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Primary and Secondary Erotomania-Concept

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Abstract

Erotomania is a rare condition in which an individual has the delusional belief that 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. On the latter, treatment should be focused on the underlying disease, while on the former, besides antipsychotic medication, attention should be paid to some 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 make a short review about the subject. We believe that this paper brings more insights into the conceptualization and approach of erotomania and the relevance of the acknowledgement of its primary and secondary forms.

Keywords: Erotomania; De Clérambault's Syndrome; Psychosis; Addiction; Addiction research; Addiction therapy

Background

Erotomania is a disorder characterized by 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]. Nowadays, erotomania is recognized as a rare type of disorder, with little available epidemiologic data [3]. Although De Clérambault had already made reference to a "pure" and a "secondary" form of erotomania, it was Hollander and Callahan that defined the current 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. 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 [4].

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 were unemployed and experiencing financial difficulties. She was admitted to a psychiatric acute ward because of a clinical picture of behavioral changes and delusional belief that a famous TV news-anchor was in love with her. She claimed that they had met in a restaurant 30 years ago and now he was talking to her and sending her signs of his love through the TV. She stated that she had never had any other previous boyfriends, nor did she intend to, because she was "saving herself" for this man. Her mood was dysphoric and she had insomnia. Concerning her pre-morbid personality, she was described by her sister as shy and mistrustful, with no friends. She had no personal or family history of psychiatric pathology. During the first days at the psychiatric ward, she would stare in front of the TV, watching the news in order to be in contact with the referred news-anchor. She was treated with valproic acid 1000mg daily and risperidone 2mg daily. After two weeks of treatment, her mood was euthymic, her sleep pattern regularized and her behavior was adequate. The erotomanic delusion 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. She maintained regular psychiatric appointments and her erotomanic beliefs slowly started to fade away, with progressive devaluation of these ideas [5].

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. 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 [6].

Clinical Presentation

Erotomania has a consistent clinical presentation across all cultural settings. 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

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perceived as physically attractive, with superior social standing, which often leads to him/her being unattainable to the subject [7].

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. Hallucinations are rare but may be present, namely tactile hallucinations, usually with a sexual connotation.

Social isolation is characteristic of these patients, who don't 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.

Etiology

The imagiological and neurobiological data on delusional disorders, including primary erotomania, are scarce. Neurochemical factors may have a role, namely imbalances in dopaminergic and serotoninergic pathways. 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.

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" 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. Hollender and Callahan 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. With this in mind, one can 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].

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.

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. 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, a practice supported by a 2015 review.

Having in mind the characteristics of the majority of patients with erotomania, various non-pharmacologic measures could be of use. 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 [10-12].

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 healthy patient with a background of poor social-economic environment, lack of affective relationships, isolation and personality traits of shyness and mistrustfulness, that developed an erotomaniac delusion. This case can be conceptualized as a case of primary erotomania and we can hypothesize that the delusion served a specific intrapsychic function, delivering narcissistic gratification and 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 [13-15].

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 [14].

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

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