De Clérambault in Court: A Forensic Romance

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Is it, in heav'n, a crime to love too well?

— Alexander Pope,
Elegy to the Memory of an Unfortunate Lady

Each branch of medicine has its very own rare and valuable curiosities, its clinical treasures, to be best savored and appreciated by the connoisseur, like ornate curios. These rare entities are very seldom encountered outside of weighty textbooks and almost never discussed with colleagues except when reviewing for a Board examination or trying to impress a newly arrived class of residents. In psychiatry, perhaps the most elegant and esoteric clinical bauble of this kind is the Syndrome of De Clérambault (also known as Erotomania or *Psychose Passionelle*). In addition to its collector's item rarity, it also evokes an aura both romantic and distinctly foreign, with a very special *cachet* in a world of mundane illnesses. In this presentation we will see this Old World syndrome transported (in the best transcultural sense) to the Harlem ghetto and the New York City Criminal Justice System.

De Clérambault's Syndrome

De Clérambault was the first to delineate methodically the features of this syndrome, in his book *Les Psychoses Passionelles* in 1942.[1] The patient (invariably a woman) holds the delusional belief that a man, usually older, of elevated social status (sometimes a public figure), and both unsuspecting and unwilling, is passionately in love with her. The syndrome occurs in two forms: a *pure* or primary form in which there is a precise and explosive onset and the disorder is limited to the erotomanic features entirely, and the secondary form, in which the onset is insidious and in which the process is

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superimposed on a pre-existing paranoid psychosis. As secondary themes the patient may believe that she watches over her lover and protects him, that they communicate indirectly, and that he makes advances to her, using his extraordinary resources, although his conduct toward her is often paradoxical and contradictory (*e.g.*, he may appear disinterested or even to hate her when he really loves her).

In all, a strikingly sporadic appearance of articles on the Syndrome is to be found in the literature, most of these in the nature of brief clinical descriptions or attempts to provide more satisfying psychodynamic formulations. Six cases appear in De Clérambault's book in 1942.[2] Balduzzi (1956),[3] Arieti and Meth (1959)[4] and Feder (1973)[5] each reported one case. Enoch *et al.* (1967)[6] reviewed all cases previously reported in the literature and added three of their own. Sims and White (1973)[7] reported a case with De Clérambault's Syndrome and Capgras Syndrome. Pearce (1972)[8] reported a case of De Clérambault's Syndrome and *Folie à Deux* in combination. Haynal (1971)[9] discussed treatment aspects of the syndrome. Hollender and Callahan (1975)[10] reported four additional cases. Raskin and Sullivan (1974)[11] reported two cases in which the man in the delusion was the patient's psychiatrist!

A number of psychodynamic formulations have been offered in an attempt to grasp the underlying meanings inherent in the psychopathology of the syndrome. An ego defect has been postulated, one that is largely shaped by feelings of being unloved or unlovable. The specific content of the delusion is then an attempt to overcome narcissistic blows by turning them into grandiose fantasies.[12] Others have speculated that the symptoms serve to ward off feelings of depression, loss and loneliness.[13] One writer contends that the syndrome is a "defensive facade of a delusional, histrionic, romantic love, behind which lies the drama of an ontogenetically earlier phase of life elaborated in psychosis." Under conditions of regression there is an attempt at restoration of the earlier blissful union with the Mother figure.[14] Finally, the search for a safe and unattainable erotized father-figure and the need to ward off homosexual impulses are also discussed in the literature.[15]

Most writers on the Syndrome have been struck by the grotesque drama that may ensue when the delusions are acted out in real life with an unsuspecting man unwillingly cast in an amorous role.

> The patients may bring chaos into the lives of their victims who usually give them no encouragement whatsoever. They may bombard them with letters, telegrams, and telephone calls without respite, both at home and at work and for long periods of time . . . . These patients may even be dangerous and may wind up making an attempt on the life of their victim or members of his family. This is particularly liable to occur when the patient reaches the stage of resentment or hatred which replaces love, after repeated advances are unrequited. They may thus require prolonged hospitalization to prevent them from carrying out the threats which are contained in their letters.[16]

Case Study

The patient, Sally F., a 39-year-old black woman, armed with a broken bottle and a stick, suddenly and with great fury attacked a neighbor, Harold, as he entered their apartment building lobby. Harold also resided in the building but on a different floor. He was taken to the hospital in shock and sustained deep abdominal wounds and slashes of the face and extremities. He subsequently lost the use of his left arm. Sally insisted that they were lovers, although the victim barely recognized her by sight. He was married and had something of a reputation in the neighborhood as a small-time but well-regarded jazz musician. Sally had lived alone in the building for the past three months since her discharge from X State Hospital. She had been hospitalized there for almost a year after her first episode of paranoid schizophrenia (she had been loud, belligerent and agitated, with auditory hallucinations and vague delusions of persecution). Antischizophrenic medication and milieu therapy led to full remission, and she was discharged with directions to attend the aftercare clinic of the hospital. It was felt that she needed followup treatment, especially maintenance medication and monitoring of her community adjustment. After leaving the hospital, however, she never reported to the aftercare clinic, and she stopped taking any medication. She began to stay in her apartment, uneasy about venturing out. She began to feel more and more convinced that her neighbor, Harold, whom she had heard two women talking about, was deeply in love with her. She believed that he wasn't really married and that he would soon come to stay with her. She also heard voices telling her this and at times heard Harold's voice. She hardly ever went out but thought about her future with Harold. The fact that he ignored her, lived with his wife and didn't know that she existed was of little moment. Sally knew he loved her, talked to him and waited for the day when he would come to her. A week prior to the assault, Sally learned that Harold's wife was pregnant and that he was moving to the West Coast. She began to feel betrayed and to hate Harold. She thought about him incessantly and heard voices saying that he deserved to die. She drank heavily for days and finally assaulted him with the whiskey bottle.

Although she was raised in a large family in Mississippi, the youngest girl with five older brothers, she lived an isolated and lonely existence almost from the very beginning of her stay in New York, which began at age 21. Fights with employers had led to a succession of jobs (factory work or office work), each ending the same way. The only report of a previous boyfriend describes an "insanely jealous" man who followed her around from job to job, relentless, causing a great deal of trouble for her. This may represent an earlier "delusional lover." Sally has never been married and has no children.

The Psycho-Legal Perspective

The attorney for the defense requested a psychiatric evaluation to determine whether an insanity defense seemed supportable. The examination took place almost two years after the crime. In the interim Sally had been at XX, a municipal hospital, where a diagnosis of acute paranoid schizophrenia

was made and she was treated with antischizophrenic medication in a maximum security setting. At that time, she was found to be incompetent to return to Court and was subsequently sent to XXX, a hospital operated by the Department of Correction. There she received antischizophrenic medication in a maximum security setting until she regained her competency and was ready to return to Court.

After a thorough evaluation of the patient, examination of the records and observations of others, the findings seemed inescapable: Sally had been suffering from a full-blown psychosis before, during and after the crime. She had displayed the following signs and symptoms during the course of her illness (among others): feelings of suspiciousness and mistrust, ideas of reference, vague delusions of persecution, hallucinations, withdrawal and isolation, along with the specific delusions of the De Clérambault type.

After leaving the hospital, she declined further therapeutic measures, including prophylactic medication. Within a three-month period she showed evidence of severe decompensation. During this period her neighbor became entwined in her delusional system, earmarked as a target for her love and hate.

The report to the Court concluded:

> In my opinion she is *not* criminally responsible for the conduct involved because as a result of mental illness (*viz.:* Paranoid Schizophrenia) she lacked the substantial capacity to know or appreciate either a) the nature and consequences of such conduct or b) that such conduct was wrong. In the full-blown paranoid psychosis, the turmoil is such that personality controls over aggression, proper reality testing, judgment and rational decision making are all severely compromised. At these times such individuals are at the mercy of their pervasive delusions and primitive impulses and are not able to impose restraints or to deal with reality in an insightful or rational way. She had woven an unsuspecting man into the fabric of her private fantasy and then, completely out of touch with reality, turned on him for his unrequited love and betrayal.[17]

De Clérambault in Court and Beyond

One month after psychiatric evaluation, Sally's case came to trial (before a judge). The proceedings were fairly brief and methodical. Sally was subdued and businesslike, showing no trace of the consuming passion that had possessed her. The Court agreed that as a result of her illness, with its major distortion of reality, delusions and poor impulse controls, she had *lacked substantial capacity* at the time of the crime. In short order she was acquitted of any crime (not guilty by reason of insanity). Thereafter she was remanded by the Court to the jurisdiction of the Department of Mental Hygiene and placed in X State Hospital, as outlined in the New York State Criminal Procedure Law. Her admitting diagnosis there was paranoid schizophrenia and she was described as mildly delusional and quarrelsome at times. Yet she participated well in ward activities, followed the therapeutic regimen without difficulty and was noted to improve substantially. Five months after admission, the Hospital Release Committee recommended that

she was apparently "ready for discharge without any danger to herself or others." After various papers had been duly filed and reviewed, she was finally released from the Hospital nine months after admission. This time she attended the aftercare clinic on a regular basis and received maintenance medication. She lived in an SRO hotel, received welfare assistance and was markedly withdrawn and isolated, but remained free of psychosis. One and a half years later she was hospitalized very briefly (one month) for drinking problems and insomnia. There was no evidence at that time of a recurrence of the psychosis. After her discharge she moved from her hotel residence. She also dropped out of treatment at the aftercare clinic and has not been heard from since that time. No report of her condition or of her disappearance from treatment or supervision was required or made by the hospital to the Court. We must consider that even under ideal circumstances. with vigorous and protracted treatment, the syndrome is basically refractory and "periodically hospitalization becomes necessary to prevent these patients from pestering their lovers or from assaulting them or their relatives . . ."[18]

Those who conceptualized and framed the Insanity Defense statute and who fought to preserve its spirit and its safeguards might have hoped for a happier ending.

The question of release procedures for these patients, treatment requirements and follow-up requirements by both the Court and the Mental Health System deserves further study.

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