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CASE REPORT

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De Clérambault's Syndrome (Erotomania) and Claims of Psychiatric Malpractice

ABSTRACT: De Clérambault's Syndrome or Erotomania was originally described as a delusional disorder in which a woman believes that an older man of higher social status is passionately in love with her. The patient's relentless pursuit of the delusional love object, often with escalating intrusiveness, may eventually involve threats or overt acts of retaliation, in response to repeated rejection, unrequited love, or alleged betrayal. Cases from the literature are reviewed in which the delusional romantic attachment involves the patient's psychiatrist or another medical specialist. The authors present a case involving a patient suffering from erotomania who develops a delusional fixation on her psychiatrist and, after her advances are repeatedly rejected, sues him for malpractice, alleging she had a sexual relationship with him in the course of treatment. The implications of the litigious paranoid, who uses the legal system to act out delusional concerns and retaliatory fantasies, are discussed. This is the first known case of an erotomanic patient claiming malpractice on the grounds that her psychiatrist had a sexual relationship with her.

KEYWORDS: forensic science, forensic psychiatry, De Clérambault's Syndrome, erotomania, paranoid disorders, stalking, psychiatric malpractice

In 1921, De Clérambault described a mental condition in which the patient (invariably a woman) holds the delusional belief that a man, usually older, successful, and of elevated social status (e.g., a member of the nobility, a political figure, or an entertainer), is passionately in love with her. The patient often desires a sexual relationship and may try to seduce the imagined lover or come to believe she is carrying his child (1). Goldstein and others have called attention to the finding that most individuals with this disorder in forensic samples are male, whereas female patients continue to predominate in general clinical samples (2–4). Formerly known as "Erotomania" or "De Clérambault's Syndrome," this condition is now enshrined in the diagnostic nomenclature as Delusional Disorder, Erotomanic Type (5). A grotesque drama often ensues when erotomanic patients act on their delusions, relentlessly bombarding their victims with telephone calls, letters, gifts, and visits. Persistent surveillance and stalking may occur. After repeated professions of love and advances are unrequited, these patients may become dangerous as resentment and rage are mobilized in response to perceived rejection by the love object. Although actual physical or sexual assaults are relatively uncommon, these patients may bring chaos to the lives of their victims by inflicting enormous psychological and social disruption as a consequence of their merciless harassment and pursuit over a period of many years. Their victims may be reduced to living in an unrelieved state of siege (6).

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Over the years, a number of reports have described cases in which physicians (including psychiatrists) have been the love objects of erotomanic patients (7–10). One psychiatrist authored a book describing the experience of being stalked for many years by a former erotomanic patient (11). Balduzzi described one of the earliest of these cases:

> an unhappily married female, aged 26 years, suddenly developed an ardent passion for a married doctor. She constantly pestered him with telephone calls and almost daily messages, and frequently visited his home . . . (She) would talk of nothing but 'him,' alleging that he had 'reciprocated several times with an ardor even more pronounced than her own.' She maintained that when she first met Dr. 'P,' she 'felt changed into another person . . . until then I had not lived.' Finally, the doctor's wife literally pushed her out the door. But threats and scenes only increased her 'love' (12).

Raskin and Sullivan reported two cases in which the delusional love object was the patient's treating psychiatrist. In one of the cases, the patient,

> a 37-year-old woman, had felt for the past 10 years that a prominent psychiatrist was in love with her. She first consulted this psychiatrist with her husband about their marital difficulties. (She) became convinced that her psychiatrist was going to marry her. During the period of counseling she had suddenly felt that he was sexually interested in her: she interpreted his behavior as communicating this interest to her. She openly acknowledged her awareness of his feelings and her interest in him, which caused the termination of treatment. During the treatment her doctor gave the patient

> medication. She is still convinced that this medication permitted him from that time on to control her mind (13).

In a recent report, Leong and Silva presented the case of a male erotomanic who developed the delusion that his mother's female non-psychiatrist physician was in love with him.

> He made many telephone calls to the physician, sent her a 'love letter' by registered mail, and sent her numerous gifts, including an engagement ring. He spent a great deal of time at the hospital where the physician attended patients and at her hair salon. Despite her obtaining a restraining order against him, the patient remained undeterred and made several attempts to contact her to complain about the restraining order. He not only telephoned and paged her answering service but also continued to visit her office and the hospital. Four months after the restraining order was filed, on Valentine's Day, the patient sent the physician a Valentine's Day card with a letter accusing her of 'gross misconduct,' 'mismanaging his mother's care,' and having 'played' on his emotions. He signed the letter, 'love always.' While in jail, he telephoned the physician and demanded to see her alone 'to avoid the inevitable' (14).

After his arrest, he was subsequently committed to a psychiatric hospital for 180 days and was prevented from carrying out his threat. It is unclear whether, in view of his history of prior litigiousness (he had filed lawsuits against various insurance companies and others), he had intended to lodge a complaint of professional misconduct or sue the physician for malpractice. The case we report in this paper represents the first time, to our knowledge, that a patient suffering from Erotomania brought a medical malpractice lawsuit against her former treating psychiatrist, alleging that he had engaged in sexual relations with her during the course of treatment.

Case Report

Ms. A was in psychiatric treatment with Dr. R for Erotomania and a mood disorder. She was treated with psychotherapy and a combination of psychotropic medications (an antipsychotic agent, a mood stabilizer, and an antidepressant). Dr. R noted that she was sexually obsessed with him, as well as physically assaultive at times. During the course of treatment, Dr. R became increasingly unavailable to the patient, as a result of his own worsening substance abuse problem. At various times, his office-mate, Dr. D, covered his practice during his absences and saw Ms. A on an *ad hoc* basis. Ms. A told Dr. D that she wanted him to become her psychiatrist. She later revealed that the very first time she had heard his "soothing voice," she had developed strong feelings for him. On one occasion, while Dr. D was with another patient, she burst into his office with an over-sized pair of gardening shears and proceeded to hack a small potted tree to pieces. Dr. D was quite shaken by the incident and immediately sent her a letter informing her that he would no longer continue to treat her when Dr. R was unavailable. Subsequently, she began to telephone Dr. D incessantly, sometimes dozens of times in a single day, claiming there was an emergency. Later, she admitted that she had made up these "emergencies" as a pretext to contact Dr. D. She sent him countless letters, love poems, and gifts of a suggestive nature (e.g., condoms and lingerie). On one occasion, disguised in a wig, she gained entrance to the hospital psychiatric ward where he worked. On another occasion, she hurled a painted brick (decorated by her with glitter and plastic pearls) through his office window. On still another occasion, he learned that Ms. A, presumably during a session with Dr. R, had changed Dr. D's outgoing message on his office answering machine. This pattern of intrusive pursuit and harassment of Dr. D escalated as Dr. R, her primary psychiatrist, became increasingly unavailable. (He subsequently had to give up his practice and enter a rehabilitation program.) Ms. A began to express her conviction that Dr. D was in love with her, planned to run away with her, and wanted her to have his baby. (In reality, he had continued to spurn her advances throughout, but did continue to take her "emergency" calls reluctantly, out of concern about her impulsiveness.)

Ms. A subsequently claimed that Dr. D had been sexually intimate with her over a period of months, allegedly telling her that she needed this "relaxation therapy," in order to get better. (The claimed sexual activity allegedly took place many months after Dr. D had notified her in writing that he would no longer treat her.) Although her description of these alleged incidents was somewhat vague, inconsistent, and variable, she maintained that Dr. D had progressed from fondling her to sexual intercourse over a six-month period at his office and on the hospital ward. The only evidence she adduced to support her claim was a number of canceled checks she had paid to Dr. D during the period in question. (Dr. D had told her on occasion that he would have to charge her a nominal fee if she continued to place the spurious emergency telephone calls to him. He never intended to charge her and never billed her for the calls; he was merely attempting to discourage her from calling. Ms. A, however, took him literally at his word and kept track of the number of calls herself, periodically mailing checks to his office. Upon receipt of these checks, his bookkeeper, unbeknownst to Dr. D, automatically deposited them into the office account. The memo section of some of the checks had notations by Ms. A, such as "I love you" or "My monster!")

Dr. D denied unequivocally that he had ever engaged in any kind of sexual relationship with the patient or that he had even seen her face-to-face during the period in question. His office receptionist and the hospital staff testified that there had been no visits by the patient at the times she claimed that impermissible sexual contacts had taken place. After the malpractice lawsuit had been initiated, but prior to trial, Ms. A claimed that her current treating psychiatrist, Dr. Z, had also been having sexual relations with her. She claimed that she had audiotapes to support this latter charge. Her allegations regarding Dr. Z were not admissible at trial. Shortly before trial, Ms. A terminated her treatment with Dr. Z and brought a malpractice lawsuit against him as well, again on the grounds of sexual misconduct. She immediately entered treatment with a clinical psychologist (Dr. X), who reported that within a short time she began to bombard him with demanding telephone calls and show up unannounced at his office. Dr. X charged her for the calls and the impromptu office visits.

The psychiatric expert retained by Ms. A testified that her claims were too detailed to be delusional and that, furthermore, he found her to be highly credible, in large part because she seemed to know a number of personal facts about Dr. D's private life. Dr. D's retained psychiatric expert testified that she presented as a classic case of Erotomania, that she had transferred her delusional fixation from Dr. R to Dr. D, as the former became increasingly unavailable to her, and that her claims of sexual misconduct were based in their entirety on her delusional system. He noted further that it has been well established that erotomanic individuals and stalkers are highly resourceful and able to acquire a detailed knowledge of their victim's personal life and movements, enabling them to maintain their relentless pursuit and harassment. He called attention to the finding

that Ms. A had regular access to Dr. D's office. Dr. D shared the same office with Dr. R on alternate days. During Dr. R's sessions with the patient, he often gave her free rein over the office. At such times, she sometimes destroyed or removed items from the office. Dr. D noticed that personal articles were often missing from his desk. On one occasion, Ms. A even managed somehow to erase Dr. D's message from his answering machine and replace it with her own voice.

After a full trial,[3] the jury returned a unanimous verdict in favor of the defendant doctor. They believed that Ms. A's claims were the product of her erotomanic delusions. Although Dr. D was relieved and felt vindicated by the verdict, he and his family had lived through years of stressful litigation, a cloud over his professional reputation and future, and the prospect of financial ruin. A verdict against him would have resulted in the revocation of his medical license and personal liability for all monetary damages awarded to the plaintiff. In cases of sexual misconduct, if proven, the malpractice insurance carrier is not responsible for the payment of damages, but only for the legal expenses of defending the doctor during litigation.

Discussion

Although there are a number of cases reported in the psychiatric literature that indicate that physicians are not immune to becoming the love object of a patient's erotomanic delusional fixation, none of the cases describe a dénouement involving a rejected patient's retaliation against the doctor in the form of either violence or suing for malpractice. This case is the first time, to our knowledge, that a psychiatrist has been sued for malpractice by an erotomanic patient, on the grounds that sexual contact had taken place. Leong and Silva's case came the closest to this, when the patient made a thinly veiled, ambiguous threat that the physician had acted unprofessionally by toying with his emotions. When the erotomanic patient reaches the stage of resentment and hatred (which replaces love) after repeated rejections at the hands of the delusional love object, not infrequently there is retaliation against the object of the patient's passion (or against third parties viewed as trying to come between the lovers). There is a potential for violent behavior and stalking in erotomanic patients, with rates of overt aggressive behavior as high as 57% in populations of primarily male subjects seen in forensic practice (15,16). In general, most stalkers who are not actual ex-intimates are not violent and psychotic stalkers are typically less violent than non-psychotic ones (17). Recent studies indicate that prior sexual intimate stalkers have violence frequencies greater than 50% (JR Meloy, personal communication, 2001).

In the context of our litigious society, it comes as no surprise that a vengeful erotomanic patient, infuriated by the perception of rejection and abandonment by the object of her passion, may resort to litigation as a means of inflicting a more measured form of retribution. In recent years, patients have become increasingly educated about the legal and ethical sanctions they may seek against their psychiatrist when boundary violations occur. The trauma of being sued for malpractice is a truly exquisite form of modern-day torture. This is even more stressful in cases involving sexual misconduct, where an unfavorable verdict means certain revocation of the doctor's license and total liability for whatever money damages are awarded to the patient.[4]

[3] The authors were involved in the trial of this case. (RLG was the defendant doctor's psychiatric expert; AML was his attorney.)

[4] In this case, the terrible stress of years of litigation exacted a staggering emotional toll on Dr. D., his family and coworkers.

Psychiatrists who are treating an erotomanic patient have an actual, real-life relationship with the delusional individual. This is in contrast to many erotomanics whose relationship with their delusional love object is non-existent in reality (i.e., a totally fantasized relationship from afar with a celebrity or stranger they have never in fact met). Is the superimposed transference that develops in psychotherapy (even to the magnitude of an "erotic transference"(18)) a factor that makes it more likely that an erotomanic patient will fixate on the psychiatrist? Although uncommon, delusional attachment to serial or multiple love objects may occur in the course of erotomania (19). A patient with pre-existing erotomania may therefore transfer the delusional fixation from the original love object to the psychiatrist. In other cases, the erotomanic fixation to the psychiatrist may be the first manifestation of the patient's erotomania. It appears that in our case, the patient transferred her delusional attachment from Dr. R to Dr. D and to others. There does appear to be a risk that in treating these patients, under certain circumstances, the delusional fixation may be transferred from the original object to the treating psychiatrist. Even in the absence of a transference *per se*, in the case of a non-psychiatrist physician (as in the case reported by Leong and Silva), the doctor may represent an attractive prototype for the patient's choice of a love object. Doctors are likely to meet the criteria of being of elevated social status, intelligent, caring and even, in the eyes of the patient, omnipotent.

Litigious paranoids may use the legal system as a vehicle to act out their delusional concerns and retaliatory fantasies against those individuals they believe have wronged them. Not infrequently, as in our case, the paranoid's victim finds himself ensnared in a protracted nightmare of litigation, seemingly without end. Even in the case of a grossly paranoid litigant, Courts usually are reluctant to deny such an individual his or her "Day in Court." The Courts recognize that there is not always a bright line between what is paranoid and what is real. Accordingly, the Courts reason that paranoids, like their "normal" counterparts, may suffer real injuries and are entitled to the protection of the legal system. Fortunately, the adversarial system in many respects is "anti-paranoid," in the sense that it encourages the presentation, analysis, and thorough discussion of the matter at issue. Vague accusations, suspicions, and delusional distortions may satisfy the paranoid individual and confirm his or her convictions in private, but this is not sufficient to withstand the unyielding scrutiny of the legal process, where they must be proven and backed up with evidence. The Courts recognize that, as the old saw goes, "even paranoids may have enemies." Like other non-bizarre delusions, erotomanic delusions involve situations that can conceivably occur in real life. It is possible, however remotely so, that an erotomanic patient may really have been sexually exploited by an unscrupulous or impaired psychiatrist. Simply because the subject matter of the lawsuit bears an uncanny resemblance to the subject matter of the patient's delusional system does not necessarily rule out a factual basis for the patient's claim. The erotomanic patient's claims cannot and should not be automatically rejected out of hand. The matter must ultimately be decided, notwithstanding the patient's incontrovertible psychotic condition, on the basis of all the evidence, as weighed and evaluated by an impartial fact finder. The unshakeable delusional system that evolves in the dark recesses of the paranoid's mind is relentlessly dissected and laid bare in the bright glare of the courtroom. Although the litigious paranoid frequently resorts to the judicial arena, often with fanatical determination, vindictiveness, and an implacable will to retaliate against his or her enemy, when it is functioning as it should, the "Court system is inherently anti-paranoid and serves as a corrective to paranoid distortions of reality (20)."

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