DE CLERAMBAULT SYNDROME AND MEDICAL PRACTITIONERS: MEDICO LEGAL IMPLICATIONS

L P Kok, M Cheang, K T Chee

ABSTRACT

De Clerambault's syndrome or erotomania is a condition in which a patient, usually a woman, develops a delusional belief that a man, usually older and of higher social status, is in love with her. This paper describes such cases where medical practitioners were involved. In a case where a doctor was brought to court, the judge stressed that because of the nature of the allegation, it was vital that there be corroborative evidence.

When faced with such patients, a prudent doctor would ensure that a nurse be in attendance at all times, that notes be carefully kept and phone calls recorded. Other measures might be necessary, depending on the situation.

Keywords: *erotomania, delusions of love, medical practitioners.*

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INTRODUCTION

The De Clerambault[1] syndrome or erotomania was described in 1942, by de Clerambault who called it the 'psychose passionnelle'; however Kraepelin[2] had originally written of a subgroup of paranoia with grandiose delusions who presented with delusions of eroticism (erotomania). The patient was usually a woman who developed the delusional belief that a man, usually much older and of much higher social status, was in love with her. Sometimes a public figure of screen or stage was said to be the lover. In its pure form the onset was sudden (like a thunderbolt) and the essential feature was that of being "in amorous communication" with this person of higher rank who was the first to fall in love with the subject and who made the first move. There was paradoxical conduct in that the patient interpreted all denials of love as secret acknowledgement of love, or a test of the subject's love, or a method to deceive other suitors.

Enoch et al[3] reviewed the literature on this syndrome and in many case examples given, the subjects had brief or no contact with the object of their love. They also stated that it was important to distinguish such cases from everyday infatuation, normal passion and nymphomania. In these latter conditions the beliefs were not delusional in that the subjects did not think the loved ones were in love with them and were seeking their affections. In addition, rejections and abuse were not seen in a distorted light. Erotomania could be divided into 2 types – the pure one with a precise onset, single object, a fundamental delusion, no hallucinations and a chronic course; and a secondary type that was secondary to another psychosis like paranoia, schizophrenia, mania or other psychoses.

Segal[4] discussed the status of erotomania as a clinical entity and noted that it was controversial – some regarded it as a form of paranoia, while others saw it as a manifestation of an underlying condition eg paranoid schizophrenia. In the American classification system DSM III, it was not listed but in the revised edition of DSM III R – it became a subtype of delusional (paranoid) disorder. Thus Kraepelin's original classification of paranoia which included delusions of persecution, morbid jealousy or grandeur was revived again, as under the delusion of grandeur he listed 4 subtypes:

a) being a great inventor
b) being descended from royalty
c) being a prophet or saint
d) eroticism (erotomania)

HOW DOES EROTOMANIA AFFECT DOCTORS?

Doctors, being practitioners in a caring profession, are often in a close and warm relationship with their patients. Indeed, some of the latter may develop crushes or be infatuated with them because of their perceived idealised qualities like empathy, gentleness and concern. Although it is not uncommon for practitioners to have patients who are infatuated with them, few are actually the perceived loved ones of patients with the de Clerambault syndrome. The following is an account of 4 such cases.

Case 1

Miss X was a young single female who worked in an office where she came into contact with professional and business men. Over a short period of a few weeks, she developed the belief that some of the members, including doctors, were in love with her, and wanted to marry her. Subsequently she sought treatment from two of them. As she had the choice of two, her dilemma was which one to select. She was convinced that they refrained from openly declaring their love to her because of the threat of other suitors who were also very much in love with her, and would never allow her

Department of Psychological Medicine
National University Hospital
Lower Kent Ridge Road
Singapore 0511

L P Kok, MBBS, DPM, FRCPsych, FRANZCP, MD, FAMS
Consultant Psychiatrist

Faculty of Law
University of Malaya

M Cheang, D.Jur. (Osgoode Hall) York University, Canada, LLM (Yale), LL.b (Singapore)
Visiting Professor

Institute of Mental Health/
Woodbridge Hospital
10 Buangkok Green
Singapore 1953

K T Chee, MBBS, DPM, MRC Psych, FAMS
Consultant Psychiatrist & Head

Correspondence to: Dr L P Kok
6 Napier Road #10-08
Gleneagles Medical Centre
Singapore 1025

to belong to another. Thus the two doctors had to pretend to reject her by not answering calls, not seeing her and by calling the police whenever she visited them. Miss X lived by herself, and had few relatives in Singapore. She led a lonely existence, there was little social support and she had no friends and no one whom she could relate to, and spent her leisure time by herself with little to do.

Case 2

Miss Y was a single woman who apparently had a history of being sexually abused by a paternal relative during her childhood. In her teens she came into contact with three medical practitioners and a counsellor whom she believed were in love with her. She sought treatment from them, wrote them letters, sent them expensive presents, rang them, waited for them by their cars and disregarded their marriages, as she was convinced they only cared for her. Each rejection only affirmed her belief that they loved her and was a proof of their passion for her. Miss Y came from a middle class background and appeared to be functioning quite well in other life areas as she was working and could look after herself. However she had no male friends and had not been sexually involved with anyone (other than the sexual abuse incident).

Case 3

Mdm Z was a young married woman who developed the belief that a practitioner who had been treating her over a period of 4 years was in love with her and had sexual relationships with her on several occasions. In addition she also had symptoms of auditory hallucinations and a belief of being controlled by a spirit who possessed her and directed her to submit to this doctor. Her husband was in the teaching profession and she had a young child. The marital relationship was viewed as satisfactory by her spouse, but she herself was unhappy with her mother-in-law and other relatives of her husband. In the past she had previous treatment for a psychotic illness and during that episode also had delusions of love.

Case 4

Miss A was a single young lady who worked with a specialist. She developed the delusion that he was very much in love with her, had been sending her messages of love and that he was so obsessed by her that he paged for her constantly wherever she was in order to show her his love. However he was not her sole love object as she had the same belief of the many doctors whom she met in the course of her work. In addition to her erotomania she also had compulsive symptoms and had to wash her hands repeatedly and bathe for long periods at a stretch.

DISCUSSION

These four cases were not typical in that unlike what de Clerambault[1] and Enoch et al[3] had described they had more than one object of love. The third patient, Mdm Z was suffering from a psychotic illness, and the erotomania was secondary to the underlying condition.

All four had as the objects of their delusional system, doctors whom they met within a professional setting or outside one. Three of them, at some time in their experience, had sought treatment from the doctors concerned and all 4 had known the practitioners more than fleetingly, in contrast to what had been described by Enoch et al[3]. However in a case involving a doctor in Enoch's series, the situation was similar to that experienced by the Singapore practitioners. The patient, an unhappily married woman, developed delusions of love for a married doctor who had attended her abortion, and pestered him with calls, messages and visits to his home, a behaviour similar to that shown by the 4 patients described above.

The aetiology of this syndrome has been attributed to a variety of psychological mechanisms[4]. Kraepelin[2] felt it was a psychological compensation for the disappointments of life, while others noted that it was due to sexual frustration[3], occurring as it were in older women who never married or that it was a result of narcissistic gratification[4]. Segal[4] described the major characteristics of such patients – unattractive people leading empty, lonely, withdrawn existences, with little sexual contacts, and working in menial jobs, who had as their objects people of much higher status, looks, intellect and wealth, which satisfied all their narcissistic needs. De Clerambault[1] believed that the mechanism was akin to what may be described as a face saving mechanism for the sake of sexual pride. It was also believed to arise out of physical unattractiveness[5], loss of husbands[6] or was a defence against heterosexuality[7] as sexual union was not wanted or expected.

In the 4 cases described above only one fell into the classical picture, while the other 3 were young, not unattractive and one of them was married and had a high status. The lonely, sad and desolate life that has been frequently described was not evident in these three, who had more in common with the patients described by Seeman[7]. The latter divided her patients into (a) those with fixed delusions who were more ill, and (b) those who had recurrent delusions. The latter group was more integrated, had fantasy relationships with several figures, and some had a high status (one of whom was working on a doctorate). The 3 Singapore cases (Cases 2, 3, 4) fell into the recurrent group, and were, like Seeman's patients, fairly aggressive in daily life. It was postulated that a possible mechanism of erotomania in this group could be the unacceptable feelings of aggression and ambition, which were transformed to admiration and a belief of being loved.

IN THE CONTEXT OF DOCTORS BEING THE OBJECTS OF EROTOMANIA, WHAT ARE THE MEDICO LEGAL IMPLICATIONS?

Doctors have a particularly close relationship with their patients, more so than any of the professionals like lawyers, priests, or psychotherapists, because during clinical examination, physical contact with patients takes place. Thus in patients with this syndrome, because of their distorted belief system that they are the objects of love of these doctors, an allegation of molestation and/or sexual assault may be made. Erotomania is not a platonic type of love, and many patients may long for a sexual relationship[3]. In most cases they do not talk of a physical relationship having occurred, and on close questioning some will state that either they have never met the object of their love, or else have only met briefly on one or two occasions, but however allege that messages were sent in a variety of ways. What would happen if a patient with such a disorder were to believe that a physical relationship had occurred and were to allege misconduct on a doctor's part? (It has been cautioned that such patients may become resentful, angry or dangerous when spurned repeatedly).

In a recent case, a Singapore doctor was found guilty by the Medical Council of taking advantage of the mental and

emotional state of a patient and committing adultery with her[8]. The main issue in this case was whether a patient, who had been diagnosed as suffering from de Clerambault syndrome was telling the truth when she claimed to have a sexual relationship with her doctor, who was the object of her love. The case was appealed and the Appeal Judge observed that it was a complex case as what had remained unresolved were legal issues such as, "the difficult questions of what was and what was not evidence, whether corroboration was necessary on the facts of this case and if so what was corroborative evidence and what was not, and other issues of what weight to give to the evidence of a hostile witness".

The Appeal Judge stated that in such a case it was clear that independent corroboration and support was necessary because of (1) the patient's psychiatric history, (2) she was still, at the time of the hearing, taking antipsychotic treatment from her psychiatrist, (3) her psychiatric illness at the time of the charge was de Clerambault's syndrome, and (4) the inherent improbability of the evidence against the doctor.

He found that there was no independent corroborative evidence in this case.

The court of Appeal was therefore unable to convict the accused.

This decision affirms the rule that when a patient with a delusional belief of love involving a doctor, makes an allegation of criminal conduct on the doctor's part, substantial evidence of independent corroboration is required as a matter of law and the charges have to be proved beyond reasonable doubt.

The above decision raises a very important issue in the law of criminal evidence, that of the need for corroboration. Although as a general rule in evidentiary law, an accused may be convicted on the evidence of one witness alone, there are however certain kinds of prosecution evidence for which corroboration is either necessary as a matter of law (for example, the unsworn evidence of a child)[9] or when the court directs itself as to the dangers of convicting without it, such as accomplice evidence[10], or as in the above case, the evidence of a complainant in a sexual misconduct case; as it was held in the English case of R V Opencer[11] where a prosecution witness is suffering from mental disorder, the judge may in appropriate circumstances need to warn (the jury) or the court itself of the special need for caution regarding corroboration.

What therefore is the law on corroboration? The word "corroboration" connotes support or confirmation. More particularly, in respect of the law of evidence, it requires that certain evidence (the evidence to be corroborated) is confirmed in its effect by admissible and other independent evidence (the corroborating evidence). Therefore, where one piece of evidence confirms and supports another, corroboration takes place if both pieces of evidence are accepted by a court of law or tribunal of fact. Lord Reid described it thus, "There is nothing technical in the idea of corroboration. When in the ordinary affairs of life one is doubtful whether or not to believe a particular statement one naturally looks to see whether it fits in with other statements or circumstances relating to the particular matter; the better it fits in, the more one is inclined to believe it"[12].

The necessary qualities of corroborative evidence are set out by Lord Reading (in R.V. Baskerville[13]) in the following terms, "... evidence in corroboration must be independent testimony which affects the accused by connecting or tending to connect him with the crime. In other words, it must be evidence which implicates him, that is, which confirms in some material way not only the evidence that the crime has been committed, but also that the accused committed it."

Corroboration of the evidence of a complaint in a sexual offence charge is most crucial; the omission of such corrobation is always fatal to a conviction of the accused. In the above case involving the Singapore doctor, not only were there no independent corroborative evidence from material witnesses who were not called to testify, but also the fact that the complainant herself was the only witness made it extremely difficult for the court to verify the truth of her allegations. This strict rule of corroboration applied in sexual misconduct cases is founded on several considerations. It has been commonly justified on the following bases:

(1) An inherent danger arises from the fact that sexual allegations are simple and often tempting to make but difficult to refute;

(2) There is always the possibility of hysterical or malicious invention[14]; or

(3) Simply the instinct for preservation of the complainant's reputation or material interests[15].

Any one or more of these features could have existed in the above Singapore case. The Court of Appeal, it would appear, took a very strict view of the law of evidence of corroboration and because no independent material witnesses testified at the trial, the court refused to convict the accused solely on the testimony of the complainant herself. In criminal trials, the prosecution bears the burden of proving the charge beyond reasonable doubt and if there is any shadow of a lurking doubt the accused has to be acquitted. As far as the law is concerned, the position is clear. However, are there any other non-legal lessons to be drawn from the decision and prudent steps to be taken in order to minimise the problems for the practitioner whose patient suffers from erotomania?

When faced with such patients, some of whom may not have full blown features of erotomania, but who may frequent a practice repeatedly, often with complaints that require thorough physical examination and who on examination are quite healthy, the wise practitioner should be aware of the possibility that the patient may be suffering from such a syndrome. He should always be accompanied by his nurse at every examination, and the date, time of the examination, and a note that a nurse is present should be made. (The name of the nurse should be recorded) Telephone calls should also be documented. Accurate and complete records are generally considered beneficial because these constitute admissible documentary evidence to assist a court of law in reaching a decision. In some situations, even taped communications between doctor and patient(s) may be resorted to. And, in the even more extreme cases where the patient may develop a potential capacity for dangerous and/or violent behaviour, the doctor should use his discretionary professional duty to report or alert the relevant authorities.Where appropriate, a psychiatric referral should also be made, so that it can be established whether the patient is or is not suffering from such a condition, and is on treatment for it. All said, good

sense should prevail to deter serious personal detriment and ensure professional safety.

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