Gaétan Gatian de Clérambault
(1872–1934)

de Clérambault was born in Bourges, in Central France. As a student he was attracted by artistic design, then law and finally medicine and psychiatry. His first senior psychiatric position was in a hospital for the criminally insane in Paris and he remained there for 30 years, eventually becoming its director. His two best-known contributions to psychiatric thought are his concept of mental automatism, an organic model of how certain mental functions could be split off from others; and erotomania, the false belief that one is loved, part of a wider concept of the psychoses derived from his notion of the passions.

The present extract traces his ideas on the nature of such passion-based psychoses and presents his views on erotomania, a condition which has been much discussed since.

Psychoses of passion

G. de Clérambault (1921–4)
(Les psychoses passionelles, pp. 323–7 of *Oeuvre Psychiatrique*, vol.1. Paris: Presses Universitaires de France, republished 1942)

The nature of delusional states of passion

The term *delusional states of passion* denotes all those delusional states which have as their basis a prolonged emotion, whether desire or anger. Any intense feeling can serve as the nucleus for such a state: a feeling of ownership, a sense of injustice, maternal love, religious sentiments, etc. The emotion will have been linked from the beginning with a distinct idea, and this 'ideo-affective association' then forms an indissoluble bond without affecting the general pattern of thinking. This state of affairs is not seen in misinterpretative or polymorphous states.

Autonomous states of passion exist without hallucinations, global thought disorder or dementia. There do exist, however, mixed states, where the delusional state of passion is part of some other process; we call these secondary or prodromal, depending on whether they succeed or precede the principal condition. The appearance of such 'syndromes of passion' in patients with an already abnormal mental

background is explained in the following way. Patients suffering from mental disorder do not suddenly lose their affective responses, but they may at first react more intensely than normal to events. At this stage of the illness their imagination is often more active than usual, while at the same time their critical faculties are diminished. In fact, it is surprising that the freeing of the constraints on passion does not cause more problems in the course of a psychiatric illness . . . An appropriate guideline is that the intensity of experienced emotion is directly proportional to the autonomy of the condition, i.e. absence of other abnormal mental phenomena . . . For example, a normal mind has to be subjected to considerable emotion before reaching a firm conviction which goes against conventional beliefs. In this case the 'ideo-affective knot' is predominantly emotional in origin. If there is a pre-existing abnormality of psychological functioning, imaginative mechanisms become more important in the development of this 'ideo-affective knot'; a patient with general paralysis of the insane, for example, may say that he is the queen's lover, but he may not even write to her or show concern about not seeing her . . .

In addition to pure, secondary and prodromal delusional states of passion there are also the associated delusional states of passion, where two or more distinct delusions co-exist. The separate delusions are both based on strong emotions, but are different manifestations of them, for example ambition and sensitivity. Although the delusions may interact, they remain relatively independent in the way they influence behaviour . . .

Finally, there are abortive or attenuated forms of these states, where the delusion is not strongly maintained or is transient in its hold on the subject . . .

Other causes of a secondary delusional state of passion are affective psychosis and obsessional and phobic neurosis. We regard these as physiological in origin because they derive from a primitive over-arousal, unlike pure erotomania where an 'ideogenic' basis exists for the overarousal. It is not easy, however, to distinguish delusions which arise in the course of a manic-depressive or obsessional illness from those which are the central feature of delusional states of passion. Both are to some extent physiological in origin, but in the former cases the attached idea in the ideo-affective knot is unstable and easily changes to another one; in the latter case, the knot is stronger, and the idea more permanent.

Delusions secondary to a 'progressive systematic psychosis' are more easily distinguished from pure delusional states of passion. In

the former case the whole range of ideas is in turmoil and other mental functions are affected. In paranoid, confabulatory and hallucinatory states, for example, it is obvious that judgement, imagination and perception, respectively, are at the root of the disorder.

Pure erotomania

The following patient is a case of pure erotomania, one of the best defined examples of a delusional state of passion.

There are no hallucinations, no generalised persecutory beliefs and no confabulatory or grandiose ideas. Erotomania is the only evidence of psychosis, the ideas are based entirely on passion and there is no progressive impairment of other mental functions. The striking features are the strength of her desire, the intensity of her reactions and the absolute conviction with which she holds her delusional beliefs. There has been no change in the content of her delusion, as one sees in polymorphous states; the belief itself is remarkably stable, and does not give way to frustration or hate. All her misinterpretations refer uniquely to the original theme and any persecutory ideas are consistent with the primary belief.

Her delusional state remained unchanged for seven years. There was no change in the object of her desire during this time and no development of persecutory, grandiose or mystical delusions.

> The patient believed that a civil servant, the secretary of a government commission, was in love with her. According to her, he looked at her lovingly, sought her out, used subordinates and prostitutes to persecute her and would, sooner or later, give in to her wishes. She was aware that the man was married and did not deny that she herself had a lover whom she was about to marry. None of these facts, in her mind, constituted an obstacle to her belief.
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> The history dated back to 1915 when the patient needed a safe-conduct pass in order to enter the military zone. The civil servant in question had refused to give her this pass. She then plagued his office with repeated demands for the pass, and wrote seductive letters in the hope of gaining his permission. All was to no avail. She became angry and suspected that she was being unfairly treated. At one point the office lost her birth certificate and she took this as a personal affront. She resorted to extreme tactics – turning up at the office in tears, threatening suicide and writing angry letters. She was admitted to psychiatric hospitals on several occasions because of her behaviour.
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> She was aged 34 when she first came under my care in 1919, her fifth admission in all. From our enquiries and her previous psychiatric notes, the following facts emerged. She had first been admitted to the Bicêtre asylum at the age of 12. She remained there for four years with the diagnosis of 'mental retardation, depression and suicidal tendencies'. Her mother had had a depressive illness and had committed suicide after a stillbirth. After her discharge she had become a prostitute. Then at the age of 19 she became convinced that a doctor was persecuting her. This was mainly attributable to anger, but it had an erotic component, and may have been the prelude to her eventual erotomania. She then lost contact with her relatives until the age of 33, when she had her second psychiatric admission in 1918. There were two more admissions in this year. Each time it was noted that she had persecutory ideas, that she drank heavily and that she was pursuing a civil servant whom she claimed was in love with her. She had three more admissions between then and 1922, each with the same presenting features.
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> The symptoms were the same in all her admissions. She had been following the civil servant and making a nuisance of herself by accosting him, attacking him and circulating scandalous stories about him. She believed that the man was in love with her, protected her in secret and, despite her conduct towards him, continued to love her . . .

The patient was misdiagnosed, in my view, by several eminent psychiatrists. Several considered that she was incapable of an independent existence but the reasons given were either her disorganisation, her impulsiveness or her alcoholism. The quarrelsome aspect to her behaviour was ignored and the erotomania went unnoticed for years.

The widespread tendency to overlook erotomania has several origins. Chief among these are the unfamiliarity of the clinical picture, and the lack of an agreed method of interviewing these patients to bring out their delusions . . .

The best interviewing technique requires a thorough acquaintance with the condition itself. An intuitive approach is of little value unless one knows what one is looking for. However, one should not proceed as if one were questioning an examination candidate. In the first place, one rarely obtains a formal declaration of the passion in question, and specific questions on this topic are either ignored or brushed aside. It is best to proceed in a more casual way, but with occasional references to the sort of ideas that one is seeking. In this way we can lead our patient gently to a state of mind in which he will feel ready to talk freely and discuss the morbid ideas, or at least feel obliged to drop hints or to pretend that he does not understand the purpose of the questions.

Either way we can gain an entry into his system of beliefs without him realising it. Patients of this kind should not, therefore, be interviewed by a series of direct questions, but rather *manoeuvred*, and in order to achieve this there is only one method – to touch on and ignite the passion in question.

The mental state of these patients is largely unrecognised in our psychiatric hospitals mainly because they do not call our attention to it by disturbing the ward, and they retain sufficient faculties to be on their guard against discovery of the real nature of their condition. Another reason why they often go unnoticed is that the psychiatrist too readily substitutes a simple banal explanation for their statements. The psychiatrist is prone to conclude falsely that 'something must have happened' to arouse their anger. Their complaints and claims of being loved are thus taken for real or slight exaggerations of reality. Another mistake is to regard their statements as consistent with a transient affective disturbance in an individual with a personality disorder . . . [De Clérambault used the traditional French term *dégeneré* for such individuals, Tr.]. Finally, the subject may be wrongly regarded as sane, responsible for his actions and therefore fit for punishment if he has contravened the law.

There are some patients whom it is difficult to distinguish in one or other of these ways. The majority, however, can easily be separated into *banal states of passion* and *morbid states of passion*. The distinguishing criteria are the *intensity of the patient's reactions*, the *persistence of their ideas* and the *incorrigibility of their beliefs*.

Secondary erotomania

The term 'secondary erotomania' is more accurate than 'associated erotomania' because it covers cases which precede (prodromal cases) as well as succeed some other condition. All such cases arise on the basis of an already disordered psychological substratum, but one can only use the term if there is already evidence of this other psychiatric condition. Prodromal erotomania is a retrospective diagnosis.

In secondary cases the erotomania is based more on imagination than on passion. It is not a sudden thing, not 'love at first sight', but a state which emerges gradually, through being worked out by the subject. There is also less energy in the pursuit of the loved one than in pure cases.

I have never seen a case of either pure or secondary erotomania in which the love was entirely platonic. In one famous case, whose love

was claimed to be platonic, I discovered on interview that the patient believed she had been married to the object of her desire and had given birth to a child by him. Another case, a girl of apparently pure and impeccable virtue, was found to have sent him pictures of naked women with her own name attached.

Prodromal erotomania

Erotomania is a syndrome whose origin lies in the sphere of emotions but which has links with the faculty of imagination. In pure cases the emotional component is maximal; in secondary cases, the imaginative element predominates. Secondary cases are those where the erotomania is an integral part of a generalised psychosis.

The stability of the delusional state and the extent to which the beliefs determine action are a function of the emotional state. Thus in secondary erotomania, whether prodromal or consequential, subjects do not tend to act on their delusions, and the specific set of beliefs grows slowly and then gets reabsorbed into a protean ensemble of other abnormal beliefs and experiences. There are often changes in the object of their desire, unlike the situation in pure cases. In addition, the object may be someone whom they have never met but merely invented through imagination, misinterpretation or transformation of the content of an auditory hallucination. Sometimes the object may be determined partly by a real event in the distant past and partly by invention. We have seen this in the case of a 60-year-old woman whose erotomania centred upon someone who had been her real lover but who had disappeared from her life 30 years before. She had had a child by him, and in the intervening years had become increasingly angry with him.

All secondary cases have a substrate of a more generalised psychosis. The pre-existing psychological abnormality allows the syndrome to develop without the necessity of an emotional state. Imagination is the determining factor. In prodromal forms this psychosis remains latent, and if this is so for several years the erotomania may be mistaken for the pure type. I once saw a case like this who eventually showed signs of dementia praecox, but who for many years presented all the features of pure erotomania.