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De Clérambault's Syndrome (Erotomania) in Organic Delusional Syndrome

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A patient with de Clérambault's syndrome (erotomania) following brain damage and epilepsy is described. The delusion appeared after brain surgery for subarachnoid haemorrhage, and remained chronic. Erotomania in this patient may be judged to be aetiologically related to organic brain damage.

De Clérambault, in the 1920s, described the most well-known of the 'erotic delusions' as "pure erotomania". This syndrome is characterised by the 'fundamental postulate' of a woman having the conviction of being in amorous communication with a person of higher rank, whom she claims was the first to fall in love (Enoch & Trethowan, 1979). The delusion becomes chronic, and secondary or mixed forms can occur.

Erotomania has so far defied precise psychiatric classification. Although de Clérambault delineated a pure form of the syndrome, most modern writers tend to consider it as related to one of the major psychoses, i.e. schizophrenia or the affective disorders. The nosological controversy may in part be due to the poor description of pre-morbid history, personality and phenomenology. The revised DSM-III (DSM-III-R; American Psychiatric Association, 1988) classifies it as a specific type of delusional disorder.

Until recently, few cases of erotomania have been reported where there was an association with organic pathology. I present a case of erotomania in a patient with organic delusional syndrome.

Case report

Miss K., a 29-year-old right-handed single female, was found on referral to have erotic and paranoid delusions. She believed that she was deeply in love with a man who worked as an estate agent, from whom she rented a flat. She also believed that he was deeply in love with her and wanted to marry her, but was prevented from doing so because of pressure from "the DHSS and others". She pestered him with letters and telephone calls to such an extent that he had to move to another city, but she managed to find him. The man strongly denied any involvement with her, apart from the time he rented her the flat. She also believed that people were spying on her and trying to kill her.

In one incident, she wrongly accused a man of trying to rape her.

The patient had been diagnosed as having epilepsy following brain haemorrhage, when she was 25 years old. At that time, she developed headaches, nausea and vomiting while having sexual intercourse with her boyfriend. Subsequently, a large haematoma in the right temporal lobe with a superficial right parietal arteriovenous malformation was diagnosed. The haematoma was evacuated and the arteriovenous malformation branching from the right middle cerebral artery was excised. She made a good recovery, but was left with a left-sided hemiparesis and a left homonymous hemianopia, sparing the macular. She developed the epilepsy three months after the operation, and this was treated first with phenytoin and later with carbamazepine (600 mg daily).

A few months after the operation, her behaviour started to change gradually. It was described as "bizarre" for most of the time, and she was said to be "not her normal self". At age 27, she became resentful and aggressive towards her mother. She became a nuisance to neighbours, collapsing on their doorsteps, and she presented herself quite frequently to several accident and emergency departments, claiming that she had had another brain haemorrhage.

On referral, she was found to have a rather peculiar facial appearance. She has a brachiocephalic skull and hyper-extensible elbows and knees, but her symptoms do not resemble any recognisable syndrome. An EEG showed a right temporal epileptic focus, but a CT scan was normal. Psychometric tests showed evidence of parietal lobe damage and cognitive impairment. Her WAIS scores were: verbal 98; performance 67; full scale 84. Her pre-morbid IQ was above average. In the Benton test, she showed cognitive impairment. On the Wechsler Memory Scale, her short-term memory was intact for simple material, but impaired for complex material.

Before her brain haemorrhage, she had no history of psychiatric illness. Her pre-morbid personality was outgoing and extrovert. She had drunk heavily since her teens and had had a one-off experience with a hallucinatory drug. She had had many heterosexual relationships, and was described as sexually promiscuous. She often acted in an impulsive way. She had had a termination of pregnancy four months before her brain haemorrhage. She had also experienced two losses in her life: her father, to whom she was very close, died when she was 20 years old; and her boyfriend left her after a seven-year relationship, following her brain haemorrhage.

She was treated with flupenthixol decanoate, which helped her paranoid delusions, but her erotomania remained unchanged. In addition to flupenthixol, her maintenance medication included carbamazepine for her epilepsy. Other management interventions included attendance at the day hospital and several attempts at retraining for a suitable job.

Discussion

This patient met the DSM-III-R criteria for organic delusional syndrome and erotomania. Her epilepsy started three months after her brain damage; several months later she developed more general delusional symptoms, and erotomania was diagnosed about three and a half years later. The average latent interval between the development of epilepsy and the emergence of the symptoms is usually 14 years (Slater *et al*, 1963). Most authors consider that the shorter the interval between head injury and the development of psychosis, the stronger is the likelihood of the conditions being linked (Weller, 1985).

Few cases of erotomania with organic aetiologies have been reported. Recently, Signer & Cummings (1987) reported two cases of erotomania in organic affective disorder. They also stated that epilepsy with partial complex seizures and temporal lobe foci appears to be particularly common among patients with focal lesions and erotomania. Among patients with organic delusional disorders, most of those with Capgras symptoms have had lesions involving the right hemisphere, whereas a majority of patients with Schneiderian first-rank symptoms have had lesions involving the left hemisphere (Cummings, 1985). The patient described here represents the only reported case of erotomania with clearly demonstrable temporal and parietal lobe damage in the right hemisphere and associated epilepsy. Of the six cases reported by Schachter (1977), one had head trauma (with fracture of the right temporal bone), and one exhibited symptoms consistent with epilepsy. A third case had left temporal lobe epilepsy and a fourth had a deep epileptogenic focus due to sphenoid wing meningioma (laterality unspecified).

De Clérambault's syndrome has been reported in patients with alcoholism (Feder, 1973; Schachter, 1977). This patient continues to abuse alcohol to a marked degree, as she has done in the past. She also had an abortion four months before her brain haemorrhage. Erotomania following abortion (Balduzzi, 1956) and ingestion of oral contraceptive (Lovett Doust & Christie, 1978) have also been reported, but the gap between the abortion and the erotomania was about four years in our patient.

Ellis & Mellsop (1985) concluded that most cases of erotomania occur in the setting of schizophrenia, but Signer & Swinson (1987) considered that the literature supports a predominant role for severe affective disorder. In our own analysis, out of a total of 80 diagnoses given to 62 patients with erotomania, 35% were for schizophrenia, paranoia and paraphrenia, 22.5% for affective disorder, 21.3% for organic disorders and 10% for neurotic disorders. These figures add support to Ellis & Mellsop's (1985) observations that de Clérambault's syndrome is an aetiologically heterogeneous disorder and, like Schneiderian first-rank

symptoms, may be seen in a variety of psychotic conditions.

More cases with full details need to be reported for the nature and the aetiology of erotomania to be understood.

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Delusions of Pregnancy in Men

Case Report and Review of the Literature

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The case of a young, unmarried boy, who had moderate mental retardation, epilepsy, and post-ictal psychosis, is described here. During the psychosis, he believed he was pregnant, and had related behavioural disturbances. The review of other such cases reveals that organic brain damage was evident in all cases. Brain damage seems to be the more likely causative factor than psychodynamic factors.

The first case involving a delusion of pregnancy was reported by Esquirol in the 19th century (Vie & Bobe, 1932). Delusions of pregnancy in men are relatively rare, and have been occasionally reported as symptoms of a wide variety of psychotic states, including schizophrenia, melancholia, senile dementia, and general paresis, and following encephalitis (Baonville *et al*, 1935; Focquet, 1935; Jacobson, 1950; Neveu & Boyer, 1950; Alliez *et al*, 1956; Jenkins *et al*, 1962). The small number of recorded instances seems to be very small, and although there may be some common psychodynamic link determining the content of the delusion, this state does not appear to bear any real relationship to the Couvade syndrome, in which almost by definition the sufferer does not entertain the idea that he is pregnant (Enoch *et al*, 1967).

Delusions of pregnancy have been reported both in single and in married men, without, in the latter, bearing any definite relationship to their wives' pregnancies. Baonville *et al* (1935) described two cases: one was a 73-year-old man suffering from chronic organic brain syndrome; the other was a 44 year-old depressed patient. Marchand (Alliez *et al*,