Gregory B. Leong,[1] *M.D.*

De Clérambault Syndrome (Erotomania) in the Criminal Justice System: Another Look at This Recurring Problem

REFERENCE: Leong, G. B., **"De Clérambault Syndrome (Erotomania) in the Criminal Justice System: Another Look at This Recurring Problem,"** *Journal of Forensic Sciences*, JFSCA, Vol. 39, No. 2, March 1994, pp. 378–385.

ABSTRACT: While de Clérambault syndrome (erotomania) has long been a subject of scientific study, it has only recently become a frequent topic of media attention. A series of five individuals who were arrested for crimes related to their erotomanic delusion are presented. The psychiatric findings from this sample have potential social policy implication.

KEYWORDS: psychiatry, erotomania, de Clérambault's syndrome, dangerousness, delusions

Erotomania, or perhaps more accurately erotomanic delusions, has been reported since ancient times [*1,2*]. Erotomania, however, did not receive formalized recognition in Western medicine until 1921 when the French psychiatrist Gatain de Clérambault described six cases of "psychose passionelle" [*1,2*]. Persons now experiencing erotomanic delusions (erotomania) are commonly referred to as having de Clérambault's syndrome. De Clérambault's syndrome has a special place in modern psychiatry. In the most recent edition of the Comprehensive Textbook of Psychiatry, Neppe and Tucker list [de] Clérambault's syndrome as a separate type of "unusual psychosis" in the book's section on "Psychotic Disorders Not Elsewhere Classified" [*3*]. The current American diagnostic nosologic system, DSM-III-R, includes "delusional (paranoid) disorder, erotomanic type" which forms the modern categorization of persons whose primary presentation is that of erotomanic delusions [*4*]. Although, as Segal observes, the DSM-III-R criteria for erotomania generally follow an earlier description of erotomania by Krapelin [*2*], this paper uses erotomania interchangeably with the eponym de Clérambault's syndrome.

Nine features comprise the de Clérambault's syndrome: the patient has a delusional conviction of being in amorous communication with another person; the object of the amorous delusion is of much higher rank; the patient believes that the object of the delusion was the first to fall in love; the patient believes that the object of the delusion was the first to make advances; the amorous delusion is always directed toward the same individual throughout the episode; the patient rationalizes the paradoxical behavior of the object of the delusion; the onset of the delusion is sudden; the course of the delusion

Received for publication 25 Feb. 1993; revised manuscript received 24 June 1993; accepted for publication 27 July 1993.

[1]Assistant Professor of Psychiatry, School of Medicine, University of California at Los Angeles; and Staff Psychiatrist, West Los Angeles Veterans Affairs Medical Center, Los Angeles, California.

is sudden; the course is chronic; and hallucinations are absent [*5*]. In DSM-III-R's delusional disorder, erotomanic type there are five criteria: (1) the presence of a nonbizarre delusion(s) (that is, situations that occur in real life) of at least one month's duration in which the predominate theme of the delusion(s) is that a person usually of higher status, is in love with the subject; (2) auditory or visual hallucinations if present, are not prominent; (3) apart from the delusion(s) or its ramifications, behavior is not obviously odd or bizarre; (4) if a major depressive or manic syndrome has been present during the delusional disturbance, the total duration of all episodes of the mood syndrome has been brief relative to the total duration of the delusional disorder; and (5) the individual has never met criterion A for schizophrenia, and it cannot be established that an organic factor initiated and maintained the disturbance [*4*]. In essence, there are three principal DSM-III-R inclusion criteria—the first three listed above. These criteria are not as restrictive as de Clérambault's since the presence of hallucinations are allowed, the delusional person need not have thought that the erotomanic object was the first to fall in love or make advances, the onset is not required to be "sudden," nor does the erotomanic object need to be constant for any specific time period after satisfying the initial one month period of delusional thinking. The fourth and fifth criteria are exclusionary criteria in which a mood disorder, schizophrenia, or an organic mental disorder is to be diagnosed irrespective of the presence of erotomanic delusions. It should be noted that erotomanic persons who can satisfy all of de Clérambault's restrictive criteria are very rare [*4*], though most erotomanic persons meet most of these criteria [*4,6*].

Statistically reliable and valid studies of the primary diagnosis of persons suffering from erotomanic delusions have yet to be performed. However, drawing from surveys in the prior literature, a trend can be identified. Ellis and Mellsop found that the majority of their study sample of 58 de Clérambault's syndrome patients suffered from paranoid schizophrenia [*4*]. El Gaddal found in his analysis of 62 patients with de Clérambault's syndrome that 35% suffered from schizophrenia, paranoia or paraphrenia, 22.5% from an affective disorder, 21.3% from an organic disorder, and 10% from a neurotic disorder [*7*]. A mail survey of psychiatrists by Gillett and colleagues found that of the eleven patients suffering from erotomanic delusions, diagnoses were as follows: three with delusional disorder, erotomanic type, four with schizophrenia, three with bipolar disorder, and one with schizoaffective disorder [*6*]. These studies indicate that erotomanic delusions occur in a few distinct mental disorders with a possible trend leaning toward schizophrenia as the most common though not necessarily majority diagnosis.

While de Clérambault's syndrome has been the subject of scientific inquiry, it has also more recently been a frequent media topic. Erotomanic delusions figure prominently in the thinking of the so-called "celebrity stalkers" or "obsessed fans." Arguably, the most recently notable person suffering from erotomanic delusions was President Reagen's would-be assassin, John Hinckley, Jr. [*8*]. Another notorious person was Prosenjit Poddar who killed Tatiana Tarasoff, leading to the landmark legal case of *Tarasoff v. Regents of the University of California* [*8,9*] and the start of a nationwide mental health "duty to protect" doctrine [*10*]. In the so-called "entertainment capital of the world," Los Angeles, there have been several media accounts of persons suffering from erotomanic delusions who attempted or perpetrated violent acts, including homicide (see for example, [*11–13*]). However, those with erotomanic delusions have not always targeted celebrities and politicians. In recognition of the growing problem of stalking and harassment to all citizens, the Los Angeles Police Department has recently set up a Threat Assessment Unit to investigate and apprehend among others, erotomanic individuals [*14*].

A search of the anglophonic psychiatric literature found only three papers whose emphasis involves the forensic aspects of erotomanic delusions. Although these papers include a very limited number of cases that do not lend themselves to a meta-analysis, the papers present some data that can be used for comparison with this paper's sample.

Taylor and associates examined 112 psychotic men who were in the British prison system as a result of a violent crime charge [*15*]. They found three fulfilling the criteria for erotomania, although the criteria they used was much less restrictive than the original de Clérambault criteria. In their sample they included a fourth subject who was receiving court-ordered treatment. However, beyond the case reports, there were few significant data that could be used for comparison and quantitative study. The ages of the subjects could only be extrapolated: one in his late twenties or early thirties, one in his mid-twenties, one in his mid-thirties, and one in his late forties. The authors noted that each of the four persons had previously received a diagnosis of paranoid schizophrenia, and they gave three of them this diagnosis at the time of evaluation. However, they expressed some doubt as to whether schizophrenia was the most appropriate diagnosis. All four erotomanic objects were females.

In Noone and Cockhill's study of six cases of erotomania, three involved non-criminal, non-forensic cases arising from a general hospital psychiatric emergency service or an outpatient referral of a college student by a faculty member [*16*]. Their three forensic cases came from psychiatric assessment during the course of a criminal case. All three forensic cases were male. Each received a primary diagnosis of paranoid schizophrenia. Their ages were 25, 34, and 36. Only one of the three criminal defendants suffered from auditory hallucinations. All three erotomanic objects were females.

Goldstein's forensic study of de Clérambault's syndrome in men included seven cases [*8*]. However, at least two cases did not appear to be from the author's own study, namely the aforementioned John Hinckley, Jr. and Prosenjit Poddar. Of the five remaining cases, three had their ages list as 23, 35, 44, "middle-aged" and "young." The diagnoses of these five were not given. All five erotomanic objects were females.

In this paper, a sample of five persons referred for psychiatric assessment by the court in a 21 month period from June 1989 through February 1991 are discussed. The five cases are briefly presented in this paper. One case (Case 5) has been previously described in detail elsewhere [*17*].

Case 1

Ms. A, a 39-year-old divorced white female, was arrested for non-sufficient check fund and grand theft of labor after receiving services in two different beauty salons to prepare herself for a confrontation with her erotomanic object. Ms. A had come to Los Angeles to file a "breach of contract suit" against a famous male singer who had allegedly "promised" to marry her and then changed his mind. She had harbored the delusion that the singer was in love with her from afar for several years prior to her arrest. Ms. A gave a history of having heard the singer's voice speaking to her. She had become further angered because she believed that this singer had previously tried to prevent her from coming to Los Angeles by having her "framed" with a shoplifting (petty theft) charge in her hometown. When she went to court for the shoplifting case, the judge ordered her into psychiatric treatment, at which time antipsychotic medication was prescribed. After arriving in Los Angeles, she went to the Department of Motor Vehicles and took out a license in the name of the wife of a famous late night television show host. Ms. A explained that she changed her name to that of the wife of the television show host because he had "accepted" her letters of complaint about the singer. Ms. A illogically reasoned that the television show host was in agreement with her position because he did not answer her letters. Since the arrest, she has accused the television host of turning against her and being in a conspiracy with the singer against her. She was given a DSM-III-R diagnosis of delusional disorder, erotomanic type.

Case 2

Mr. B, a 30-year-old never married white male, was arrested for residential burglary. He believed that the house he had entered belonged to a famous female singer toward whom he harbored a long-standing erotomanic delusion. In fact, the house was near the house of the singer's parents. This was not the first time he had been near the gated security neighborhood of the singer's parents; Mr. B had been picked up by the local police and involuntarily hospitalized a few months prior to his arrest. During the hospitalization he was prescribed antipsychotic medication. In addition, he had written several letters and telephoned the singer at the home of her parents, assuming that she resided there. The singer's parents had requested extra police patrols a month prior to his arrest. Mr. B harbored the delusion that the female vocalist had been in love with him for five years preceding his current arrest, ever since he first saw one of her music videos. Mr. B denied ever experiencing auditory hallucinations. He had a past history of arrests for burglary, petty theft, battery, possession of a dangerous weapon, and possession of a controlled substance. He was given a DSM-III-R diagnosis of schizophrenia, paranoid type, chronic.

Case 3

Mr. C, a 34-year-old never married white male, was charged with three counts of vehicle burglary, one count of attempted vehicle burglary, and one count of making annoying or threatening phone calls. All the crimes were directed at his former female psychotherapist whom he had initially seen when she was in training. She continued to see him for a while after completion of her training program, using her apartment as an office. Mr. C began to become "obsessed" with her and stalked her, even though he knew where she lived. He also had harbored other delusions for the preceding eight years, including believing that he had AIDS because of putative changes in skin color and that his body emanated an odor telling others he was a "latent homosexual." Mr. C denied ever experiencing auditory hallucinations. Prior to meeting this psychotherapist, he had received inpatient and outpatient psychiatric treatment, including antipsychotic medications, elsewhere. Mr. C had no prior criminal history. He was given a DSM-III-R diagnosis of schizophrenia, paranoid type.

Case 4

Ms. D, a 31-year-old separated or divorced black female, was charged with making annoying or threatening phone calls to a reserve military officer whom she had seen during her weekend reserve duty years ago. Her only interaction with him was that he had said "Hello" during one weekend. She believed that this gesture served as proof of the officer's love for her because he had been "unduly familiar" with an enlisted person by the use of the everyday salutation. Ms. D only saw the officer for four weekend tours before he transferred out of her unit and did not have any other interaction with him. Despite never seeing him again on weekend reserve duty, she developed a "compulsion" to contact him and had served previous jail time for making harassing phone calls to the officer. In fact, during her current jail time for the instant arrest, she telephoned the officer from the jail. Ms. D gave a history of having heard the officer speaking to her. During her previous jail time for the initial harassing phone calls charge, she had been psychiatrically hospitalized and treated with antipsychotic medication. She was given a DSM-III-R diagnosis of schizophrenia, paranoid type.

Case 5

Mr. E, a 39-year-old never married white male, was charged with violation of a court order. The court order was a restraining order taken out by the 40-year-old woman who was Mr. E's former physician. Mr. E first met the woman physician seven years before his arrest when he accompanied his mother on his mother's medical appointments with the woman physician. The physician subsequently also became Mr. E's personal physician as well. About a year before his arrest, Mr. E developed the delusion that the woman physician was falling in love with him. After numerous attempts at returning her putative love, including sending her an engagement ring, as well as frequently showing up at her office, hospital, and even beauty salon, the physician took out a restraining order.

Mr. E had a brief course of outpatient psychiatric treatment, including antipsychotic medication, after the onset of his erotomanic delusion and before the restraining order was taken out. About a year prior to the development of the erotomanic delusion, Mr. E reported being monitored by overhead helicopters, had his telephone wiretapped, and that his apartment had been burglarized only of the legal papers of the many lawsuits he had been filing against insurance and aerospace companies. He had even traveled to Washington, DC to report this harassment to government authorities. He gave no history of auditory hallucinations. Mr. E had no prior criminal history. He was given a DSM-III-R diagnosis of schizophrenia, paranoid type.

Discussion

Demographic Characteristics

All five of the present cases were in their 30s. This finding is consistent with the age range found in the previous literature [*8,15,16*]. The erotomanic delusion of all five of the present cases persisted for at least one year, indicating chronicity of the delusion. The age at which this five individuals presented to the criminal justice system has ominous implications, since they are relatively young and their delusions have already demonstrated permanence. While persistent delusions in of themselves may not be significant, the fact that these five persons translated their erotomanic delusions into action is of major concern.

The three males in the present study had never married. The two females had failed marriages. This is consistent with the poor overall interpersonal adaptation of chronically psychotic individuals. The ethnic distribution of the sample was unremarkable.

The Erotomanic Object

The erotomanic objects targeted by these five delusional individuals showed no particular trend: two were health care providers (Cases 3 and 5), two were celebrities (Cases 1 and 2), and one had been an occupational superior, the reserve military officer (Case 4). While the risk for attracting erotomanically prone individuals is greater if the target is a high profile figure, such as an entertainment celebrity, politician, or professional athelete, this sample suggests that health care providers may also be at an increased risk. In comparison to the high profile individual, the health care provider is more likely to have met and established some type of professional relationship with the delusional person. This could serve as a "real" basis for their delusions as the caring and concern given by health care providers during the course of their job can be easily misinterpreted by the delusionally susceptible person. Psychotherapists may be at even greater risk than other health care providers because transference phenomena that occur during therapy can be a stimulus for the development of the erotomanic delusion.

The stimulus for the erotomanic delusion need only be minimal as demonstrated by Case 4 in which a simple "Hello" was sufficient. In Case 2, the delusional man needed only to have viewed a music video to develop his erotomanic delusion. But as noted above, once the delusion takes hold, it is persistent and chronic. In three cases (1, 2, and 4), the erotomanic object had no significant relationship with the delusional person. This serves to highlight the distress and exasperation erotomanic objects can experience, especially when they have had no personal involvement in the development of the delusion.

All five erotomanic objects were the opposite gender of the delusional person. This conforms to the results of the prior forensic studies [*8,15,16*] and of the published literature on erotomania. However, cases of erotomania involving the same sex in both the delusional individual and erotomanic object have been known to occur [*18*].

Psychiatric Factors

Only two of the five individuals (Cases 1 and 4) acknowledged experiencing auditory hallucinations. These hallucinations were of the voice of the respective erotomanic objects. Three of the five acknowledged harboring other delusions (1, 3, and 5). Of these three, all experienced other persecutory delusions and one (Case 3) described somatic delusions. In the remaining two cases (2 and 4), only the erotomanic delusion was acknowledged.

All five individuals had received previous psychiatric treatment, although two had no previous inpatient treatment prior to their present arrests (Cases 1 and 5). All had been prescribed antipsychotic medication in the past, although all were non-compliant with medication recommendations. None of the five exhibited any psychological insight into their delusional thinking, insisting on the accuracy of their perception of love by the erotomanic object.

Diagnostically, each had a differential diagnosis in which the two most likely possibilities were schizophrenia, paranoid type and delusional disorder, erotomanic type. Based on their mental status examinations and psychiatric histories, four were more likely to have been suffering from schizophrenia (Cases 2 to 5) and one from delusional disorder (Case 1). However, as in the study by Taylor and colleagues, there was some doubt as to whether paranoid schizophrenia best fit four of this sample's subjects [*15*]. Even with the precision of the DSM-III-R nosology, the diagnosis of schizophrenia versus delusional disorder was not readily apparent. This finding is also consistent with the idea that paranoid schizophrenia merges with delusional disorder along a continuum, at least in terms of phenomenology, though not necessarily biologically. Nevertheless, aside from the complexities of the DSM-III-R diagnostic dilemmas, each of the five cases fit most of the de Clérambault syndrome criteria and behaved accordingly.

Dangerousness

A history of physical violence is the best indicator of future acts of physical violence; and the more crimes a person has committed, the more likely he or she will commit additional ones in the future [*19*]. Only three cases had a prior criminal history (Cases 1, 2, and 4). Of those with a prior criminal history, Mr. B's criminal past, that included a battery charge, strongly suggested a significant potential for either future physical violence or future criminality. Ms. D might be considered to be at higher probability for future violence given her continued verbal threats by telephone despite arrests and incarceration. Her failure to respond to the criminal-legal sanctions is a significant danger signal and her behavior could readily escalate beyond verbal assault. However, the greatest threats posed to the erotomanic targets appear to have come from the men in the sample (Cases 2, 3, and 5). In addition, a past criminal history was not a useful

indicator as two of these three had none (Cases 3 and 5). Both delusional females (Cases 1 and 3) had criminal histories, but appeared to present a lesser danger than the males. This appears to be consistent with who commits violent acts in our society given the marked predominance of men over women in the prison system.

Despite the small sample size, trends can be identified. Forecasting future acts of physical violence cannot be made with a high degree of accuracy [*19*]. Nonetheless, these five individuals have already demonstrated themselves to be a higher risk because of the behavioral actualization of their erotomanic delusions. The sole similar feature found among all five cases in this sample was the presence of the erotomanic delusion. Psychodynamic explanations for the behaviors may explain the genesis of the delusion and behaviors [*8,15,16*], but cannot adequately answer which individuals will act on their delusions.

Future Directions

To realize the goal of providing a more definitive answer to questions about de Clérambault's syndrome in the criminal justice system, a large sample needs to be studied and followed. Such individuals could be identified at the time of the first entry into the criminal justice system and then followed for several years using a longitudinal national criminal database. Only by compiling multiple biopsychosocial factors as was done in the present sample might a correlation with future aberrant behavior be developed along an actuarial model. Society will then be given a clearer notion as to the approximate probabilities that different subsets of erotomanic individuals will create problems for others.

Of significance to social policy makers is that the data from the current sample and previously published literature suggest that the average age at which these individuals enter the criminal justice system is in the thirties. Given that the erotomanic delusion and associated erotomanic object had already become a permanent mental fixture and the delusional individual had transcended the threshold for criminal behavior in an attempt to reach the erotomanic object, the danger posed by these individuals could conceivably last the lifetime of the delusional person—about an average of 30 more years. The fact that the crimes perpetrated by those in the present sample had not yet reached tragic proportions does not alleviate the need to develop social policy to consider heightened social control of these individuals. The low optimism for efficacious psychiatric intervention as reported in the psychiatric literature [*1,15*] and demonstrated by the five persons in this series, implies that social policy should not place much emphasis on psychiatry and other mental health disciplines in diminishing the erotomanic delusion for the foreseeable future. Thus, involuntary psychiatric treatment does not appear to be a viable solution. Social policy makers will have to decide what actions need to be taken to address the vexing problem of the de Clérambault's syndrome individual. If they do not apply a new approach, then the erotomanic objects will remain as potential victims. Moreover, as Dietz observed (as cited in [*20*]), it is not only the erotomanic object, but also those persons blocking the pathway to the object that are at risk for harm by the delusional individual. Whether there is a criminal or civil remedy, efforts need to be taken to decrease the likelihood of harm to the erotomanic object, or more aptly erotomanic target.

References

[*1*] Enoch, M. D. and Trethowan, W. H., *Uncommon Psychiatric Syndromes*, John Wright and Sons, Bristol, England, 1979, pp. 15–35.

[2] Segal, J. H., "Erotomania Revisited: From Kraepelin to DSM-III-R," *American Journal of Psychiatry*, Vol. 146, 1989, pp. 1261–1266.
[3] Neppe, V. M. and Tucker, G. H., "Atypical, Unusual, and Cultural Psychoses," *Comprehensive Textbook of Psychiatry/V*, Volume 1, H. I. Kaplan and B. J. Sadock, Eds., Fifth Edition, Williams & Wilkins, Baltimore, 1989, pp. 842–852.
[4] *Diagnostic and Statistical Manual of Mental Disorders*, Third Edition-Revised, American Psychiatric Association, Washington, DC, 1987.
[5] Ellis, P. and Mellsop, G., "De Clérambault Syndrome—A Nosological Entity?" *British Journal of Psychiatry*, Vol. 146, 1985, pp. 90–95.
[6] Gillett, T., Eminson, S. R., and Hassanyeh, F., "Primary and Secondary Erotomania: Clinical Characteristics and Follow-up," *Acta Psychiatrica Scandinavica*, Vol. 82, 1990, pp. 65–69.
[7] El Gaddal, Y. Y., "De Clérambault's Syndrome (Erotomania) in Organic Delusional Syndrome," *British Journal of Psychiatry*, Vol. 154, 1989, pp. 714–716.
[8] Goldstein, R. L., "More Forensic Romances: De Clérambault's Syndrome in Men," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 15, 1987, pp. 267–274.
[9] Tarasoff v. Regents of the University of California, 17 Cal. 3d 425 (1976).
[10] Felthous, A. R., *The Psychotherapist's Duty to Warn or Protect*, Charles C Thomas, Springfield, IL, 1989.
[11] Axthelm, P., "An Innocent Life, A Heartbreaking Death," *People Weekly*, Vol. 32, No. 5, July 31, 1989, pp. 60–66.
[12] Schindehette, S., "Vanna White and Teri Garr Ask the Courts to Protect Them from Fans Who Have Gone Too Far," *People Weekly*, Vol. 34, No. 2, July 16, 1990, pp. 40–41.
[13] O'Shaughnessy, L., "Woman is Ordered to Avoid Supervisor," *Los Angeles Times*, July 11, 1990, p. B3.
[14] Zona, M. A., Lane, J., and Sharma, K. K., "A Comparative Study of Erotomanic Subjects in a Forensic Sample," presented at the 44th Annual Meeting of the American Academy of Forensic Sciences, New Orleans, February 17–22, 1992.
[15] Taylor, P., Mahendra, B., and Gunn, J., "Erotomania in Males," *Psychological Medicine*, Vol. 13, 1983, pp. 645–650.
[16] Noone, J. A. and Cockhill, L., "Erotomania: The Delusion of Being Loved," *American Journal of Forensic Psychiatry*, Vol. 8, 1987, pp. 23–31.
[17] Leong, G. B. and Silva, J. A., "The Physician As Erotomanic Object," *Western Journal of Medicine*, Vol. 156, 1992, pp. 77–78.
[18] Lovett Doust, J. W. and Christie, H., "The Pathology of Love: Some Clinical Variants of De Clérambault's Syndrome," *Social Science and Medicine*, Vol. 12, 1978, pp. 99–106.
[19] Monahan, J., The Clinical Prediction of Violent Behavior (DHSS Publication No. (ADM) 81-921), U.S. Department of Health and Human Services, Rockville, Maryland, 1981.
[20] Meloy, J. R., "Unrequited Love and the Wish to Kill: Diagnosis and Treatment of Borderline Erotomania," *Bulletin of the Menninger Clinic*, Vol. 53, 1989, pp. 477–492.

Address requests for reprints or additional information to
Gregory B. Leong, M.D.
Psychiatry Service (116 AA)
West Los Angeles VAMC
11301 Wilshire Blvd.
Los Angeles, CA 90073