

Response to electroconvulsive therapy in a case of erotomania

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Respuesta a la terapia electroconvulsiva en un caso de erotomanía

Summary

Secondary erotomania has mainly been associated with functional psychosis (especially schizophrenia) and bipolar disorder. Traditionally, erotomania has been considered chronic and refractory to treatment, although cases of secondary erotomania with response to benzodiazepines, lithium, anticonvulsants, antipsychotic drugs and electroconvulsive therapy have been described.

In this paper, we present a clinical case of secondary erotomania related to paranoid schizophrenia with good response to electroconvulsive therapy and neuroleptics.

Key words: Erotomania. De Clerambault. Psychosis.

Resumen

La erotomanía secundaria se ha relacionado fundamentalmente con las psicosis funcionales (especialmente esquizofrenia) y trastorno bipolar. Tradicionalmente, la cronicidad y resistencia al tratamiento han sido consideradas características intrínsecas de la erotomanía, aunque se han descrito casos de erotomanía secundaria con respuesta a benzodiazepinas, litio, anticonvulsivos, antipsicóticos y terapia electroconvulsiva.

En este trabajo presentamos un caso clínico de erotomanía secundaria asociado a esquizofrenia con buena respuesta a terapia electroconvulsiva y neurolepticos.

Palabras clave: Erotomanía. De Clerambault. Psicosis.

INTRODUCTION

In 1921, Kraepelin¹ included erotomaniac delusions in the delusion of grandeur, which together with persecution delusions and delusional jealousy, would form a part of the spectrum of paranoia. He defines it as «insidious development, depending on internal causes and with a continuous evolution, of a lasting and unmodifiable systematic delusion, associated with a complete maintenance of lucidity and order of thought, will and action.»

EROTOMANIA: OVERALL ASPECTS

In his book *Les psychoses passionelles* (1921) Gaetan Gatian de Clerambault described several cases, differentiating two forms of erotomania: a pure one, in which the delusion is developed suddenly and is not recorded in a global psychotic process and another secondary one, of insidious development and in which the delusion

is included in a global psychotic process having a disorganized and deteriorating course. The pure cases would be differentiated from erotic type paranoid delusions described first by Kraepelin by its sudden onset^{1,2}.

De Clerambault thought that erotomania could appear as a superimposed and transitory syndrome, which is sometimes a premonitory syndrome and other times an independent entity.

Ellis and Mellsop³, based on the De Clerambault postulates, defined the following diagnostic criteria of pure erotomania: *a)* delusional conviction of being in a loving communication with another person; *b)* this person has a much higher social status; *c)* this person was the first to fall in love; *d)* this person was the first to make an approach; *e)* the onset is sudden; *f)* the love object is unalterable; *g)* the patient has an explanation for the paradoxical behavior of the person; *h)* the course is chronic; *i)* absence of hallucinations.

In the present classifications (ICD 10/DSM IV), primary erotomania is included within the delusional disorders^{4,5}.

Secondary erotomania has been basically related with functional psychoses (especially schizophrenia) and bipolar disorder, although it has also been described in other entities such as major depression⁶, paraphrenia⁷, mental weakness⁸, Alzheimer's dementia⁹, hysteric psychosis¹⁰, borderline personality disorder¹⁰, organic affective disorder¹¹, subarachnoid hemorrhaging¹², amphet-

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mines and alcohol abuse¹³, use of anovulatory¹³, treatment with corticosteroids¹³, meningioma(13), alcoholism¹³, HIV¹⁴, etc.

Traditionally, chronicity and resistance to treatment have been considered intrinsic characteristics of erotomania, although cases of secondary erotomania with response to benzodiazepines¹⁵, lithium¹⁶, anticonvulsants¹⁷, electroconvulsive therapy¹⁸, neuroleptics¹⁹ and second generation antipsychotics such as risperidone²⁰ or olanzapine²¹ have been described.

For some authors, the pessimism in relationship with the treatment and prognosis of erotomania is erroneous and the therapeutic response reflects the nature and severity of the underlying condition²².

CLINICAL CASE

A case of a 21 year old woman who is admitted to our service due to behavior disorders is presented. Since three months ago, she is convinced that a professor she met at her cousin's home one year ago and with whom she has coincided on few occasions has fallen in love with her. She states that she realized this suddenly, by the signs that he makes and because she hears his voice whispering love sentences. In addition, she believes that they are referring to her in a certain television program and given clues on her relationship and she hears voices that comment on her acts. She adds that on that day, she agreed to meet the professor and tell him that he should not address her directly «because she knew that he was not going to achieve his intentions».

She was born by full term delivery and without complications, had a normal psychomotor development in the different age phases. Described as introverted, she never had sentimental relationships. She is studying the second year of Philosophy. No psychiatric background is known in her family.

Recently, the family consulted a psychiatrist who prescribed flupentixol without improvement in the picture, so that they decided to bring her to the hospital. In the psychiatric examination, she was vigilant, uncooperative and auto- and allpsychically oriented in time and space. Her speech lacks spontaneity and she acts confused and distant. Anxious mood. She presents delusional ideation having erotomantic and autoreferential content, with auditory type hallucinatory activity related with the subject of the delusion (she hears the voice of the professor). Difficult to obtain her attention and concentration, with psychomotor agitation. Total absence of insight.

Complete blood count and global biochemistry, syphilitic serology, hepatitis B, C and HIV serology, thyroid study, brain CT scan and EEG that did not show abnormalities. A diagnosis of paranoid schizophrenia was made and treatment prescribed with haloperidol (15 mg/day). Paralelly, six sessions of electroconvulsive therapy were applied, achieving the almost complete remission of the symptoms in somewhat less than one month. At

present (after more than two years of follow-up in the medical visits), the patient is stabilized with antipsychotic treatment and psychotherapy aimed at improving insight.

COMMENTS

The case presented fulfills several of the Ellis and Mellsop postulates of primary erotomania. The patient has the delusional conviction of being in communication with her professor, who was the first to fall in love, the beginning was sudden and she finds an explanation for his paradoxical behavior. On the contrary, the existence of auditory hallucinations, not always related with the delusional subject matter as well as the patient's age and previous personality suggest the diagnosis of paranoid schizophrenia.

The erotomania probably is not an indicator of poor prognosis by itself and the response to treatment is based on the nature and severity of the underlying disease. In the clinical case presented, belonging to a patient with the diagnosis of paranoid schizophrenia, treatment with electroconvulsive therapy, neuroleptics and psychotherapy focused on insight was effective, as the clinical stability shows after two years of follow-up.

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