A Review of Erotomania in Developmental Disabilities and New Case Report

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Erotomania is a delusional disorder characterized by an irrational belief that another person, usually of higher social status, is in love with the patient. It may arise in the course of a mental illness or may exist as a singular delusion. It occurs in men and women, encompasses homosexual and heterosexual orientation, and in some cases, leads to stalking and serious risk to the loved person. Erotomania has been reported in persons with developmental disabilities, and a review of the clinical characteristics of this literature is summarized, with special attention to differences in presentation among case reports of patients with developmental disabilities. A new case of erotomania in a man with multiple congenital birth defects and mild mental retardation is presented. He developed the erotomania in the course of a major depressive episode. His loved person was fictional, associated with a TV-cartoon character; thus, the delusion was somewhat "child-like," and this is probably related to the patient’s developmental disability. In addition, he showed a Fregoli-like phenomenon, which is a delusion that a familiar person has become another person, typically seen in neurological patients. This patient illustrates three rules of diagnosing mental illness in persons with developmental disabilities. While presentation will be easily recognizable, features associated with developmental delay and/or neurological impairment may also be present.

Erotomania is a delusional disorder that appears to occur in persons with developmental disabilities (DD) in much the same way as it occurs in the general population. On the other hand, differences in presentation have also been reported, some related to the developmental nature of the delay, and others related to the underlying neurological deficit. In this paper, we discuss these issues and present a new case of erotomania. Our patient had a presentation clearly affected by his developmental delay, as well as a content-specific delusion typically seen among neurological patients.

Erotomania

Patients with erotomania firmly believe that someone is in love with them, despite the fact that the loved person has taken no action to encourage such a belief. The delusion is intense, and preoccupies the patient. Although this disorder is recorded in even Greek and Roman times, it generated little research or clinical interest until recent years, perhaps because erotomanics may stalk their "love" interest resulting in forensic interventions. The "loved person" is typically a person of higher social status, who may even be unknown to the patient but is a public figure. Erotomania usually occurs in individuals for whom a full romantic or sexual life has been not attained, with unmet narcissistic needs for love, and with accompanying serious social skill deficits (see Table 1).

Erotomania is a heterogeneous disorder. It can arise in the course of a mental illness or occur as a singular delusion (deClerambault’s syndrome), with no other accompanying pathology. Erotomania occurs in patients who suffer from a wide range of disorders, including schizophrenia, schizoaffective disorder, mood disorders, and neurological diseases. It occurs in men and women, and encompasses heterosexual and homosexual orientation. It may respond to pharmacotherapy with antipsychotic medication, pharmacotherapy of the underlying mental disorder, or be resistant to pharmacotherapy.

The essential elements of erotomania are the conviction of being loved despite the loved person having done nothing to encourage that belief. The patient has an intense preoccupation with the loved person, and interprets/distorts any actions of the loved person to fit. They may act on the delusion by approaching or communicating with the loved person, which can include stalking, threatening, or menacing behavior. In some cases, erotomania has led to assault and potentially fatal outcome for the victim.
### Table 1. DSM-IV Criteria for Delusional Disorder Under "Schizophrenia and Other Psychotic Disorders"

| A. | Non-bizarre delusions (i.e., involving situations that occur in real life, such as being followed, poisoned, etc.) of at least one month’s duration. |
| B. | Criteria A for Schizophrenia has never been met. Note: Tactile and olfactory hallucinations may be present in Delusional Disorder if they are related to the delusional theme. |
| C. | Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre. |
| D. | If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods. |
| E. | The disturbance is not due to the direct physiological effects of a substance (e.g., drug abuse) or a general medical condition. |

**Erotomanic Type**: Delusions that another person, usually of a higher status, is in love with the individual.

When the erotomania arises during the course of a mental illness, treating the illness can sometimes be successful in the resolution of the erotomania. In de Clerambault’s syndrome, or pure erotomania, treatment with antipsychotic medication is the treatment of choice. Psychotherapy can be difficult, as the person with a fixed delusion does not respond rationally. The patient does not see himself or herself as ill, but rather "blessed with romance."17,18

Psychotherapy can be effective for some patients if they stay in treatment. It is important that the therapist not directly confront the delusion, as that increases the chances that the patient will flee. Mullen stressed that the patient must be referred to social networks to provide relationships, as social failure is a contributing cause of the delusional state.17,19,21 In many cases, patients with erotomania are treatment refractory and can carry the delusion for many years.

There are few studies to guide treatment protocols for practicing clinicians because many of these patients do not come to the attention of mental health personnel. Ruddon and her colleagues reported a retrospective study of patients matched with other delusional patients from an inpatient and outpatient service.20 Twenty-eight patients with erotomania were identified; 12 were diagnosed with schizophrenia, 2 with bipolar disorder, 7 with other disorders including schizoaffective disorder, and 7 with a delusional disorder. The patients with the singular delusion had the best prognosis; for example, three patients had held the erotomic delusion for 2, 4, and 24 years while holding a job. Of these 28 patients, 75% were female, and 68% had never married. A systematic study of erotomic symptoms among schizophrenics was conducted by Philips et al.19 They administered the Scale of Assessment of Positive Symptoms to 448 randomly selected schizophrenic patients from four psychiatric hospitals in China and found erotomania symptoms in 9.4% of patients; 7.4% had fixed erotomic delusions. The patients with erotomic delusions were generally more grandiose, with less severe negative symptoms.

**Erotomania in Persons with Developmental Disabilities**

Reports of persons with DD who present with erotomania of the pure type, or erotomania that occurred within the course of an illness, are summarized as follows (see Table 2). Case reports in journals were located using MEDLINE with keywords erotomania and research of references in those reports. These cases are quite similar in presentation to those seen in patients of normal intelligence. Each patient developed a delusional belief about a loved person, and these individuals were
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<th>Age/Sex/Disability</th>
<th>Living Situation</th>
<th>History</th>
<th>Erotomania</th>
<th>Treatments</th>
<th>Outcome</th>
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| 1. Bhaumik and Collacott<sup>2</sup>  
28 yo male mild MR | facility/residential home | in childhood, behavioral problems, aggression, sexual aggression         | believed famous singer was in love with him; no other signs of mood or thought disorder; he carried her photograph, listened to her music, believed they were in communication and that they would marry | cyproterone acetate, thioridazine | within 2-3 years, resolved; pt moved to community residence |
| 2. Collacott<sup>1</sup>  
44 yo female mild MR | at home with parents | history of tantrums, hoarding, shy and withdrawn personality traits | at age 44, sudden onset; famous actor; normal mood and no signs of formal thought disorder, auditory hallucinations of his voice declaring his love | phenothiazine | illness resolved dramatically with drug therapy |
| 3. Collacott<sup>1</sup>  
15 yo female mild MR XXX syndrome seizure disorder | long hospital stay | behavioral disorder since age 11; schizophrenia, obsessive-compulsive traits | onset at age 15; she believed a rock and roll star was in love with her; auditory hallucinations of talking with him; she would scream when mail arrived and none from him | phenothiazine butyrophenones tricyclic antidepressants | no response to treatment; this delusion persisted for seven years until another patient informed her that this star had passed away; three years later (age 25), she developed hallucinations about the Devil; auditory hallucinations; compulsions and rituals developed; she continued to be unresponsive to drug therapy |
| 4. Collacott and Napier<sup>2</sup>  
42 yo female Down syndrome | lived in community residence, had been very close to her father | since father’s death, transient visual hallucinations of him; at one point during the erotomania, she developed grandiosity e.g., believing she was the best ballet dancer in the world; later depressed mood with diurnal variation seen | onset of erotomania several years after father’s death, when she “recognized” a bus driver as her father; at the same time, believed her Bible instructor to be a famous bible instructor, and that he loved her; she wrote him letters, misidentified a man driving a car as he (Fregoli-like misidentification syndrome) | Thioridazine 50mg tid | limited response to treatment; at anniversary of death, she believed her saw him and then that he was buried outside her window; she buried some of her father’s papers there, and gradually gave up the delusion after this incident |
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<th>Outcome</th>
</tr>
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<td>5. Ghaziuddin and Tsai1</td>
<td>community residence</td>
<td>six months previous began major depressive episode, with sexually disinhibited behavior, aggression, crying, and self-biting increased; thought she was disliked and was found with cloth tied around her neck</td>
<td>believed head teacher was in love with her, claimed to have sex with him, insisted on seeing him at school; no other signs of thought disorder</td>
<td>imipramine 75mg; later 100mg</td>
<td>responded to treatment, relapsed, then responded well to raised dose</td>
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<td>6. Greyson and Akhtar7</td>
<td>lived at home with parents who became ill</td>
<td>no pre-existing illness or behavior; however, patient was very dependent on parents; had not left home without them for years until they became ill</td>
<td>believed a teenage girl in church wanted to marry him, urging this would happen before his parents die, left house to search for her one night; a subsequent episode, three years later after father died and mother was hospitalized; a teenage girl wanted to marry him and came to his room and had sex; no other signs of formal thought disorder</td>
<td>thioridazine for first episode; he refused medication for second and was hospitalized</td>
<td>improved after first episode; in hospital after second occurrence, patient understood fear and dependency relating to his mother’s illness, but no insight into the relationship between this dependency and his delusion; did not report final response to second episode</td>
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<td>7. John and Osview11</td>
<td>had lived with mother</td>
<td>schizophrenia/psychotic disorder nos; after death of mother had grieved loss; auditory hallucinations; delusion that transmitter was in his head; no other formal thought disorder</td>
<td>patient was dependent on mother and she died; six months later gradually became agitated with delusion that a former female school friend (married with children) was in love with him; refused to believe she was married; attacked people who disagreed with him</td>
<td>haloperidol to 30mg; discharged on 10 mg haloperidol, benztpine; changed to thioridainze 100 mg daily</td>
<td>responded slowly, agitation, hallucinations and delusions improving; however, erotomania remained unchanged</td>
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**Table 2. Case Summaries for Patients with Developmental Disabilities and Erotomania (cont.)**

<table>
<thead>
<tr>
<th>Age/sex/disability</th>
<th>Living situation</th>
<th>History</th>
<th>Erotomania</th>
<th>Treatments</th>
<th>Outcome</th>
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<tr>
<td>8. Mann and Foreman</td>
<td>living at home with parents.</td>
<td>schizophrenia; first rank symptoms, blunted affect, auditory hallucinations</td>
<td>patient had been infatuated with male neighbor for several years; after birth of neighbor’s son, developed delusion; would watch his house, have tantrums if ignored by him, resisted going to the day center so he could watch the neighbor; then believed neighbor and wife were his adoptive parents; then his mother was that wife; then became sexual, heard neighbor’s voice calling to him at night telling him to masturbate; seen as Capgras and Fregoli-like delusions</td>
<td>chlorpromazine 100 mg; later changed to sulphiride 200mg bid</td>
<td>responded well to drug therapy; when mother stopped medication he became overtly psychotic again</td>
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<td>9. McGuire et al</td>
<td>lived alone; had given birth to child at age 19 or 20</td>
<td>developed erotic and paranoid delusions, somatic sexual hallucinations.</td>
<td>wrote police complaining that elderly man followed her, having sex with her, focused on a “fat man” looking for him during the day; somatic delusions that a man was touching her (during a police interview); then focused on a male community nurse who was her “suitor”</td>
<td>thioridazine, trifluoperazine; then pimozide 2 mg and procyclidine 5mg</td>
<td>improved within six months with pimozide and social supports</td>
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<td>10. Silva et al</td>
<td>unknown</td>
<td>depressed mood, mood lability, anxiety, hostility, suicidal and homicidal ideation previous to erotomaniac symptoms</td>
<td>believed has girlfriend, who had ended their nine month relationship, communicated via telepathy professing her love for him; no other psychotic symptoms were noted</td>
<td>previously on carbamazepine for seizure history; tricyclic antidepressant, antipsychotic medication</td>
<td>medication resolved most symptoms; however, erotomaniac symptoms persisted for next three years</td>
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<td>11. Hurley and Moore</td>
<td>lived at home with parents</td>
<td>behavioral disturbance and depression since adolescence; irritability; eating disorder (hyperphagia), withdrew, stayed in bed, did not care for self; major depressive episode age 28</td>
<td>onset during a major depressive episode; fictitious girlfriend was sister of famous TV and cartoon character, and they had a son together; Fregoli-like delusion of his nephew being his “son”</td>
<td>nefazodone 100mg bid; trazodone 100 mg hs; then haloperidol 1mg bid; then prolixin decoante IM 25mg q 3 weeks due to noncompliance.</td>
<td>patient was non-compliant to all medications, including those for physical conditions; did not respond to drug therapy; deteriorated; moved to a specialized facility</td>
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Table 3. Differences in Presentation of Erotomania Between Patients of Normal Intelligence and Patients with Developmental Disabilities

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<tr>
<th>Normal Intelligence</th>
<th>Developmental Disabilities</th>
<th>Source of Difference</th>
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<tr>
<td>loved person of higher status</td>
<td>higher status may be relative to the lower status of the person with the disability</td>
<td>developmental</td>
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<tr>
<td>motivation of sexual-love gratification</td>
<td>motivation may include dependence needs based on developmental disability</td>
<td>developmental</td>
</tr>
<tr>
<td>serious stalking or threats common</td>
<td>serious stalking or threats uncommon, although sexual allegations may cause potential legal difficulties if believed by others</td>
<td>developmental</td>
</tr>
<tr>
<td>unusual to find content-specific delusions</td>
<td>reports of content-specific delusions seen in neurological disorders</td>
<td>impairment/neurological</td>
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All but two cases (Cases #7 and #10). The cases involved males and females; heterosexual and homosexual orientation. In 5 of the 10 previously reported cases, the erotomania was clearly associated with a mood disorder or psychotic illness. As noted in the literature on intellectually normal patients, the majority of the individuals with DD lived with a parent or alone, and few had satisfying personal relationships with peers. In Case #10, information regarding living situation was not provided.

The case reports differ from those seen among patients of normal intelligence in several ways (see Table 3). First, the loved person chosen by patients with DD were not all traditionally persons of higher status. Loved persons included a Bible instructor, a head teacher, a teenage girl, a male neighbor, a former school mate, and a community male nurse. It can be argued that for persons with DD, these loved persons were viewed as persons of higher status. In Cases #4 and #5, the instructor and teacher were seen as higher status because of authority. In Case #6, the man had threats of imminent loss of the parent on whom he depended for survival; thus, a teenage girl of normal intelligence was the person to care for him and insure his survival. In Case #8, the 19-year-old man saw the neighbor and his wife as more accomplished and caring. Further, during his delusion, he later substituted his own mother for the wife, because the wife was too small to care for him properly (i.e. the physical care required for a man with cerebral palsy). In Case #9, the community male nurse was a person of authority in the community. In Case #7, the loved person, a former school mate, was not of higher status and was a peer. There was no mention that she was of perceived higher status or seen in a care-taking function. It is of interest, however, that this man developed his delusion after the sudden death of his mother. Because he was in a wheelchair, he was physically dependent on her for care, as well as relying on her for his housing and basic needs. Case #10 differs as his loved person was his ex-girlfriend.

Secondly, the presumed motivation for the erotomania was not always sexual gratification and love among the patients with DD, and other motivations were apparent. Because of developmental dependence on parents, and arrested development in earlier psychological stages, patients with DD may have a different dynamic-defense structure. In Case #4, the motivation was assumed to have been the loss of the women’s father, and the grief reaction was compounded because of her dependence on her parents well into her adulthood due to her developmental disability. In Case #6, the man developed his erotomania after his parents’ illness, and then his father’s death. The patient was entirely dependent on his parents for his survival, and his teenage “love” object was conceived as a wife-caretaker to him. As stated above, Case #7 developed his delusion in the mourning period after the sudden loss of his mother and caretaker. In Case #8, the man perceived the neighbor and his wife as his “adoptive parents,” and later substituted his own mother due to her better caretaking abilities. Thus, the issue of life-long parental dependence due to disability was interpreted as the motivating factor in the development of the delusions.

Third, there is an absence of serious stalking or threats against the loved person or competitive suitors reported in these cases. It may be, however, that this sample is too small to find trends of major differences, and more research is needed.
Lastly, among the persons with DD, the erotomanias included a case of Fregoli-like phenomenon (Case #4), and another case of a possible Fregoli or Capgras-like syndrome (Case #8) in the previously reported cases. In Fregoli phenomenon, the patient believes a person/persecutor is assuming the appearance of a known person. In Capgras syndrome, the patient cannot identify the known person before him and believes that the person is an imposter. These conditions are generally seen among patients with damage to the nondominant hemisphere of the brain. Because persons with DD have abnormal brain development/injury, they may experience such associated symptoms more frequently.

Erotomania may be unrecognized in persons with DD because others assume this is a "childish" fantasy, due to the nature of developmental delay. Further, it is acknowledged that psychiatric diagnosis is quite challenging in this population due to developmental and neurological impairments. As a result, treatment or needed interventions will be delayed, and in some cases, the love-object "victim" will be exposed to possible stalking, harassment, or possible serious legal consequences should others believe tales of inappropriate sexual exploits.

In this paper, we present a new case of erotomania with several unique features. First, the erotomania was directed at a totally fictional love-object, created from a TV character. Second, as has been reported in several other cases, a Fregoli-like delusion occurred during the course of this illness.

Case Report of Mr. A.

Mr. A. was a 29-year-old man with mild mental retardation who lived with his parents and had become unmanageable at home. He missed work, stayed in bed all day, was irritable and argumentative, displayed marked overeating, and had disturbed sleep for approximately one year. His parents brought him for consultation because he had also recently developed a delusion that he had a girlfriend who was the sister of a famous TV, movie and cartoon character in the "Batman" story, whom the patient believed was a real person; they had a 9-month-old son and had been seeing each other for about 10 years. He presented as tall and overweight, with severe psoriasis, poor grooming, poor eye contact, and verbal responses given in a slow, monotonic voice. His affect was blunted, with lack of facial expression range. With the exception of his singular delusion, there was no evidence of psychosis, hallucinations, and no suicidal or homicidal ideation. His cognitive status was within normal limits for a person with mild mental retardation. The patient was diagnosed with major depression due to his irritable mood, withdrawal, anhedonia, disturbed sleep and appetite, and was treated with nefazodone 100mg bid, and 100mg trazodone for sleep.

Mr. A.'s family history was negative for neuropsychiatric problems. He was the product of a normal birth and delivery, with seizures in the neonatal period, and the following noted: bilateral epicanthal folds, dolochecephaly, low set ears, bilateral planar vagus, and weight and height at height 97% percentile. In childhood, he was diagnosed with hypoparathyroidism, hypercholesterolemia and acidosis. During adolescence, he developed psoriasis. Clinical genetics evaluations and neurological evaluations failed to identify any specific neurological or mental retardation syndrome throughout his childhood and early adulthood. Mr. A. functioned in the mild range of mental retardation.

In childhood, Mr. A. attended special education classes and was described as able to get along well with his peers, and do well at school. In adolescence, his behavior changed dramatically. He disliked school and developed compulsive overeating, noncompliance, verbal aggression, and began throwing objects. He was described as depressed, articulating sadness and anger regarding his disability as he saw relatives make friends, have romantic partners, attend college and live on their own. After making suicidal statements, he received psychotherapy for some time, and for the next several years he was relatively stable. Mr. A. finished school at age 22, and was employed at a local business part-time. His family was his main source of social relationships as he had no personal friends.

After his initial visit, he was noncompliant with all medications, and several weeks later, he was admitted to the hospital, believing that his nephew was his 9-month-old son, and that he had been jumping on top of him in bed, a Fregoli-type phenomenon. The patient was admitted to a medical unit, due to his complex medical condition, and his total calcium was remarkable at 6.8. A CT Scan showed bilateral symmetric calcification in the basal ganglia, caudate nuclei, and thalamus. The patient was transferred to the Psychiatry Service, and where he was treated with haloperidol 1mg bid, and trazodone 100mg hs for sleep. He was discharged on 1,500 mg calcium carbonate tid, Ergocalciferol 50,000 units once weekly, and creams to manage his severe psoriasis, which now covered 60% of his body.

Six months later, he was admitted to the hospital again, as he had gone to another state to meet his "girlfriend" and her family. The patient was disturbed because he had "cheated" on his girlfriend by having sex with another woman and he was worried that this new woman might be pregnant. He embellished the delusion, widening her fictional circle of friends to include more famous TV characters. The patient had an increase in appetite, eating any food available, and was up during the night making food. He often refused to get out of bed, had blunted affect, refused to bathe or use the toilet. He was treated with prolisin decoante due to medication noncompliance, and discharged.

A full psychological evaluation was ordered. Psychological testing found Mr. A. to function in the mild range of mental retardation (Verbal IQ 50; Performance IQ 60, and Full Scale IQ 57). Mr. A. had a total score of 32 on the Reiss Screen for Maladaptive Behavior (9 is cut-off indicating mental illness). He was oriented and conversed well, and he participated fully and appropriately in the psychological evaluation. Throughout the evaluation, however, he continually talked about his girlfriend
(now his wife), his 9-month-old son, and the many social occasions he enjoyed with the famous TV personalities. Despite these delusions, projective testing with the Thematic Apperception Test (TAT) and Rorschach were firmly grounded in reality. Characters on the TAT felt a variety of emotions, and characters solved their problems in an impulsive manner, resorting to temper tantrums. On the Rorschach, he gave simple clear responses with no evidence of a thought disorder. His delusions did not emerge during any part of projective testing.

Major depression was considered to be his primary diagnosis with symptoms of irritable mood, poor grooming, hyperphagia, isolation, withdrawal, blunted affect, lack of facial expression range, and frequent night awakenings. He then became more irritable and combative, and starting gambling with scratch tickets, spending for example, $120 at a time. A diagnosis of bipolar disorder was considered, but due to noncompliance with medications, mood stabilizers were not used and the patient remained on prolixin decoante IM 25mg q 3 weeks. His condition did not improve, however, and his family placed him in a specialized residential service.

**DISCUSSION**

Mr. A. was a patient with mild mental retardation who presented with an erotomanic delusion that arose in the course of a major depressive episode, and later considered to possibly have a bipolar disorder. He believed he had a girlfriend and son, and the "girlfriend" was an invented fictional character, related to a famous TV, movie and cartoon character, whom the patient believed was a real person. The patient was noncompliant for medication, treated with prolixin decoante IM 25mg q 3 weeks and was finally admitted to a facility as his illness could not be managed at home.

The patient’s noncompliance with medication was a major barrier to treatment, and it also affected his medical condition. It is also interesting to note that the patient’s psoriasis worsened over previous years, involving 60% of his skin, and the relationship between psoriasis and stress is well documented. In this case, the extreme nature of the psoriasis also affected Mr. A.’s difficulty in meeting social needs for acceptance and friendship due to his appearance.

One interpretation of the erotomania was that it filled his needs for friendship, social status, and romance. In addition, unlike other cases of erotomania, the delusion of a girlfriend and a child fulfilled not only his need for sexual gratification and love, but hints of family and independence, advancing to the next developmental stage which he so clearly was disturbed by in adolescence.

Overall, the clinical picture of erotomania in developmental disability is quite like that of erotomania in intellectually normal patients. The loved person was a person of higher social status, related to a famous TV and cartoon character. In addition, the motivation for the erotomania was need for sexual gratification and love. Lastly, the erotomania arose with the context of a mental illness.

This patient also presented symptoms seen predominantly among persons with DD. First, his loved person was invented and related to a fictional TV, movie-cartoon character popular with children. Because of his mental retardation, the patient believed these characters to be "real" people. Secondly, the patient presented to the emergency room after a Fregoli-like delusion of misidentifying his nephew as his son, a condition typically seen in other neurological patients, and his neurological deficit was well-documented.

This case, and the previously reported cases, illustrate what might be the of presentation of mental illness among persons with DD. First, the general presentation of the illness is quite similar to that seen among patients with normal intelligence. Second, there will be differences in presentation based on the patient’s developmental delay so that features common among children or adolescents will be seen. Third, patients may also display symptoms characteristic of neurological impairment or genetic syndrome.

Of great interest is the possible prevalence of erotomania in less intense, but related, "pathologies of love" among persons with DD. Mullen and Pathe 

proposed that another category of "borderline erotomania" or "pathological infatuation" be developed to include the breadth of pathology that is an exaggeration of dispositions found in normal lovers. This category would include delusions or preoccupations that become pathological and result in, for example, stalking. Within the context of exaggeration of normal love, persons with DD are exquisitely vulnerable to social isolation and rejection. Thus, it is possible that a higher frequency of erotomanias, or lesser "pathologies of love" exist. Cooper and Collacott 

did report a case of pathological jealousy in a man with mild mental retardation. These conditions are largely undocumented, but clinical experience has shown that such situations are frequently reported in persons with DD by families and support staff in residential and day services. Fantasies regarding TV figures or exaggerated infatuation with peers or staff can become problematic and interfere with the life of the person, or the loved persons, if unwanted attention or stalking develops.

Finally, the present case series documents that persons with DD are indeed vulnerable to the same mental illnesses that strike the general population. Clinicians who see patients with DD presenting with symptoms of erotomania should take the situation quite seriously. Swift treatment with appropriate pharmacologic agents is recommended. Staff and family should be discouraged from confronting the patient about the delusion, and at the same time, developing strong interventions to support
normal, healthy relationships and social functioning. If the loved person is a real person and there is evidence of stalking or menacing behavior, steps must be taken to separate the patient from the loved person.

References


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