Borderline Personality Disorder Within Erotomania

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Dedication

To my mother, Lori Ferro.

Thank you for your unwavering strength and guidance.

To my late grandparents, Gertrude Rizk and Ronald Rogers.

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Abstract

The occurrence of borderline personality disorder (BPD) among those with erotomania is currently unknown. However, there are similarities between the symptoms of these two disorders that may increase comorbidity between them. These include harmful behavioral temperament, fear of abandonment and the necessity of another individual in their lives. This study was aimed at determining specific commonalities between the two disorders in order to better treat those with comorbid erotomania and BPD.

Keywords: borderline personality disorder, erotomania, borderline erotomania, stalking

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The Problem Statement

The occurrence of borderline personality disorder (BPD) of among individuals with erotomania is unknown. However, the idea that BPD and stalking are not exclusive should be acknowledged. According to Sansone and Sansone (2010), attachment styles of those with BPD may lead to a number of various stalking behaviors. Cases in which individuals have been diagnosed with both disorders show that the rate at which erotomania occurs within BPD is currently unknown. Once any relationships have been established, common triggers can then be determined to try and prevent erotomania among those with BPD.

Problem Statement

Although those who have been diagnosed with BPD are likely to have comorbid disorders, there is a lack of research regarding the comorbidity between BPD and stalking, specifically erotomanic stalking. Erotomania involves a "morbid infatuation and 'projection' of the affected individual's own attitudes onto the perceived 'love object'" (Enoch & Trethowan, 1991, as cited in Brüne, 2003, p. 83). When looking at the diagnostic criteria of BPD, it can be assumed that a person with unstable interpersonal relationships and poor self-image may be more likely to project their attitudes onto others. Research regarding the occurrence rate of BPD among individuals with erotomania can help determine common life events that trigger the onset of BPD, allowing for preventative measures to be ascertained.

Purpose of the Study

Little is known regarding similar life events that may cause a person to present with both BPD and erotomania. This study aims to determine the occurrence rate of BPD within

erotomania, with a view to identifying similarities between individuals with BPD and erotomania.

Research Questions/Objectives

This study has been designed to determine the occurrence rates of BPD among those with erotomania. Different ways in which BPD and erotomanic stalking may be related will be discussed. For example, borderline-erotomania which may help link BPD and erotomanic stalking will be observed (Brüne, 2003). Once occurrence rates have been determined, common life events between those with BPD and erotomania will be researched in order to better determine precautionary measures that can be taken among those with BPD. For example, are there common factors that trigger erotomania among those with BPD? If so, are there preventive measures that may be taken?

Scope

This study includes research regarding individuals with BPD and erotomania. Also, the occurrence rate of BPD among individuals with erotomania is investigated; however, this study does not examine the comorbidity between the two disorders.

Assumptions

This research has been conducted assuming that there is a small incidence of BPD among those with erotomania. It is assumed that there will be similar life events that trigger the onset of erotomania within those with BPD. It is also assumed that the existing literature pertaining to the topic was undertaken in an ethical manner, yielding valid results. There will be supposed missing information in regards to all aspects of the individuals' lives within the cases used.

Definition of Key Terms

Borderline Personality Disorder - *"A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked by impulsivity, beginning by early adulthood and present in a variety of contexts" (American Psychiatric Association, 2013, p. 663).*

Erotomania – Erotomania is a delusion disorder and is specified as "The presence of one (or more) delusions with a duration 1 month or longer…In erotomanic type, the central theme of the delusion is that another person is in love with the individual (American Psychiatric Association, 2013, p. 90, 91).

Review Of The Literature

Borderline Personality Disorder

The Diagnostic and Statistical Manual of Mental Disorders defines borderline personality disorder (BPD) as, "A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked by impulsivity, beginning by early adulthood and present in a variety of contexts" (5th ed.; *DSM–5*; American Psychiatric Association, 2013, p. 663). Due to the fact that BPD is a personality disorder, the difficulties faced by individuals with this condition are pervasive, inflexible, and impairing. Although most individuals with BPD begin treatment around age 18, symptoms can be identified earlier. For example, 30% of patients begin self-harming at age 12 or younger, while another 30% begin to self-harm between the ages of 13 and 17. Though there are some identifiable precursors to BPD, the course of the disorder during childhood is unstable, with only 40% of adolescents with BPD meeting the diagnostic criteria at a two-year follow up (Beskin, 2015). However, this could be explained by research conducted by Houben et al. (2016), which characterizes BPD as large changes in emotional intensity with negative emotions being more variable over time. During adulthood, overall symptoms may decrease; however, behaviors relating to impulsivity tend to remit much more quickly than other symptoms (Biskin, 2015).

Signs and symptoms of BPD. According to the *DSM-5*, signs and symptoms of BPD include the following: frantic efforts to avoid real or imagined abandonment; a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; identity disturbance – markedly and persistently unstable self-image or sense of self; impulsivity in at least two areas that are self-damaging; recurrent suicidal behavior; affective instability due to a marked reactivity of mood; chronic feelings of emptiness;

inappropriate, intense anger or difficulty controlling anger; transient and stress-related paranoid ideation or severe dissociative symptoms (American Psychiatric Association, 2013).

Gender differences among BPD. Silberschmidt, Lee, Zanarini and Schulz (2015) state that women have higher diagnostic rates among those with BPD; however, this may be due to the different ways in which they present their symptoms when compared to males. It has been found that women internalize their symptoms more than their male counterparts. Internalizing may lead to comorbidity of post-traumatic stress disorder, anxiety disorders, somatoform disorder, affective disorder, eating disorders, as well as histrionic personality disorder. Conversely, males may express their symptoms through externalizing with higher rates of dangerous behaviors such as substance abuse, antisocial personality disorder, narcissistic personality disorder, schizotypal personality disorder, passive aggressive personality disorder, and sadistic personality disorder (Silberschmidt et al, 2015). Although there are clear differences regarding the symptomology between males and females, Busch, Balsis, Morey and Oltmanns (2016), discuss the selection bias that has occurred within BPD prevalence studies. Through a careful literature review and study, the authors found that women do in fact have a greater number of symptoms relating to BPD; however, both males and females are disabled equally (Busch et al., 2016).

Erotomania

Erotomania is a delusion disorder and is specified as "The presence of one (or more) delusions with a duration 1 month or longer…In erotomanic type, the central theme of the delusion is that another person is in love with the individual" (American Psychiatric Association, 2013, p. 90, 91). This belief is generally applied to a person of a higher social status (Almada, Luengo, Casquinha, & Heitor, 2016). Erotomanic type is one of many delusional disorders. For example, there is also grandiose type, jealous type, persecutory type, somatic type, mixed type

and unspecified type (Kelly, 2005). Kelly states that there are two classifications in which erotomania can occur. Primary erotomania occurs "in the absence of other aetiologically significant organic or psychiatric disorder", while secondary erotomania occurs "in the presence of another aetiologically significant organic or psychiatric disorder" (2005, p. 658). It was found that the occurrence of primary erotomania is believed to be rare, which is in concordance with other research. For example, Guillard, Mallet and Limosin (2016), found that there is a frequent association between erotomania and mood disorders.

Signs and symptoms of erotomania. Signs and symptoms of erotomania include the following:

> One or more delusion lasting longer than one month, criterion A for schizophrenia has not been met, functioning has not been impaired and behavior is not obviously bizarre or odd, if manic or major depressive disorders have occurred, they have been brief relative to the duration of the delusional periods, and the delusion is not attributable to substance use or another medical condition. (American Psychiatric Association, 2013, p. 90)

Gender differences among erotomania. According to research conducted by Kelly (2005), "delusional disorder in general has been reported as approximately 15 cases per 100,000 of the population per year, with a female: male ratio of 3**:**1" (p. 657). Kelly (2005) further states that it was historically thought erotomania was a disorder that occurred exclusively in women. Although this research suggests that there are a larger number of females with delusional disorder, research undertaken by Brüne (2003), shows that criminal offenses associated with erotomania occur more frequently among men. However, Brüne (2003) also suggests that this may be due to the fact that "forensic services are the major source of case reports of male erotomania, there may be a potential bias towards the forensic significance of erotomania in

men" (p. 86). Erotomania in men appears to be more frequently associated with violent behavior, which is primarily directed towards the pursued love object, her kin, or persons who are perceived as ‘‘rivals’’ (Brüne, 2003). Furthermore, Kelly (2005) notes that primary erotomania tends to be more prevalent among women, suggesting that secondary erotomania does not have the same gender ratio.

Comorbidity

Previous research suggests that comorbid disorders are extremely common in patients with BPD. However, comorbid disorders found within BPD are frequently mood disorders such as major depressive disorder (MDD), anxiety disorders, and eating disorders. It was also found that among personality disorders, comorbidity is more common within those who have been diagnosed with BPD when compared to patients with other personality disorders (Biskin, 2015). Clinical work documented by Meloy (1989) shows that clients that had been diagnosed with erotomania had also been diagnosed with a personality disorder such as narcissistic, histrionic, antisocial, borderline, or paranoid, or a combination of the aforementioned disorders. It was also found that if there were a true erotomanic delusion, there would generally be both an Axis I and an Axis II diagnosis, according to the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *DSM–III*; American Psychiatric Association, 1980). Delusional erotomanic symptoms may also appear in patients with schizophrenia, an organic mental disorder, schizoaffective disorder, or other mood disorders.

Borderline erotomania. Meloy (1989) hypothesized that erotomania occurs in two forms. The first is delusional erotomania, in which an individual believes that another person is in love with them, and the second is borderline erotomania, in which no delusion is present but an extreme disorder of attachment is apparent in the pursuit of, and in the potential for violence

toward, the unrequited love object. Although both delusional erotomania and borderline erotomania characteristically involve a history of emotional engagement with the object, it has been found that:

> 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. (Meloy, 1989, p. 481)

As stated previously, men are more likely to become violent offenders due to erotomania, which can be explained through the rage that Meloy (1989) discusses. In conjunction with this, Kelly (2005) states that certain subtypes of delusional disorders have been associated with criminal behavior. One key characteristic that may cause criminal behavior is that of pathological jealousy. This particular trait may cause an individual extreme anger, which can lead to harassment, stalking and violence. Furthermore, research has found that those with secondary erotomania have more "carnal" delusions that may shift between objects, causing a greater chance of crime. The risk factors associated with the relationship between BPD and erotomania call for further research.

Stalking

Racine and Billick (2014) discuss several stalking typologies presented in previous research. First, stalker-victim types, presented by Zona, Sharma and Lane (1993) are considered. Within this typology, there are three major categories: simple obsessional, love obsessional, and erotomanic. Simple obsessional, the most common of the three, involves a stalker and victim who have knowledge of each other and have generally been in a relationship. Conversely, love obsessional stalking involves instances where the stalker and victim have no previous

relationship and, in most cases, have never met. Erotomanic stalking is based on the delusional belief of the stalker that the victim is in love with them (Zona, Sharma & Lane, 1993). This form of stalking will be further discussed.

Other typologies considered are those of Mullen, Pathe, Purcell and Stuart (1999). These typologies include the rejected, intimacy seeking, incompetent, resentful, and predatory. Rejected stalkers are those who victimize previous intimate partners in order to seek revenge or gain reconciliation. Intimacy stalkers are those who desire to be in an intimate relationship with their victim, while those who are incompetent stalkers have a sense of entitlement within their perceived relationship and are unable to distinguish the lack of emotional reciprocity from the victim. These two categories would encompass Zona, Sharma and Lane's (1993) typology of an erotomanic stalker. The last two categories are much more violent in nature with the resentful stalker seeking revenge through fear and the predatory stalker targeting victims for assault (Mullen et al., 1999).

Although many cases of stalking involve those without a mental disorder, there are cases in which the perpetrator has a mental illness. According to McGuire and Wraith (2000), the characteristics of such stalkers include, "erotomanic delusions, presenting either as a primary illness or secondary to another mental illness" (p. 316).

Erotomanic stalking. There are two different relationships that a stalker may have with their victim. First, those who have known their victim on an intimate level, and second, those who have never met, or have only had a brief encounter with, their victim (McGuire & Wraith, 2000). This study will focus on the latter, especially regarding erotomanic stalking.

According to Davis and Chipman (1997), erotomanic stalking is the delusional belief that the stalker is loved by the victim. The victim is usually a celebrity figure and is unattainable for

the stalker. The researchers state that there are three types of erotomanic stalkers. The first type is the Random-Targeting Stalker, who selects their victim at random. The second type is the Celebrity-Targeting Stalker, who pursues an unattainable celebrity or other well-known public figure. The Celebrity-Targeting Stalker is very aggressive through acts of harassment via mail, internet, and telephone. The third type is the Single-Issue Targeting Stalker, who chooses victims based on specific areas of focus such as social, political or economic matters. According to the researchers, all three types of erotomanic stalkers focus on a spiritual bond between themselves and their victims, which decreases violence towards the victim's physical self. However, violence may arise if a third party tries to interfere with the relationship (Davis & Chipman, 1997).

BPD and erotomanic stalking. In cases that look at Cluster B disorders such as BPD within stalkers, most studies have found that while characteristics of BPD have been established, the "explicit prevalence rates" have not (Sansone & Sansone, 2010, p. 44). In fact, the researchers located only five studies that report apparent rates of BPD among stalkers. However, the results of these studies ranged greatly, from 4 to 45 percent, most likely due to their methodology (Sansone & Sansone, 2010). With this lack in consistent research comes the lack of understanding of any links that may exist between those with BPD and erotomania, and more specifically, erotomanic stalkers.

An examination of the extant literature may reveal a number of links and commonalities between BPD and erotomania that have yet to be found. For example, gender similarities, aggression patterns, and impulsivity are seen within both disorders. Furthermore, these traits may also be seen within erotomanic stalking cases as well.

Cases

The following four cases pertain to specific instances of stalking in which the stalker has been diagnosed with erotomania. Each case will be compared to a checklist designed with reference to the diagnostic criteria for BPD in the *DSM-5*. If the individual meets five or more of the criteria, it will be assumed that they can be diagnosed with BPD.

Case one. In April 1971, the senior author began seeing a 21-year-old Caucasian female who presented with a very intense delusional system. She was well-dressed and presented herself in a very dignified manner. She talked in the manner that would give the impression that she was quite well-adjusted and free of psychotic delusions. However, as she began to talk about her intended boyfriend, it was obvious that there were delusions present. She began to talk about him as if they were engaged in a romantic relationship. However, they had never had a date and she had only seen him in class. She went on to say that she knew he loved her, and she was attracted to him because of his extreme love for her. In other words, she loved him because he loved her so much. She realized he was empty without her and was pursuing her, but enemies were preventing them from uniting. The enemies included a number of people: people in her family, her classmates, neighbors and many other persons who were plotting to keep them apart. She knew that her conclusions were accurate because he would send messages to her proving his love. These messages would often present themselves as the license plates on cars of a certain state, the color purple and other indications that she received from the environment that proved to her that he loved her. She also indicated that he gave meaning to her life, and she was certain she gave meaning to his despite the fact that they were not yet together. She also said that she would not relate to any other

man because, if so, she would be unfaithful to him. She insisted that she would wait for him eternally. She also indicated that the world knew about this—even the president of the United States and other important people were very much aware of their love for each other. He provided meaning to her life that she did not have before and if she did not have him, her life would have no meaning. During the course of three or four years, these delusions persisted.

In addition to the persistence of the delusions, she developed additional delusional ideas. One was that he visited her at night for many years, married her and impregnated her, and that she had given birth to a large number of children. These children had been taken away from her by her parents and her psychiatrist and given up for adoption without her permission. She is very angry about that.

There were also times during the course of follow-up in the initial three or four years that she would become violent toward her family if on a given occasion, such as a holiday, he did not come. This was especially true during the early years. There was also a period of time in which she would not leave the house and would confine herself to her parents' or sister's home for months at a time for fear that someone (i.e., one of the enemies) would harm her.

She was hospitalized in 1978 for a short period of time and given electroconvulsive therapy. The result of that was a very brief resolution of her delusive process. A review of that would reveal that she was only relatively free of the delusions for about two or three weeks after treatment. But after that, they returned and have continued. Various antipsychotics over the years have been helpful in controlling the

extremes of her agitation; her potentially dangerous behavior has minimized. However, the erotomanic delusions have continued unchanged throughout this period of time.

In view of the fact that this young lady has not exhibited the majority of the symptoms of schizophrenia and has not had more bizarre delusions other than those described above, she has been able to function in the community and her home with some degree of success. Her diagnosis is delusional disorder persecutory type (Jordan et al., 2006, pp. 797-788).

Case Two. W., a 31-year-old, single, unemployed, Chinese female was admitted to the psychiatric ward in March 1973 for having the unmanageable behaviour of stripping herself naked at home and threatening to kill her mother with a knife. She had been treated for chronic schizophrenia since 1973 and had had five previous admissions. As early as 1977, she was noted by her doctor as having undesirable transference feelings towards him. She was subsequently transferred to the care of a private female psychiatrist.

In July 1981, she was admitted to the wards for treatment of an episode of relapse of her schizophrenic illness. During this admission, she was under the care of another male therapist who was rather soft and gentle to her. Gradually, she began to have sexual fantasies about him and started writing letters to him. The letters gradually became more intimate and frequent, and he received as many as three letters a day. The letters asked him to marry her and she expressed her doubt as to how the therapist could love his wife when W. was so good to him. Despite the therapist having tried to convince her that he was already very happily married to his wife and that he did not love her, her harassment continued. The therapist had even brought the matter to the attention of her parents but

this did not stop her from thinking about the therapist. By October 1982, the therapist could no longer tolerate her harassment and she was subsequently put under the care of a female therapist.

W. took this rejection by her former male therapist rather badly and at home, she would strip herself naked to attract the attention of a male neighbour. When her parents scolded her, she would become aggressive and threaten to kill her mother.

In the ward, she admitted to having visual hallucinations of shadows and auditory hallucinations of men talking about her. She also had ideas of reference about her neighbours and her affect was rather fatuous. Physically, she was fit. A diagnosis of residual paranoid schizophrenia with erotomania was made. She was treated with Inj, Fluphenazine (Modecate) 37.5 mg I/M monthly, Chlorpromazine (Largactil) 100 mg 1.d.s. and Benzhexol (Artane) 2 mg t.d.s. She subsequently settled but her erotomania about the male therapist persisted (Hien, 1984, p. 294).

Case Three. A 31 year-old married woman patient, "Charity", was a high level executive, well-educated, intelligent, attractive, and privileged. She spent her childhood in the late 1960s and 1970s with a free-thinking, hippie, single mother who seemed to be as highly devoted to the welfare of the poor and underprivileged as she was to that of her only and out-of-wedlock child. In the name of protection, her mother made sure that Charity's biological father, who had left her shortly after their baby was conceived, never had contact with Charity, an action that had life-long effects on Charity's choice of men. An unforgettable bit of family lore that the mother told her daughter when she was about six is that the father did attempt to maintain a connection with his daughter. The mother refused the father's request and succeeded in her efforts to keep Charity's father at bay.

Charity has harbored a grudge against her biological father ever since. Although she focused on her father's abandonment of her, her chronic anger and the chip on her shoulder could be viewed as indirect resentful expressions toward her mother for forbidding any encounter in the name of "benevolent" social intentions toward strangers above the family. Charity was nursed until four and slept in her mother's bed until she was eighteen. She developed an overly close primary erotic tie and symbiotic attachment to her "preoedipal" mother that intertwined with her life-long "oedipal" paternal search for men who were hardly suited to gratify her as a woman of accomplishment.

Charity had become sexually enthralled with a 62 year-old homeless man, Hank, a drug addict who had been convicted of, and imprisoned for, the manslaughter of his wife. On parole, he started, during their trysts, to physically abuse her, and threaten to destroy her marriage to a man who was, not surprisingly, given her mother's predilections for the poor and downtrodden, her educational, economic, and social inferior. Frightened by the parolee, who had begun to stalk her, and by her own inexplicable, obsessional attraction to him, she sought treatment and an order of restraint against her stalker. Hank was jailed and then released again on parole. Instead of checking in regularly with his parole officer, he went into hiding, stalked Charity around town, phoned ceaselessly, and suddenly stopped his frightening pursuit. Charity then felt abandoned, unattractive, and jealous of other women she imagined he had begun to stalk. She began to seek him out, reversing the stalker-stalkee pattern fairly successfully, and when she could, made sure he discovered her whereabouts.

Before treatment began, and during its early phases, Charity developed a theory that her ego-alien sexual obsession with the homeless, older man who was addicted to

drugs was a symptom that represented a search for her now deceased father, whom she never knew. She bolstered her theory *ad infintum* and argued that her incestuously based search for her now dead father must be the psychological root of her troubles. Charity noted that she had never been involved sexually with a man her own age or even a bit older, but only with men twenty or more years her senior. She was attempting, in these protestations, to prove that her enthrallment was a helpless and hopeless condition that she felt doomed to repeat. At the height of her irresistible attraction to this stalker, she had been married for eight years to a sixty-year-old divorced man—the same age as her stalker—who was a father of two children from a former marriage. He was extremely caring and protective of her and she saw him as a compensation for her fanaticized creation of her lost father. She may have also imagined that her stalker satisfied her perverse version of maternal nurturing and safety. Although she focused on her father's abandonment of her, the chip on her shoulder about her father may have been displaced anger toward her mother for preventing any relationship whatsoever between Charity and her father, and her strange object choice may have been a mockery of mother's 1970s exclusionary social values. Charity's sexual obsession, thus, rings both of oedipal rivalry and of preoedipal fixations and "disorganized attachment" to her mother during her early years.

During the course of treatment, Charity came up with the idea that she obsessively and repeatedly sought out dangerous relationships to keep her level of sexual excitement as high as possible. In fact, one reason she sought treatment was because she had knowingly exposed herself to AIDS some twelve years before she began treatment with me, in a sexual encounter with another socially marginal man who was HIV positive.

After that enactment, she was beset by a paralysis of will and action in which she refused to get an AIDS test. She lived in dread of being HIV positive all those years and even went into cognitive-behavioral treatment for help in "being forced" to go for testing. Once, accompanied by several supportive friends, she went so far as to have the test done, but never asked for, or learned the results. So, she kept herself at the edge of the excitement by choosing a partner who stalked her. She was, so to speak, "stalked" by the specter of AIDS, a specter she refused to give up. Charity earnestly wanted to hear that she tested negatively for AIDS because she wanted a child of her own with her current husband, or, if she decided to leave him, as a single woman, repeating in fantasy the story of her own birth and early rearing by a single hippie mother.

In sum, when Charity was stalked she no longer felt bored, empty, dis-enlivened, and deadened. She yearned to resume her dangerous liaison, believing and theorizing elaborately that she had a "monstrous" sexual addiction that was the bane of her existence. Her search for excitement and danger served to regulate dysphoric affective states. One major motive for Charity's self-endangering repetitive attempts at object seeking and object refinding by maintain a high level of sexual excitement from being stalked is a variant of what Ernest Jones (1927, 1929) called "aphanisis". Jones, basing his idea on the Greek translation of the word, defined aphanisis as the fear of total extinction of the capacity and opportunity for sexual pleasure and excitement. In men, according to Jones, this specific fear takes the form of castration; in women, of separation, which can be fanaticized and/or, as in this case, actually realized, as "coming about through the rival mother intervening between the girl and the father" (1927, p. 462). This is precisely the situation that Charity believed as underlying her urges for

dangerous sexual encounters that included stalking, and her shaky motivation to contain them. She never abandoned her theory that her mother's attempt to disemparent her father accounted for her misery. Both oedipal longings to refind the fantasized father and a primary maternal erotic tie have primed this woman to live her life around seeking and then dreading situations in which her craving to be alive sexually and in every other way have misfired. As a stalkee, she has put herself at maximum risk: by realizing her sexuality, she has maximized her excitement. (Gediman, 2016, p. 14-17)

Case Four. Case Presentation: Mr. X is a 21-year-old single male admitted to a state psychiatric hospital after being found not competent to stand trial on charges of stalking, harassment, trespassing and telephone harassment. During initial interview, he was belligerent and did not understand why he was being admitted. He stated he and a former high school classmate, Ms. A, were in love. He had been communicating with Ms. A through Facebook for two and a half years. During this time, he left more than 50 voicemail messages daily and loitered at her school and house. After Mr. X appeared at Ms. A's home on at least five occasions, her father called the police and Mr. X was arrested. The admission mental status examination revealed constricted and guarded affect, with very limited engagement. Mr. X had poor eye contact and moderate psychomotor retardation. His speech was non-spontaneous, with very brief responses to questions. He denied hallucinations, and demonstrated thought blocking. His delusions were well systematized, with major themes of love and infatuation. He showed no insight.

Mr. X had no prior psychiatric hospitalizations or medications, although he acknowledged seeing a counselor for 18 months for "depression" in high school. His

family described him as introverted and isolative. Family history was positive for depression in his mother and half-sister. Mr. X had no known substance abuse history. Laboratory studies, including urine studies, standard blood work, chest x-ray, HIV screening and head CT scan, were unremarkable.

After admission, Mr. X frequently became agitated and required numerous emergency interventions for dangerous behavior towards staff. His outbursts were motivated by intrusive, ruminating thoughts that Ms. A was waiting for him outside; he assaulted staff so he could grab their keys and attempt to elope. Numerous medications, including both typical and atypical antipsychotics, did not impact his violent behavior, or his belief that Ms. A was in love with him.

During supportive therapy, Mr. X revealed the extent to which SMN dominated his interactions. At home, where he lived with his family, the updates and activities posted by his Facebook "friends" set the tone for his day. After working the night shift with minimal interpersonal contact, he returned home and pursued SMN sites and online gaming. He did not have face-to-face interactions with peers; his only contact with "friends" was via Facebook.

Mr. X's stalking behavior centered around SMN [social media network]. Ms. A had accepted his Facebook "friend" request several years earlier when they had shared one high school class. He began over-identifying with her, although they never communicated offline. The ease with which he learned details of her personal life may have fueled development of his underlying psychopathology. He interpreted her general posted updates as evidence of her "love" for him, requested a real-world relationship with

her, and began to pursue her via phone and in person. These actions led to his arrest and hospitalization. (Krishna et al., 2013, Case presentation para. 4-8)

Method

Participants

For this study, four previous cases of erotomania will be examined and compared to a checklist containing BPD criteria (Appendix A). The first case examines a 21-year-old female who presented with intense delusional systems regarding a male classmate. This individual's delusion worsened throughout the case, which can be observed through her belief that her love interest married and impregnated her. Furthermore, mood disturbances could be witnessed through violence and isolation. The woman in this case was diagnosed with delusional disorder persecutory type. Next, a case involving a 31 year-old female is examined. This individual had a history of chronic schizophrenia and had been previously hospitalized for this disorder. The individual began to have intense feelings for two male therapists which she acted upon. When rejected by her love interest, the individual became hostile. She was diagnosed with residual paranoid schizophrenia with erotomania. The third case involves a 31 year-old woman who was highly educated. This individual developed a relationship with a man who began to stalk her; however, after rebuffing him, she began to stalk him while putting herself in dangerous situations. The final diagnosis of this individual was not mentioned within the case. Lastly, a 21 year-old male is assessed. This individual began to stalk and harass a female with whom he communicated online. He had history of depression and was admitted to hospital for surveillance. During this time, he believed that his love interest was waiting in he parking lot and would act upon these beliefs, becoming violent towards the staff. His final diagnosis was not mentioned within the case.

Design

A collective case study was utilized in order to better understand commonalities between those with BPD and those with erotomania. According to Yin (2003), a collective case study can be used in order to find both similarities and differences between multiple cases. Furthermore, Yin (2003) states that the aim of the researcher is to replicate the findings across all cases, which would confirm a positive relationship between said cases. This study aimed to use qualitative methods in order to better understand the relationship of BPD and erotomania. Here, BPD and erotomania was studied through a connective approach, looking at qualitative data in order to better analyze the question: are there common events that trigger erotomania among those with BPD?

Procedure

The sample used was based on previous cases that were located and studied for the diagnostic criteria for BPD. A checklist was utilized in order to cross-examine each case with these diagnostic criteria. If "no" was checked, nothing has been mentioned in the case regarding that specific criterion. If "unknown" was checked, an aspect of the specific criterion was mentioned; however, there was not enough information to state, "yes". The sample was selected from existing research in a non-invasive manner. It was assumed that all participants gave their consent when the data was initially collected. All data was be kept on the hard drive of the author.

Data Analysis

The data collected from previous cases was examined in order to identify common themes. These erotomanic case studies where checked against diagnostic criteria for BPD and analyzed in order to better identify any existing relationships between BPD and erotomania.

Results

Checklist – Case One The individual must meet five or more of the following:

The individual uses frantic efforts to avoid real or imagined abandonment:

The individual in this case used frantic efforts to avoid real or imagined abandonment. She became violent toward her family when her love interest did not attend holiday events.

The individual has unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation:

The individual in this case had unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation. This can be seen through her relationships with her mother and sister. She would alternate between being violent and hostile towards them when angered and using their homes to hide when afraid that others were trying to harm her.

The individual has a markedly and persistently unstable self-image or sense of self:

The individual did not have a marked or persistent unstable self-image or sense of self.

The individual is impulsive in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating):

The individual was not impulsive in at least two areas that are potentially self-damaging.

The individual has engaged in recurrent suicidal behavior, uses gestures or threats, and/or engages in self-mutilating behavior:

It is unknown if this individual has engaged in suicidal or self-mutilating behavior. It could be argued that self-harm was present when the individual would lock herself inside for months as this is unhealthy and may cause further emotional instability.

The individual has an affective instability due to marked reactivity of mood:

The individual had an affective insatiability due to marked reactivity of mood. She was easily angered due to her love interest not appearing at holiday events. When this occurred, she would become angry, hostile and violent towards her family.

The individual has experienced chronic feelings of emptiness:

It is unknown if the individual experienced chronic feelings of emptiness. It does appear that she felt that her life meaning came from her love interest. The case states, "he gave her meaning", which may indicate that she felt that her life did not have meaning without him.

The individual has experienced inappropriate, intense anger or difficulty controlling anger:

The individual experienced inappropriate and intense anger that she was unable to control. This can be seen when she became hostile towards her family due to difficulty controlling her anger.

The individual has experienced transient, stress-related paranoid ideation or severe dissociative symptoms:

The individual experienced paranoid ideation that people were trying to harm her. This ideation caused her to hide in her mother's or sister's house for months due to the fear associated with this paranoia.

Checklist – Case Two

The individual must meet five or more of the following:

The individual uses frantic efforts to avoid real or imagined abandonment:

The individual in this case used frantic efforts to avoid real or imagined abandonment. This is indicated through her behaviors of violence towards her mother, as well as getting naked in front of her male neighbor. These actions were based on her fear of rejection from her love interest.

The individual has unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation:

It is unknown if the individual had unstable interpersonal relationships. The relationships between the individual and her parents are not fully stated. However, even if the individual and her parents were regularly on good terms, there may be extremes of idealization and devaluation that can be observed when the individual became angered and threatened her mother.

The individual has a markedly and persistently unstable self-image or sense of self:

The individual did not have a marked or persistent unstable self-image or sense of self.

The individual is impulsive in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating):

The individual was not impulsive in at least two areas that are potentially self-damaging.

The individual has engaged in recurrent suicidal behavior, uses gestures or threats, and/or engages in self-mutilating behavior:

The individual has not engaged in recurrent suicidal behavior, used gestures or threats, and/or engaged self-mutilating behavior.

The individual has an affective instability due to marked reactivity of mood:

The individual had an affective instability due to marked reactivity of mood. She was easily angered and became violent when prohibited from seeking her love interest.

The individual has experienced chronic feelings of emptiness:

The individual has not experienced chronic feeling of emptiness.

The individual has experienced inappropriate, intense anger or difficulty controlling anger:

The individual experienced inappropriate anger and experienced difficulties controlling anger. She became hostile toward her family and threatened to kill her mother.

The individual has experienced transient, stress-related paranoid ideation or severe dissociative symptoms:

The individual has not experienced transient, stress-related paranoid ideation or severe dissociative symptoms.

Checklist – Case Three

The individual must meet five or more of the following:

The individual uses frantic efforts to avoid real or imagined abandonment:

The individual in this case used frantic efforts to avoid real or imagined abandonment. She felt abandoned when her stalker stopped pursuing her. She then began stalking him in an effort to avoid her perceived abandonment.

The individual has unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation:

The individual had unstable interpersonal relations. She initially rejected her stalker and filed a report against him. However, once he stopped stalking her, she became infatuated and wanted all of his attention.

The individual has a markedly and persistently unstable self-image or sense of self:

The individual had a persistently unstable self-image. This can be observed throughout the case, which explicitly states that she "felt abandoned, unattractive, and jealous of other women".

The individual is impulsive in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, and binge eating):

The individual was impulsive in at least two self-damaging acts. First, she had a reckless sex life, in which she slept with multiple men. This included a man in which she was aware had tested positive for HIV. The individual had multiple affairs and was in reckless physical relationships, dating men who physically abused her. The man that she stalked and had a previous relationship with abused drugs. It is unknown if she used drugs with him; however, it is a possibility.

The individual has engaged in recurrent suicidal behavior, uses gestures or threats, and/or engages in self-mutilating behavior:

It is unknown if the individual engaged in recurrent suicidal behavior or self-harm. There is not enough to information to state definitively whether she engaged in recurrent in self-harm. However, knowingly having repeated unsafe sexual relations, including a sexual relationship with a man who she knew was HIV positive, could be potentially life-threatening and may be considered as repeated self-harm.

The individual has an affective instability due to marked reactivity of mood:

The individual has not experienced an affective instability due to marked reactivity of mood.

The individual has experienced chronic feelings of emptiness:

The individual experienced chronic feelings of emptiness. This could be observed in the case, which stated the individual was, "bored, empty, disenlivened and deadened".

The individual has experienced inappropriate, intense anger or difficulty controlling anger:

The individual experienced inappropriate and intense anger. This can be seen when the individual believed her stalker/love interest was stalking other women. Upon this realization she became angered and sought "revenge" by stalking him. Furthermore, her therapist stated, "I understand her chronic anger," when observing her relationship with her mother.

The individual has experienced transient, stress-related paranoid ideation or severe dissociative symptoms:

The individual experienced "dysphoric reckless states," during which she would need the excitement of her reckless sex life to pull herself out.

Checklist – Case Four

The individual must meet five or more of the following:

The individual uses frantic efforts to avoid real or imagined abandonment:

The individual in this case used frantic efforts to avoid real or imagined abandonment. He stalked and harassed a girl that was his friend on social media, leaving her more than 50 voicemail messages.

The individual has unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation:

The individual has not experienced unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation.

The individual has a markedly and persistently unstable self-image or sense of self:

The individual had a markedly and persistently unstable self-image. He had been depressed and spent a lot of time on his computer rather than physically socializing with others. The case states that he was very introverted and preferred socializing through social media rather than in person.

The individual is impulsive in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating):

The individual has not engaged in at least two areas that are potentially self-damaging.

The individual has engaged in recurrent suicidal behavior, uses gestures or threats, and/or engages in self-mutilating behavior:

The individual has not engaged in recurrent suicidal behavior, used gestures or threats, and/or engaged in self-mutilating behavior.

The individual has an affective instability due to marked reactivity of mood:

The individual had an affective instability due to marked reactivity of mood. This was easily triggered when the individual believed that Ms. A was outside of the hospital. He would become violent towards the staff at the facility in hopes of going out to meet her.

The individual has experienced chronic feelings of emptiness:

The individual had experienced chronic feelings of emptiness. The individual had met with a therapist in the past for depression. It was noted that he was "introverted" and "showed no insight".

The individual has experienced inappropriate, intense anger or difficulty controlling anger:

The individual experienced inappropriate and intense anger. This can be observed when he "became agitated and required numerous ER trips for violence towards staff" in hopes of meeting with Ms. A.

The individual has experienced transient, stress-related paranoid ideation or severe dissociative symptoms:

The individual had paranoid ideations that Ms. A was waiting outside for him. When this would occur, he would become agitated and demonstrated "thought blocking".

Discussion

Due to the lack of research regarding the comorbidity between BPD and erotomania, there is poor understanding of the relationship between these two disorders. This study aimed to determine the occurrence rate of BPD among those with erotomania in order to better understand any commonalities that may occur between individuals with both disorders. It was found that there was a moderate occurrence rate of BPD within the erotomanic cases presented in this study. Three of the four cases examined met the diagnostic criteria for BPD. These findings exceed the expectation that there would be a slight occurrence rate of BPD among those with erotomania. Each criterion was represented differently among the four cases and can be broken down as follows.

The Individual uses Frantic Efforts to Avoid Real or Imagined Abandonment

It was determined that the individuals in all four cases used frantic efforts to avoid real or imagined abandonment. The use of frantic efforts among erotomanic individuals in order to avoid real or imagined abandonment may be strongly linked to BPD, as delusions would drive them to seek their love interest further.

The Individual has Unstable and/or Intense Interpersonal Relationships Characterized by Alternating Between Extremes of Idealization and Devaluation

Only two of the four cases had unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation, with one case being unknown. These findings may be attributed to the fact that erotomanic individuals become so infatuated with their love interest that they will not devalue them. Cases one and three may be checked due to the unstable interpersonal relationships between the individuals and those who interfered with their love interest.

The Individual has a Markedly and Persistently Unstable Self-Image or Sense of Self

Both of the individuals in cases three and four had a persistent unstable self-image. The weak link between erotomania and low self-image within this study may be due to the delusional component of erotomania. When erotomanic, an individual believes that their love interest is truly in love with them as well, allowing them to maintain a strong sense of self.

The Individual is Impulsive in at Least Two Areas that are Potentially Self-Damaging

Only one individual out of the four was reckless in at least two areas of potentially damaging activities. In the other three cases, the individuals appeared to only be reckless in their erotomanic delusions, acting in whatever means necessary to acquire their love interest. These findings suggest that those with erotomania are less likely to be reckless in multiple categories than those with only BPD.

The Individual has Engaged in Recurrent Suicidal Behavior, Uses Gestures or Threats, and/or Engages in Self-Mutilating Behavior

No cases met this criterion with certainty; however, with more information, it may be possible that both cases one and three engaged in recurrent suicidal or self-mutilating behavior. The lack of certainty in this criterion suggests that those who present with erotomania are less likely to self-harm than those with BPD. This criterion has the weakest association between erotomania and BPD.

The Individual has an Affective Instability due to Marked Reactivity of Mood

Three of the four individuals had an affective instability due to marked reactivity of mood. The high occurrence rate of this criterion may relate to the impulsivity that occurs among those with erotomania when seeking their love interest.

The Individual has Experienced Chronic Feelings of Emptiness

Two of the four individuals experienced chronic feelings of emptiness with one individual possibly meeting the criterion. It is likely that those with erotomania experience feeling of emptiness when their love interest does not reciprocate their feelings. However, in the cases listed in this study, it was more common that these feelings came from their view of self-worth rather than the rejection of their love interest.

The Individual has Experienced Inappropriate, Intense Anger or Difficulty Controlling Anger

All four individuals experienced inappropriate, intense anger in which they had difficulty controlling. The strong link of anger between erotomania and BPD is not surprising. Those who have delusional love interests and persist in maintaining a false relationship are likely to be angered by the constant rejection. Furthermore, intense anger is common within BPD.

The Individual has Experienced Transient, Stress-Related Paranoid Ideation or Severe Dissociative Symptoms

Three of the four individuals experienced paranoid ideation or dissociative symptoms. These ideations can be observed in many different ways throughout the four cases; however, the fact that erotomania is a delusional disorder may cause those with both disorders to have extreme ideations relating to their delusions.

These findings suggest that there are a number of factors that may relate erotomania and BPD; however, these links need to be further explored. While the results suggest that the two disorders may be comorbid, there is a possibility of incorrect diagnosis. It is possible that those with BPD are diagnosed with erotomania when stalking due to the extreme behaviors that they engage in. These extreme behaviors may present similarly; therefore, a clear pattern of delusions should be present in order for the individual to be diagnosed with erotomania.

Conclusion

There is a moderate occurrence rate of BPD among those with erotomania. This link may be related to several factors, including attachment styles and behavioral temperament.

Attachment has been found to play an integral role among the development of both disorders. Ramos, Canta, de Castro and Leal (2016) discusses attachment styles and BPD, stating that among the present research, three insecure attachment styles have been linked to BPD. These attachment styles include anxious, insecure and preoccupied. Likewise, Roberts (2007) found that those with erotomanic symptoms were more likely to have preoccupied attachment styles. These findings suggest that there may a link between preoccupied attachment, BPD, and erotomania, which would contribute to the need for attention and approval that is associated with both disorders. Due to the nature of attachment and the young age at which it develops, life events that trigger BPD and erotomania may be discovered at a young age.

The behavioral temperament of those with BPD and/or erotomania can be very unstable. The criteria used for diagnosing BPD is rooted in behaviors used to avoid perceived abandonment and poor temperament is one of the most debilitating symptoms within BPD. Likewise, those with erotomania may act upon their delusions in a destructive way as they seek their love interest. As stated previously, it is not uncommon for those with erotomania to have comorbid personality disorders (Meloy, 1989). There may be a link between these two disorders based on the similarities regarding damaging behavior among those with BPD or erotomania. Furthermore, both disorders greatly affect behaviors triggered by relationships. The need for another individual within their lives is one of the root triggers of their unstable behavior patterns.

Recommendations

The findings of this study may be useful to those within the field of psychology. If there is a link between BPD and erotomania, therapists may be able to better treat those with these disorders.

Seeman (2016) discusses the treatment methods used among those with erotomania, stating the importance of a healthy relationship between therapist and client. Healthy relationships allow the client to trust their therapist, and enable the therapist to boost the client's self-esteem before addressing the delusion. Seeman (2016) then suggests the Metacognitive Assesment Scale pared with gradual constructive feedback as well as medications such as antipsychotic, antidepressant and/or antianxiety drugs. Lastly, risk management plays an integral role in the treatment of erotomania, which may also be beneficial those with BPD.

Currently, there are several treatment methods that professionals employ with those who have been diagnosed with BPD including cognitive behavior therapy (CBT), anger management, and transference-focused therapy (TFP). However, many of the treatment methods currently utilized are not reaching those with BPD. This is due to the high costs associated with them; the cost to the client as well as the cost of educating therapists in these methods. Mentalization-based treatment (MBT), a therapy method that is beneficial to those with severe cases of BPD, aims at enhancing the individual's mentalizing capacity; however, this treatment is very expensive for clients (Laurenssen et al., 2016). Leppänen, Hakko, Sintonen and Lindeman (2016) discuss two underused psychotherapeutic treatments that are beneficial for those with BPD. These include dialectal behaviour therapy (DBT) and schema-focused psychotherapy (SFT). DBT has been found to lower rates of self-harm, suicide attempts and the hospitalization of those with BPD, while research suggests that SFT decreases all symptoms of BPD.

By examining the treatment methods of both disorders it can be determined that a combination of one particular therapy and any medication requiered to combat delusions, as well as the building of trust and slow, gradual feedback would be the best method for treating an individual with comorbid erotomania and BPD. Both disorders require treatment based in sensitivity and, at times irrational beliefs, which allow the treatment of both disorders to be completed with synchronicity.

If psychologists are presented with an erotomanic client, it may be advantageous to negate the possible diagnosis of BPD. The way a client is treated may change drastically based on their full diagnoses. Although most treatment methods required for erotomania would also be beneficial to an individual with BPD, additional therapeutic methods may be considered.

Limitations

The limitations of this study include the insufficient history of the individuals within the cases. Without a full history, it was impossible to find common life events that may have caused a person with BPD to become erotomanic. The cases also lacked enough information to fully answer some of diagnostic criteria, which may have affected the diagnoses. Furthermore, the sample size was small, prohibiting further understanding of exact commonalities between the population.

Future Research

There is much research that still needs to be undertaken in order to better understand why there is a moderate occurrence rate of BPD among erotomania. Specifically, more in-depth case studies need to be completed in order to examine previous life events of those with both disorders. Furthermore, more comprehensive studies may be completed in order to determine specific attachment styles associated with comorbidity between BPD and erotomania.

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APPENDICES

APPENDIX A

CHECKLIST

Checklist

The individual must meet five or more of the following criteria:

The individual uses frantic efforts to avoid real or imagined abandonment:

For example: An individual who threatens suicide if being left by significant other or an individual who becomes pregnant in order to keep ones significant other from leaving, even if they had no intentions of doing so.

Yes □ No □ Unknown □

The individual has unstable and/or intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation:

For example: An individual who proclaims their love for another, then accuses them of abuse. "I love you, I hate you".

Yes □ No □ Unknown □

The individual has a markedly and persistently unstable self-image or sense of self:

For example: An individual who is constantly changing major aspects of their lives - such as religion or appearance.

Yes □ No □ Unknown □

The individual is impulsive in at least two areas that are potentially self-damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating):

For example: An individual goes on a shopping spree before going out at the casino and engaging in reckless drinking and promiscuity.

Yes □ No □ Unknown □

The individual has engaged in recurrent suicidal behavior, uses gestures or threats, and/or engages in self-mutilating behavior:

For example: An individual who threatens suicide and/or engages in self-harm such as cutting or binge-eating/purging.

Yes □ No □ Unknown □

The individual has an affective instability due to marked reactivity of mood:

For example: An individual has a rapid change of emotional state, if triggered, may become very angry and anxious very quickly.

Yes □ No □ Unknown □

The individual has experienced chronic feelings of emptiness:

For example: An individual who always feels that they are not worthy, they may feel that they do not have a purpose.

Yes □ No □ Unknown □

The individual has experienced inappropriate, intense anger or difficulty controlling anger:

For example: An individual who lashes out at others for minor occurrences, loses temper very quickly and is unable to control outbursts.

Yes □ No □ Unknown □

The individual has experienced transient, stress-related paranoid ideation or severe dissociative symptoms:

For example: An individual may not remember physically attacking another because they had dissociated during the altercation.

Yes □ No □ Unknown □