

# CLINICAL PERSPECTIVES:

## Clinical Case Rounds in Child and Adolescent Psychiatry

### Erotomania in an Adolescent Male with Concomitant Gender Identity Issues

Blair Ritchie MD, FRCPC<sup>1,2</sup>

<sup>1</sup>*Clinical Fellow, Department of Psychiatry, University of Ottawa, Ottawa, Ontario*

<sup>2</sup>*Children's Hospital of Eastern Ontario, University of Ottawa, Ottawa, Ontario*

*Corresponding email: britchie@cheo.on.ca*

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#### Introduction

While stalking in the adolescent age group is relatively common primary erotomania is almost unheard of. The case of a male teenager with this diagnosis and concomitant gender issues is described. Names in this report are false.

#### Case

When John, now sixteen years of age, met Fred (a senior student) at the beginning of high school he immediately believed that they were meant to be together. Over the next few years John had little contact with Fred. Then, John started writing to Fred about his feelings for him. Fred did not write back but John continued to contact him and started to collect pictures of him even after Fred had left the city. John next found Fred's e-mail address and tried to correspond with him over the web. When John's teachers became aware of his pursuit of Fred they discouraged it. John then became dysphoric and started talking about suicide. Staff at John's school referred him for a psychiatric assessment. By this time John had been infatuated with Fred for over 2 years but had only started to act on his thoughts for about half a year. He was convinced that a relationship with Fred was meant to be. This belief was unshakeable. He explained that Fred had not responded to his advances because Fred's parents disapproved. He had no evidence to support this. Also, Fred had never been publicly involved in a same sex relationship. John could not explain what attracted him to Fred. He denied any perceptual disturbances such as auditory hallucinations or other psychotic symptoms. John's suicidal ideation was transient. He denied any plan to harm Fred or his family. John had also come to the conclusion that he had gender identity disorder (GID). He insisted that he felt like a female in a male body. He wanted to be with Fred as a woman and the possibility of GID was considered.

The remainder of the psychiatric history was non-

contributory. No other obsessions were elicited. John drank occasionally but denied any other drug use. He had no past psychiatric history and no active medical conditions. He had no known family history of mental illness. John was born a few weeks early by cesarean section but there were no apparent negative consequences from this. Development was normal and John did well academically over the years. John's father left the family when John was young and did not remain in contact. John had detailed plans for post-secondary schooling and a future career. There was no history of abuse.

On exam John was alert and oriented and his neurological examination was normal. Pertinent positives on mental status exam included the picture of Fred that he had on his person and his infatuation regarding Fred described above. Brief Conners ratings scales were distributed to staff and family members and scores did not support a diagnosis of attention deficit hyperactivity disorder. The Symptom Checklist-90-Revised (SCL-90-R) was performed and T-scores on all domains were between the 42nd and 57th percentile.

John was admitted to the inpatient psychiatry unit for about one week. John declined a medication trial. Given that he understood our diagnostic assessment and understood the consequences of forgoing a medication trial we did not question his capacity to make this decision. He participated in all ward activities which included an exercise group, a cognitive therapy group, psychoeducational groups, as well as an occupational therapy skills group. He was also seen by the psychiatry team on a daily basis. By the end of his stay in hospital he was able to say that he was unsure if Fred actually had feelings for him. John understood that continued contact with Fred could result in criminal charges and he was confident that he would be able to discontinue all contact. However, he also said that he was not ready to move on from Fred yet. John cancelled his first outpatient appointment but came to a rescheduled appointment. He was back in school and

there were no more reports of harassment at the time of follow-up. Unfortunately, after this John declined further follow-up appointments.

## Discussion

Erotomania is usually described as a disorder seen in adults (Kelly, 2005). Only three cases of erotomania were described in the child and adolescent literature, to my knowledge. The cases include a 13 year old girl whose victims included her female teacher and psychiatrist (Urbach et al, 1992), a 15 year old male with schizophrenia who developed erotomania towards a female classmate (McCann, 1998), and a 17 year old young woman who started stalking a male classmate (Myer and Ruiz, 2004). When erotomania develops not secondary to an organic cause or another psychiatric illness, like schizophrenia, it is called primary erotomania (Kelly, 2005). Delusional disorder erotomanic type was initially described by Clérambault as one of the “psychoses passionnelles” (Berry and Haden, 1980). A delusion of an intense love often initiated by the victim is central to the diagnosis. This delusion often has a sudden onset. The object of affection is usually of higher standing or is unattainable. Usually, the patient does not develop feelings for more than one person. Paradoxical interpretations of the victim’s actions by the patient are common. Other psychotic symptoms are usually not present (Kelly, 2005).

People with erotomania often develop stalking behavior. Unlike erotomania, stalking is common; 12-32% of females and 4-17% of males are stalked in their lifetime (Dressing et al, 2006). Stalking is generally divided into three subtypes: primary erotomania, secondary erotomania (or love obsessional), and simple obsessional (or borderline erotomania) (Dressing et al, 2006, McCann, 2000, McCann 1998). Since the first two categories are rare the third category must make up the vast majority of cases. In simple obsessional stalking the behavior develops following a relationship breakup (McCann, 1998). Half of stalkers threaten their victims explicitly and 15-33% are violent (Dressing et al, 2006).

Our team believes that John suffered from delusional disorder-erotomanic type. DSM-IV-TR criteria are met as his infatuation was of delusional intensity, it was non-bizarre, it lasted more than 1 month, his belief did not markedly impair his function outside of areas directly related to it, and his beliefs could not be better accounted for by another psychiatric or medical condition (First, 2000). The possibility of GID also makes this case noteworthy. John may have been suffering from erotomania secondary to GID or gender orientation confusion. Another possibility is that his desire to be a woman devel-

oped secondary to his infatuation with Fred who John assumed to be heterosexual. The temporal course of the gender identity symptoms goes against the diagnosis of GID. Not only did the symptoms develop following his infatuation but he also did not describe symptoms until his middle teenage years. Also, he had never tried to pass as a woman, had never experimented wearing feminine clothing, nor did he express much distress with his body the way it was and current gender role (First, 2000).

Although harassment by letter writing is described extensively in the literature, reports of people sending unwanted e-mail messages, like in this case, were not found (McCann, 2000). Communication utilities like Facebook™ may make cyber harassment even more common in the future.

John’s belief seemed to decrease from delusional intensity to that of an overvalued idea with therapy alone over a very short period of time in the hospital environment. Myers and Ruiz have reported the use of cognitive and family therapy as part of the treatment of a 17 year old with erotomania (Myer and Ruiz, 2004). While our opportunity to work with John was quite limited we did initiate these therapies. John’s improvement could be viewed as inaccessibility and a desire to get out of hospital as soon as possible. However, we believe that some true improvement was seen since his beliefs were initially completely unshakable.

## Acknowledgements/Conflict of Interest

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