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# Unrequited Love and the Wish to Kill

## Diagnosis and Treatment of Borderline Erotomania

J. Reid Meloy, Ph.D.*

*Abstract:* The author hypothesizes that erotomania, or de Clérambault's syndrome, occurs in two forms: the clinically accepted delusional erotomania, in which patients believe that another person is in love with them; and borderline erotomania, in which no delusion is present, yet an extreme disorder of attachment is apparent in the pursuit of, and in the potential for violence toward, the unrequited love object. The author reviews the empirical literature concerning erotomania and then develops an object relations understanding of the disorder, focusing on the presence of narcissistic, hysterical, paranoid, and psychopathic traits in the erotomanic individual. (*Bulletin of the Menninger Clinic, 53,* 477–492)

> You know a few things about me, dear sweetheart
> Like my obsession with fantasy
> But what the rabble don't yet understand
> Is that fantasies become reality in my world.
>
> John Hinckley, Jr.
> (cited in Caplan, 1987, p. 62)

On February 16, 1988, Richard Farley, an unemployed computer technician, shot his way into a Sunnyvale, California, electronics firm that had recently fired him. He killed seven people and wounded three others, including Laura Black, a young woman who had consistently rejected his romantic overtures for several years. Two weeks earlier, Black had finally secured a temporary restraining order against Farley and had expressed relief to a friend that her ordeal might finally be over. On February 17, 1988, the Santa Clara County

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* Chief, Forensic Mental Health Services, San Diego County; Adjunct Professor, University of San Diego School of Law; Assistant Clinical Professor of Psychiatry, University of California, San Diego, School of Medicine, San Diego, California.

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Reprint requests may be sent to J. Reid Meloy, Ph.D., 964 Fifth Avenue, Suite 435, San Diego, CA 92101.

Superior Court of the State of California made the temporary restraining order permanent.

Violent behavior toward self or others as the denouement of unrequited love is as old as antiquity. Yet the empirical and psychodynamic understanding of such behavior remains elusive. In this article, I will summarize the current status of empirical research in this area and then develop a fuller psychoanalytic understanding of such behavior: the wish to injure or kill the once-loved, and now-hated, object of affection.

## Empirical Research

The psychiatric and psychological literature has focused on the obviously more pathological form of unrequited love called de Clérambault's syndrome, or erotomania, which was first described by Esquirol (1838/1965). The French psychiatrist de Clérambault (1942) carefully defined this delusional disorder and classified it as either pure or secondary (the latter superimposed on a preexisting paranoid disorder; see also Fenichel, 1945). Erotomania has historically been conceptualized as a female delusional disorder wherein a woman believes that a man, usually of higher social status, is passionately in love with her. In fact, no such relationship exists, and the love object has had, at most, only brief contact with the delusional individual (Hollender & Callahan, 1975; Seeman, 1978). Recent reports, however, suggest that men also develop this disorder; examples are often found in a forensic context because male erotomania is more likely to result in violent acting out (Goldstein, 1986, 1987a; Taylor, Mahendra, & Gunn, 1983).

Some experts believe that two recent cases of violent acting out that received national attention were forensic examples of de Clérambault's syndrome. (1) Prosenjit Poddar, who murdered Tatiana Tarasoff, developed a delusional fixation on her as a love object. After a New Year's Eve kiss, followed by her active discouragement of his love, Poddar planned to create a disaster from which he would rescue her and which would result in her recognition that she loved him. His plans ran amok, he stabbed her to death, and the civil suits resulting from her murder changed the parameters of privilege in the doctor–patient psychotherapy relationship (Blum, 1986; *Tarasoff v Regents of the University of California,* 1976; Winslade & Ross, 1983). (2) John Hinckley, Jr., tried to assassinate President Ronald Reagan on March 30, 1981, after his repeated failure to romance movie actress Jodie Foster. He neatly scripted a note to her just prior to the shooting: "Jodie, I would abandon this idea of getting Reagan in a second if I could only win your heart and live out the rest of my life with you" (Caplan, 1987, p. 21).

Although not included in *DSM-III,* de Clérambault's syndrome appears in *DSM-III-R* (American Psychiatric Association, 1987) as the erotomanic subtype of delusional (paranoid) disorder with the central theme of "an erotic delusion . . . that one is loved by another" (p. 199). This delusion usually focuses on idealized romance or spiritual union rather than sexual attraction, and the fixated object is often of higher social or economic status. The delusion must be present for at least a month; auditory or visual hallucinations are not prominent; and other behavior is not conspicuously odd or bizarre. Organic factors, of course, must be ruled out.

Dietz (1988a), who gathered data from an empirical study of letters sent to celebrities and politicians and from other case studies, reported several findings from a sample of 65 erotomanic individuals: (1) erotomania should not be considered a rare disorder, (2) it is not a predominantly female disorder, (3) the most likely recipient of violence is the person perceived to be standing in the way of the desired object, and (4) fewer than 5% of erotomanic individuals are violent. Dietz also noted that erotomanic individuals do not necessarily remain fixated on one object, but may shift to other targets. The mobility and tenacity of erotomanic persons tend to make their celebrity love objects accessible to them. If there is a common thread among female celebrity victims, it may be that their public demeanor is affectionate and caring enough to invite approach.*

Except for Dietz's study, the empirical literature has been limited to case examples of erotomania, with a gradual recognition that the disorder is not limited to women and is less rare than was once assumed (Doust & Christie, 1978; Enoch & Trethowan, 1979; Evans, Jeckel, & Slott, 1982; Feder, 1973; Freud, 1911/1958; Goldstein, 1987a; Greyson & Akhtar, 1977; Pearce, 1972; Raschka, 1979; Sims & White, 1973). Prevalence rates, however, are unknown, and published research does not significantly differentiate erotomanic individuals on the basis of biological, psychological, or social variables. Their distinctive psychometric characteristics, if any, are also unknown.

## Psychodynamics and Structure

Erotomanic delusional disorder is clinically quite obvious because of its psychotic nature. These patients, even when faced with substantial evidence

* Dietz (1988a) also reported that of the 214 subjects who wrote to celebrities, 16% had erotomanic delusions. Eleven subjects believed they were married to the celebrity. Among the 100 subjects who wrote to senators and congressmen, five had erotomanic delusions and two believed they were married to the politician.

to the contrary, remain convinced that their fixated object passionately loves in return. It is clinically critical, however, to consider erotomania in the *absence* of the delusional belief that the love object feels the same way. In other words, these individuals may pursue their love object, yet be aware that the love object does not reciprocate. This argument was raised in the Hinckley trial by the prosecution psychiatrists, who maintained that there was *no* evidence that Hinckley delusionally believed Jodie Foster loved him. His bizarre behavior was fueled, they contended, by the frustration of knowing she did *not* care for him, and he therefore pursued a course of events designed to bring him to her attention (Low, Jeffries, & Bonnie, 1986). This differential diagnosis between delusional erotomania and what I would call *borderline erotomania* is clinically significant and also has legal implications concerning pleas of insanity. The former implies the presence of psychosis; the latter indicates a gross disturbance of attachment or bonding, but not necessarily a loss of reality testing.

I selected the term *borderline* because it captures the intense and tumultuous attachment problem of this nondelusional form of erotomania. Other writers have developed the relationship between separation, loss, and erotomania, but always in the context of delusional thinking (e.g., Evans, Jeckel, & Slott's 1982 formulation of erotomania as a variant of pathological mourning in some patients). Borderline erotomania implies a *level* of personality organization (Kernberg, 1984), which I will describe in detail later. Although certain erotomanic individuals may fulfill the criteria for the diagnosis of borderline personality disorder in *DSM-III-R*, I am not implying that all nondelusional erotomanic individuals should be so diagnosed.

Implicit in this distinction between delusional erotomania and borderline erotomania is the nature of the attachment between erotomanic persons and their objects. In delusional erotomania, there has usually been no actual historical attachment. The attachment, or cathexis, is directed toward an object *concept* (Meloy, 1985) in a mind embellished with meaning and emotions that have no basis in reality. This fantastic object concept may be perceptually supported by external stimuli that are sought out by the erotomanic individual: photos of the love object, responses to fan mail, public appearances by a celebrity love object, or arranged private encounters—perhaps unknown to the erotomanic person's target. In extreme cases, the erotomanic delusion includes beliefs of union or merger with the love object that suggest an intrapsychic loss of representational boundaries between self and other object concepts. Such beliefs are usually accompanied by a loss of perceptual distinctiveness between self and others. In common parlance, the

individual is psychotic. My evaluation of a 38-year-old erotomanic male illustrates this phenomenon during the mental status examination:

> The patient does report, at times, hearing Linda's voice (the erotomanic target). Although he denies the voice is heard like a sound, he does believe that she is communicating with him in an extrasensory fashion. He also reports seeing her face in a "vision" and reports incidents of mistaken identity (Capgras syndrome) on the street when he was sure he saw her. He reports one incident of dissociation from his own body, and also reports the experience of autoscopy, the visual seeing of himself. He reports that he believes Linda's husband, George, is controlling her mind. This control, however, is "not magical, but influential."

In contrast to delusional erotomania, borderline erotomania usually involves some history of actual emotional engagement with the object. This relationship may vary from a friendly glance and smile to a terminated relationship that included emotional and sexual dimensions. *The degree of disturbance is the amount of discrepancy between the attachment behavior of the love object and the intensity of the erotomanic person's own emotional attachment to the love object.* Borderline erotomanic individuals view separation as abandonment, and rejection by the object evokes abandonment rage.

Rejection, in the mind of the delusional erotomanic person, may be conceived in autistic fantasy without any actual precipitating behavior by the object; on the other hand, rejection in the mind of the borderline erotomanic person is usually a grandiosely elaborated and distorted childhood abandonment fantasy that is recapitulated in the present by the object. Such actual rejection may represent the culmination of a pattern of selecting love objects who are unable or unwilling to respond to the erotomanic individual's affections, what Kernberg (1988) has called pathological, or masochistic, infatuation.

My clinical experience with the few erotomanic patients I have evaluated in a forensic setting indicates that there is invariably a *DSM-III-R* personality disorder, usually descriptively diagnosed as narcissistic, histrionic, antisocial, borderline, or paranoid, or a combination thereof. If there is a true erotomanic delusion, then there will usually be both an Axis I and an Axis II diagnosis. Delusional erotomanic symptoms may also appear in patients with schizophrenia, organic mental disorder, schizoaffective disorder, or other mood disorders.

Kernberg's (1984) model of personality organization helps to elucidate this clinical phenomenon. The erotomanic individual is usually organized at a

borderline level, with distinctive defensive operations and identity issues, and with only marginally adequate reality testing.

The genotypic defensive operation of splitting (Freud, 1938/1964; Grotstein, 1980) underscores the blatantly contradictory perceptions and affect states of the person with erotomania: The love object is initially idealized, but then ragefully devalued; intense love and intense hatred exist concurrently, but are experienced only in alternate, split-off affect states; and the narcissism and grandiosity of the violent act betray the defensive projection of devalued parts of the self *into* the victim (Klein, 1946/1957b). This final defensive maneuver of projective identification is most apparent in the omnipotent control and devaluation of the victims during the act of violence itself. Richard Farley, the erotomanic man who killed and injured the people in the electronics firm, stated that he wanted only to wound his unrequited love so that she would know the suffering *her* behavior had caused.

The delusional erotomanic person will also exhibit defenses characteristic of borderline disorders but, as Kernberg (1984) noted, at a psychotic level of personality organization these defenses protect the patient from experiencing further disintegration of boundaries between self and object, both intrapsychic perceptual representations and actual interoceptive–exteroceptive sensory–perceptual experience. In such circumstances, the more fixed and false the erotomanic belief, the more regressed to a psychotic level of personality organization the erotomanic individual has become. Paradoxically, the intensity of attachment to the actual object may lessen (evidenced by less proximity-seeking behavior) as the erotomanic individual retreats to more autistic levels of relatedness to fantasied object concepts and percepts (Meloy, 1985).

Identity disturbance in erotomanic individuals is evidenced by their intense, yet tumultuous, attachment to their love objects. They yearn for affection, yet may eventually wish to destroy the love object, or at least devalue the person's life. Klein's (1957/1975a) notion of envy is paramount here: the motivation to destroy the good object in the face of inevitable frustration. These contradictory self-concepts of lover and destroyer *directed toward the same object* are symptomatic of poorly integrated identity and are kept apart through splitting defenses such as denial and dissociation. Other erotomanic individuals may, through aspiring narcissism, seek a twinship alliance (Kohut, 1971) by their acts of violence and eventual identification in history with the famous, unrequited love. In other words, erotomanic individuals pursue a narcissistic wish to be like the love object to enhance their own grandiosity.

This desire for identification is illustrated in the Hinckley case during the testimony of Park Dietz, one of the government-appointed psychiatrists:

> On June 7, 1981, I interviewed Mr. Hinckley, and I asked him if he had been trying to impress Jodie Foster, and he said, "Well, it is a combination of things: To impress her, almost to traumatize her. That is the best word. To link myself with her for almost the rest of history, if you want to go that far." (Low, Jeffries, & Bonnie, 1986, p. 44)

The erotomanic individual's reality testing is usually not completely lost, but is clearly more impaired if an actual delusion of love is apparent. More often the reality testing is marginal at best, and is exemplified in the erotomanic person's intentional blending of fantasy and reality: Richard Farley would surreptitiously take photographs of his love object at her aerobics class and then show them to friends, stating that they were taken during a skiing trip together in Colorado. Prosenjit Poddar would audiotape conversations with Tatiana Tarasoff, and then splice the tapes to produce false utterances of love and affection (Blum, 1986). This conscious manipulation and unconscious *denial* of certain realities is typical of borderline defensive operations in general, and of borderline erotomania in particular.

Erotomanic individuals with a borderline level of personality organization also have distinctive characterological traits such as narcissism, hysteria, paranoia, and psychopathy that may contribute to their propensity for violence toward the love object. The clinician should be alert to these traits during the evaluation and treatment of the erotomanic individual.

## Narcissistic Traits

Reik (1963) and Hollender and Callahan (1975) believed that narcissism played a significant role in shaping erotomanic delusions. This "felt quality of perfection" (Rothstein, 1980, p. 17) may find its projective vehicle in the unattainable love object of the erotomanic person. In certain cases, this narcissism may represent masochistic subjugation to an unattainable object (Kernberg, 1988), a sense of profound pride that one can endure the greatest rejection and still, like Sisyphus, relentlessly pursue one's unattainable goal, the ideal love. In other cases, narcissism may be apparent in the aspiration and inherent grandiosity of forming a twinship alliance with the object. As noted in the case of John Hinckley, Jr., this pursuit may represent a defensive stabilization of the grandiose self-structure through fusion of the ideal self and ideal object concepts in the erotomanic individual's mind. The object concept would, of course, be the idealized love, perhaps implicating a dis-

placement from earlier, but unattainable or lost (Evans, Jeckel, & Slott, 1982), objects of affection. I distinguish this conceptual fusion from *perceptual* fusion between the self and object in the mind of the erotomanic person (Meloy, 1985), and herein lies the psychotic decompensation, because no distinction remains between the boundaries of the self and other, either intrapsychically as representation or interpersonally as actual objects. The erotomanic individual has merged with the love object in a psychotic condensation. This merger may be verbally expressed by the erotomanic patient in a religious or teleological manner. Arthur Jackson, a paranoid schizophrenic individual who erotomanically pursued the actress Theresa Saldana and then stabbed her numerous times during an attack outside her Los Angeles apartment, expressed it this way:

> Q. Why did you stab her?
> A. It was divine inspiration . . . but the forces of darkness intervened . . . I went by instinct and I have a benevolent trust in God, a blind trust . . . it was spiritual lovesickness and divine inspiration . . . it's always been aesthetic and Platonic . . . what if it was the other way around? She was the victim and I was the assailant? (Dietz, 1988b)*

The narcissism of the erotomanic individual is most apparent in the sense of entitlement and gross disregard for the suffering of the victim. As narcissistic self-absorption increases, empathic regard for others diminishes, increasing the likelihood of public acting out—perhaps in the form of violence.

## Hysterical Traits

De Clérambault's syndrome is the psychopathology of romance. Imbued with a sense of idyllic union and platonic love for the object, erotomanic persons often exhibit clear hysterical traits in their emotional lability, overinvolvement, dependent and exhibitionistic needs, pseudohypersexuality and sexual inhibition, competitiveness with the same sex, and masochism (Kernberg, 1975).

Emotional lability is circumscribed to the pursuit of the object of affection. It may suggest a borderline level of personality organization in its rapidly

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* Note Jackson's confusion. It *was* the other way around. Saldana was the victim and he was the assailant. This reversal could be interpreted as a parapraxis that reveals Jackson's continued delusional belief that Saldana was the assailant and he was the victim. Perhaps this reversal is further indication of projective identification as the actress continues to carry and contain for Jackson his own aggressive and malevolent selfobjects.

shifting and polarized expression of boundless affection or unbridled rage, affective correlates of defensive splitting.

Overinvolvement may be manifest in overt efforts to achieve proximity to the love object in the face of strong aversive consequences, such as temporary restraining orders or threats from those protecting the object. Other adaptive areas of psychosocial functioning may suffer due to the concentrated pursuit, yet erotomanic individuals demonstrate a quality of *la belle indifference* to the problems they create. Intrapsychically, the overinvolvement may be expressed in overidentification with the emotional implications of the fantasy of blissful and romantic union with the unrequited love. Such phenomena may signal regression as the erotomanic person becomes unable, or unwilling, to test these fantasies against reality. An infantile personality, in contrast to the hysterical personality, may express erotomanic desires in a more oral-aggressive, demanding, desperate, and inappropriate manner (Kernberg, 1975).

Dependent and exhibitionistic needs of erotomanic persons may blend with narcissistic traits but center around the demand to be the focus of the unrequited love's attention. Affectional coldness in the pursuit of such attention suggests a more narcissistic psychopathology.

Pseudohypersexuality and sexual inhibition will be most apparent in the contradictory behavior of the erotomanic person toward the love object. Overt behavior may suggest a desire for sexual union, but expressed fantasy may reveal a much more inhibited and split-off sexuality; the union with the object may be portrayed in a religious or aesthetic manner. More primitive borderline-level defenses may be apparent in erotomanic patients' gross denial and projection of sexual aggressiveness onto other individuals, and these patients may fantasize rescuing the object of love from such primitive sexual behavior, thus placing third parties at greater risk of violence.

The erotomanic individual's competitiveness with another person of the same sex suggests oedipal rivalry for the affections of the unattainable maternal or paternal object. In the case of the erotomanic woman, competitiveness with the male may be evidenced in masculine striving, such as more aggressive pursuit of the object than is warranted by a woman in her particular sociocultural milieu, or possession of and practice with weapons if the actual or imagined rejection of the erotomanic person has led to predatory and retaliatory fantasies.

Masochism is inherent in erotomania because of the pleasurable suffering of unrequited love. This pathological infatuation with an unattainable love object would be appropriate unconscious punishment for the hysterical character's devalued oedipal meanings of all sexual interest (Kernberg, 1988). The

"dirty and disgusting" scatological character of sexuality in the mind of the hysterical person may be at least partially denied by the "long distance touching" of the unavailable object: looking, viewing, calling, or perhaps other scoptophilic or paraphilic pursuits within which the sexual arousal pattern toward the erotomanic object is consciously denied.

## Paranoid Traits

Recent theorizing continues to suggest an association between erotomania and the paranoid disorders (Goldstein, 1987b). The obvious basis for the erotomanic delusion—that another is in love with oneself—is projection, the defensive operation central to paranoia. Erotomania also finds a psychodynamic linkage to paranoia through a more socially acceptable form of aggressive competition for the exclusivity of the object of attachment, that is, jealousy (S. McGreevy, personal communication, February 13, 1988). Meissner (1978) noted the jealous individual's sense of wounded narcissistic expectation and injustice toward the object.

In erotomania, the intensity of the attachment and the reality basis of the fantasy may be colored by paranoid ideation if the relationship to the object becomes triangulated. Sullivan (1953) was the first to note this distinction between envy and jealousy; the latter necessitates a third party and therefore suggests the oedipal triad. In erotomania, the risk of violence may increase when third parties, such as the court or friends, attempt to dissuade erotomanic persons from their pursuit of the object. Or a third party—such as a same-sex celebrity or national political figure—may represent an idealized source of oedipal rivalry whose devaluation, perhaps through assault, will usher in the conquest of the erotomanic object. Spielman (1971) distinguished jealousy from envy by noting that the former included a partial component of envy in the wish to possess the object, but that with jealousy, anger was more consistent and intense, suspicion and mistrust were heightened, and greater tension existed due to unconscious homosexuality when the heterosexual striving was frustrated.

## Psychopathic Traits

Severely psychopathic individuals will not develop erotomania because their attachment disorder is the opposite of borderline erotomania: They are profoundly detached and seek interpersonal relations only to devalue others and to shore up their grandiose self-structure (Meloy, 1988a). However, erotomanic individuals may display psychopathic traits, giving cause for clinical

alarm because they signal an increased likelihood of aggressive activity, predation, and acts of sadism to hurt and control the object.

Aggression and criminality are often present in the history of erotomanic individuals with psychopathic traits. Purposeful devaluation of heterosexual objects through emotional or physical injury conveys the necessity for psychopathically disturbed erotomanic individuals to relate on the basis of dominance and intimidation, rather than affection. For example, a 26-year-old male, diagnosed with bipolar mood disorder and antisocial personality disorder, developed an erotomanic attachment toward the female superior court judge who had tried his criminal case. Some of his correspondence conveys his aggressiveness and identification with evil as he relentlessly pursued her:

> Red blood out and black blood in,
> My Nannie says I'm a child of sin.
> How did I choose me my witchcraft kin?
> Know I as soon as dark's dreams begin.
> Shared is my heart in a nightmare's gin.
> Never from terror I but may win.
>
> (Meloy, 1988a, p. 281)

As this man's fantasies of attachment increased during the next several weeks, he sent the judge some notes that conveyed both his narcissistic aspiration for attachment and his derision: "I love you because you've got the balls to wear black" (Meloy, 1988a, p. 282). Subsequently, his striving turned to more blatant devaluation, as the judicial system punitively responded to his erotomanic quest: "You're so prim and proper I'll bet you have lilacs for pubic hairs, you whore" (Meloy, 1988a, p. 285). After being found incompetent to stand trial, this patient was finally hospitalized for 90 days and restabilized on lithium carbonate. His erotomanic fixation diminished. Or so he claimed.

Predation is a purposeful, planned, and emotionless mode of violence, in contrast to the more common mode of emotional, or affective, violence (Meloy, 1988a). Its presence in erotomanic persons with psychopathic traits suggests a higher risk of unexpected assault against the erotomanic object. Predation generally does not appear in pure form in these people because they do experience the narcissistic wounding and retaliatory rage that accompany erotomanic violence. But predation does allow for stalking the victim over extended periods of time, rehearsal fantasies prior to the violence, a fueling of narcissistic characteristics to steel themselves for the task, and the use of transitional objects in fantasy as preparation for the violence itself (Fintzy, 1971; Meloy, 1988a). Transitional objects not only help maintain the

illusion of omnipotent control over the erotomanic object, but they also function as a Janus-faced object that facilitates both distancing and disidentification with reality (Meloy, 1988a).

Sadism is the derivation of pleasure from inflicting physical or emotional pain on the erotomanic object. It is the wish to hurt and control the object in the face of unrequited affection. The young man who developed an erotomanic attachment to the female judge sent her an audiotape in which he politely introduced himself, screamed obscenities at her, and then sang her a love song, accompanying himself with a guitar. As Shapiro noted (1981), sadomasochistic sexuality is a highly ideational matter. Ideas and symbols of erotic sexuality are most exciting in a concentrated, extreme, and detached form. Sadism is purposive, willful behavior in which the idea of subjugating the erotomanic object is so stimulating because the actuality of sexual abandonment is unfathomable. John Hinckley, Jr., expressed this dynamic quite well:

> I seem to have a need to hurt those people that I love the most. This is true in relation to my family and to Jodie Foster. I love them so much but I have this compulsion to destroy them. On March 30, 1981 I was asking my family to take me back and I was asking Jodie Foster to hold me in her heart. My assassination attempt was an act of love. I'm sorry love has to be so painful. (Caplan, 1987, pp. 129–130)

## Evaluation and Treatment

In evaluating erotomanic patients, clinicians should be aware that once these individuals are coerced into treatment by friends or the judicial system, they may quickly recognize the social desirability of *not* expressing erotomanic beliefs. Therefore they are likely to dissemble, or conceal their beliefs from the clinician, even if they continue to harbor such thoughts. One should clinically assume the continued presence of erotomanic beliefs, even if patients deny them during treatment. A patient may have successfully assaulted the erotomanic object or a third party and accomplished certain narcissistic goals (such as talionic revenge, union with the object, or notable publicity) yet still be erotomanically attached. Again, Dietz's testimony during the Hinckley trial is instructive: "I asked . . . whether he thought he had accomplished that goal, and he said, 'You know, actually, I accomplished everything I was going for there. Actually I should feel good that I accomplished everything on a grand scale' " (Low, Jeffries, & Bonnie, 1986, p. 44).

Several guidelines should be followed in the evaluation and treatment of erotomanic individuals.

First, the individual's personality structure and functioning should be assessed using both objective and projective psychological tests. Specific attention should be given to the degree of narcissism, hysteria, paranoia, and psychopathy in the character organization, because these factors may predict the degree of violent acting out that could occur.* Generally, the more obvious the presence of paranoid and psychopathic traits, the greater the risk of violence, especially if the erotomanic individual meets other criteria, such as use of alcohol or psychostimulants, that correlate with violence (Meloy, 1987, 1988b).

Second, both Axis I and Axis II *DSM-III-R* descriptive diagnoses should be considered. A delusional (paranoid) disorder, erotomanic subtype, will often mask the more salient personality structure, or at least divert the clinician's focus. The clinician should also carefully rule out the schizophrenias, mood disorders, and organic disorders, because erotomanic symptoms may accompany these diagnoses.

Third, although psychotherapeutic treatment is difficult, if not impossible, neuroleptic medications may provide symptomatic relief (Goldstein, 1987a). Other pharmacotherapy—such as lithium carbonate—may help patients whose symptomatology includes an affective component. There is currently no published research, except anecdotal reports, concerning the pharmacological management of the erotomanic patient; therefore psychiatrists should not be dissuaded from trying various medications that might be efficacious.

Fourth, legal interventions to protect the erotomanic person's love object must be carefully weighed. In some cases, they will work; but in other cases, judicial sanction may only enrage the erotomanically disturbed patient, spurring the person on to more intrusive and violent behavior. Individual and situational correlates of violence risk (Meloy, 1987) must be thoughtfully considered, with particular attention to the individual's history of violence, the intensity and irrationality of attachment to the object, and the nature and extent of narcissistic, hysterical, paranoid, and psychopathic character traits. It may be useful for the clinician who attempts to treat an erotomanic patient to secure a consent from the patient to release treatment information to the

* The Rorschach is particularly useful in understanding the structure and dynamics of the erotomanic individual. From a structural perspective (Exner, 1986), careful attention should be paid to the following indices, which *may* indicate a higher risk of violence: FC<CF+C, Pure C, FM>M, Egocentricity Index >.45 or <.30, Affective Ratio >.80, Ma<Mp, and T>1 or <1. Content analysis should look for indications of borderline defenses (Cooper & Arnow, 1986) and modes of relating (Kwawer, 1980). Responses that refer to predation or aggression with morbid content are quite revealing and may be indicative of sadistic, masochistic, or psychopathic traits.

love object. Thus the clinician can play an active role, with the patient's full knowledge, in advising the love object of the progress, or lack thereof, of treatment. Such preliminary measures can also diminish the impact of a *Tarasoff* warning to the love object if the erotomanic patient begins to devalue, and perhaps overtly threaten, the love object during treatment.

Finally, clinicians should urge officers of the court to act judiciously when managing such an individual. Often clinicians can directly influence court decisions if they will risk initiating contact with the various attorneys and the judge involved in a particular case. Mental health professionals, however, must understand their role in any single case (e.g., court-appointed examiner vs. therapist) and be cognizant of local statutory and case law concerning privileged communication.

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