healthy patient that develops an erotomaniac delusion with no underlying pathology. This case can be conceptualized as primary erotomania. According to the possible psychodynamic factors involved in the etiology of primary erotomania, one can hypothesize that, in a patient with personality traits of shyness and mistrustfulness, isolation, a poor social-economic environment and lack of affective relationships and unsatisfactory life context, this delusion of being loved by a famous news-anchor may have solved her narcissistic needs by providing a stable loved person. The second case shows a clinical picture of erotomania as secondary to another psychiatric condition. This case illustrates how a patient with schizoaffective disorder may present an erotomaniac delusion with theme-associated hallucinations concomitant with a manic episode, which remitted when her mood symptoms improved.

There are still limitations regarding clinical aspects of erotomania. One of the reasons for this is that erotomania, especially in its primary form, is considered a rare disorder, making it difficult to study in large scale trials with much of the information on the disease being based on case reports. With this in mind, we consider our case report of much relevance, as it provides more evidence that treatment with atypical antipsychotics combined with non-pharmacologic measures can be effective in the treatment of primary erotomania.

We believe that it is important to continue to study and describe erotomania to further characterize this disorder and its optimal approach.

Conflicting Interests
The authors have declared no competing interests exist.

Funding
The authors have declared no external funding was received for this study.

BIBLIOGRAFIA / *REFERENCES*

1. Kelly BD. Love as delusion, delusions of love: erotomania, narcissism and shame. Medical humanities. 2018;44(1):15-9.
2. Berrios GE, Kennedy N. Erotomania: a conceptual history. History of psychiatry. 2002;13(52 Pt 4):381-400.
3. Jordan HW, Lockert EW, Johnson-Warren M, Cabell C, Cooke T, Greer W, et al. Erotomania revisited: thirty-four years later. Journal of the National Medical Association. 2006;98(5):787-93.
4. Hollender MH, Callahan AS, 3rd. Erotomania or de Clerambault syndrome. Archives of general psychiatry. 1975;32(12):1574-6.
5. Diagnostic and statistical manual of mental disorders. Am Psychiatric Assoc. 2013;5th ed.
6. ICD-10 : international statistical classification of diseases and related health problems(10th revision). 2004; 2nd ed.
7. Kelly BD. Erotomania : epidemiology and management. CNS drugs. 2005;19(8):657-69.
8. Kennedy N, McDonough M, Kelly B, Berrios GE. Erotomania revisited: clinical course and treatment. Comprehensive psychiatry. 2002;43(1):1-6.
9. Segal JH. Erotomania revisited: from Kraepelin to DSM-III-R. The American journal of psychiatry. 1989;146(10):1261-6.
10. Seeman MV. Erotomania and Recommendations for Treatment. The Psychiatric quarterly. 2016;87(2):355-64.
11. Munro A, Mok H. An overview of treatment in paranoia/delusional disorder. Canadian journal of psychiatry Revue canadienne de psychiatrie. 1995;40(10):616-22.
12. Skelton M, Khokhar WA, Thacker SP. Treatments for Delusional Disorder. Schizophrenia bulletin. 2015;41(5):1010-2.