

# Frequency of reporting and socio-demographic characteristics of help-seeking clinical-population of delusional jealousy in Sri Lanka

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## ABSTRACT

**Introduction:** Delusional jealousy has received limited attention in the psychiatric literature. Information on prevalence and demographical trends of delusional jealousy are essential in the design of effective control measures are sparse and fragmentary. Present study was aimed to describe case numbers and socio-demographic characteristics of patients with delusional jealousy reported to selected mental health services in Sri Lanka.

**Methods:** A descriptive cross-sectional study was conducted from May to August 2017, in three public hospitals and one private psychiatric clinic. Data were collected using a general information sheet and a structured interview schedule.

**Results:** Fifty (65.78%) out of 76 reported cases during the period were new cases. The mean (SD) age of the patients was 44.15 (11.58) years. Selected sample consisted of 55 patients (male=39, 70.9 %). Thirty-seven (67.2%) were married and lived with their spouses. The majority were Buddhists (N=50, 90.9%) and Sinhalese (N=54, 98.2%). Fifty (90.9%) had children together with the partner. Twenty-three (41.68%) were not Ordinary Level qualified and 36 (66.7%) patients were employed.

**Conclusions:** The majority of patients were married, middle aged males, from lower educational and economic backgrounds. Follow-up consultations were less. Most patients were functional despite the condition. The majority of the patients lived together with their partners and children in the same household which might precipitate a risk of violence towards the partners and subjective exposure of children towards violence.

**Keywords:** *Delusional jealousy, demographic characteristics, help-seeking*

## Introduction

Jealousy sits high atop among the very human emotional experiences. In spite of the unequivocal presence in interpersonal relationships, jealousy is hard to be defined and its origin, nature and rationale are meagrely understood (1). Similarly, the concept of jealousy is both ambiguous and imprecise and therefore, deriving a scientific account out of an

everyday term has been arduous. In the context of romance, jealousy is generally viewed as a multifaceted negative emotional reaction that is activated when a valued relationship or its quality is threatened by a real or imaginary rival. Even amidst of questions and debates surrounding terminology of jealousy, today a majority of

clinicians are in consensus that a jealousy which is maladaptive and dysfunctional in terms of causing distress and disrupting a relationship is morbid and pathological (2).

#### *Diagnosis of pathological jealousy*

Even though, a definition of pathological jealousy based on delusion of infidelity of the partner seems to narrow down the clinical scope of jealousy (3), the mandate for clinical diagnosis remains the same. The present nosological systems, International Classification of Disorders, Tenth Edition (ICD-10) and DSM-V defines clinical jealousy as delusional disorder-jealous type, the predominant delusional theme in delusional disorder (4, 5). In the current communication, the term delusional jealousy is used to refer delusional disorder-jealous type, which entails that an “individual experiences persistent, unrelenting delusions concerning the fidelity of his/her long-term romantic partner without rational or objective evidence that can be explained by a history of schizophrenia, drugs, alcohol abuse or physical illness” (4). Besides its clinical importance, pathological jealousy is also conspicuous for it carries a risk to the patient and others (6). Therefore, clinicians of all specialties and paradigms are required to be conversant in the diagnosis and management of pathological jealousy. Enoch and Trethowan in 1979, stated that morbid jealousy which is one form of many pathological jealousy conditions, as an uncommon disorder. However, there is evidence that clinicians encounter this syndrome routinely (6). Large population-based demographic and health surveys and reproductive health surveys conducted since the mid-1990s by the World Health organization (WHO) and other organizations, have included interview modules on male possessiveness of women and have exposed growing levels of possessiveness in relationships (7). However, pathological jealousy is not exclusive to males but rather common in both sexes (8) and observed in both heterosexual and homosexual relationships (9).

#### *Gender differences in jealousy*

Various strands of evidence coming from previous research suggest that male and female jealousy are fundamentally different in terms of function and

phenomenology. While males are reportedly more concerned about sexual infidelity due to paternal uncertainty, females were more alarmed by emotional infidelity due to loss of potential partner investment (10). A greater number of clinically relevant cases of pathological jealousy have been reported in men, notwithstanding the evolutionary explanations for its origin and maintenance (11).

#### *Sociocultural underpinnings of jealousy*

The concept of jealousy has evolved with the shifting social and cultural milieu over the history. Jealousy was widely observed in monogamous societies where monogamy was both a moral and social imperative. Jealousy for one's spouse or partner is conventionally viewed as a necessary emotion to preserve social bonds. It rendered the function of preserving social esteem in societies. Therefore, both institution of marriage as well as the instinct of jealousy served fundamentally the same purpose (12).

Furthermore, Bhugra (1993) takes the view that motives for jealousy are a product of culture, and thus can vary across cultures. Social structures, economic, political, and legal systems, and patterns of kinship are all involved in jealousy as an end product. Some societies are more prone to jealousy for they treat their partners as possessions and place more importance on the exclusive ownership of a partner. In such cultures, jealousy is considered as part and parcel of a normal sexual relationship. Despite jealousy being an undesirable and unpleasant experience, in such societies, it is yet a valid justification for marital discord. Societies that are inclined to consider partners as possessions also place much importance on the gender-role behaviour. Male partner is assumed dominant over the female partner. Therefore, dominant male has a sense of sexual ownership over the submissive female partner which is by and large tolerated by the former (12). Similarly, these conventional societies generally discourage autonomy of female partners. Therefore, there is a tendency of interpreting any independent activity by a partner as proof of unfaithfulness towards the other. However, there are some other societies, which place less importance on the exclusivity and thus inhabitants of such societies are less vulnerable to jealousy and its negative influences (12).

### *Epidemiology of pathological jealousy in Sri Lanka*

Epidemiological data on any form of pathological jealousy are absent in most countries including Sri Lanka. The available published data on prevalence is coming from a study carried out with psychiatric inpatients in the university psychiatry unit of National Hospital, Sri Lanka by Kapugama *et al.*, in year 2013. The prevalence of morbid jealousy among psychiatric inpatients was only 1.3% (13). Further, a clinical exploration of morbid jealousy by De Silva and De Silva in 1999 explained how Sri Lankan culture may have a role in the morbid jealousy and its epidemiology in the Sri Lankan context (14).

Current study presents frequency and demographic profile of patients with delusional jealousy in help seeking clinical population of Sri Lanka.

### **Methods**

A multi-centre, descriptive cross-sectional study was conducted for duration of three months from May 2017 to August 2017 at National Institute of Mental Health (NIMH), University Psychiatry Unit of National Hospital Sri Lanka (NHSL), University Psychiatry Unit of Teaching Hospital Karapitiya (THK), and private psychiatric clinic at Norris Clinic in Sri Lanka. Ethical clearance for the study was granted by Ethics Review Committees of Faculty of Medicine, University of Ruhuna, National Hospital and National Institute of Mental Health. All the patients who presented to any of the study settings from May 2017 to August 2017 with a complaint related to infidelity of his or her partner that makes the patient to hold a strong false belief (delusion) that his or her partner is unfaithful, causes distress in one or both partners, causes a disruption of the relationship and consented to take part in the study were recruited as study participants. Patients with a past history of schizophrenia, a limiting language impairment for communication, acutely ill (with delusions, thought disorders where they cannot rationally communicate and medically ill), violent and/or disturbed and patients who cannot declare consent were excluded from the study.

Age, partner's age, age difference between patient and the partner, gender, relationship status, religion, ethnicity, number of children, employment status and income of patient and the partner and

educational level of patient and the partner were recorded. Data were obtained from a self-administered pre-tested general information sheet and a structured interview conducted by the primary investigator.

### **Results**

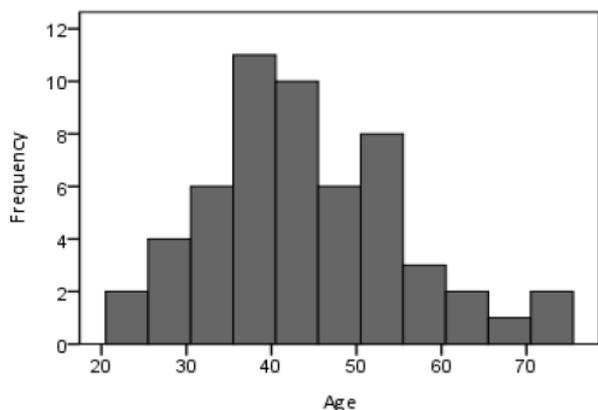
#### *1) Frequency of cases reported*

Altogether, seventy six patients with delusional jealousy reported to the four study settings over the three months period. A total of 22 patients reported to NIMH (11 in-patients and 11 out-patients). Ten (90.9%) out of 11 in-patients and 05 (45.4%) out of 11 out-patients reported to NIMH were new cases of delusional jealousy. A total of 32 patients reported to NHSL (12 in-patients and 20 out-patients). Ten (50%) out of 20 out-patients at NHSL were referred by the courts. All 12 (100%) in-patients, 12 (60%) out of 20 out-patients were new cases of delusional jealousy. Seven (70%) out of 10 patients referred by courts were new cases of delusional jealousy. A total of 14 patients reported to THK (08 in-patients and 06 out-patients). Five (62.5%) out of 08 in-patients, 02 (33%) out of 06 out-patients were new cases of delusional jealousy. Eight outpatients were reported to Norris clinic. Seven (87.5%) out of 08 outpatients reported Norris clinic were new cases of delusional jealousy. Fifty five out of 76 patients reported during the study period participated in the study.

#### *1) Sociodemographic characteristics*

##### *A. Age and sex distribution of patients and partners*

Age of the patients ranged from 24 to 73 years. (Figure 01). Mean (SD) age of the patients was 44.15 (11.58) years. Sample consisted of 39 (70.9 %) male and 16 (29.10 %) female patients. When male patients were considered, the age ranged from 24 to 73 years with a mean age (SD) of 44.9(11.67) years. Age of female patients ranged from 23 to 63 with a mean age (SD) of 43.31(11.68) years. When the age of the partners was considered, the age ranged from 21 to 75 years with a mean age (SD) of 42.94 (12.82) years. Age difference between the patients and the partners ranged from 0 to 38 years with a mean (SD) age difference of 4.63(5.77).



**Figure 1:** Age distribution of the patients

*B. Relationship status*

Thirty seven (67.2%) of the sample were married and living with their spouses, 15 (27.2%) were married but lived separately, 2(3.6%) were unmarried, in an intimate relationship and lived separately, 1 (1.8%) experienced jealousy in relation to the extramarital lover (Figure 02).



**Figure 2:** Relationship status of the patients

*C. Demographic Characteristics*

Among them 50 (90.9%) patients were Buddhists, 4 (7.3%) were Christians, and 1 (1.8%) was a follower of Hinduism. When the ethnicity of the sample is considered, 54 (98.2%) and 1 (1.8%) belonged to Sinhalese and Tamil ethnicities respectively.

*D. Children*

Fifty (90.9%) patients had children together with the partner. Mean (SD) number of children was 2.32 (0.913).

*E. Educational status of the patients and the partners*

In the sample, 4 (7.40%) patients had received formal higher education, 9 (16.66%) were Advanced Level qualified, 18 (33.33%) were Ordinary Level qualified, 23 (42.59%) did not complete Ordinary Level and 2 (3.70%) had not studied beyond grade 5 (Table 01). Among the partners, 5 (9.61%) of partners of delusional jealousy patients had received formal higher education, 7 (13.46%) were Advanced Level qualified, 14 (26.92%) were Ordinary Level qualified, 26 (50.00%) were not Ordinary Level qualified and 3 (5.76%) had not attended school beyond grade 5.

*F. Employment status and income of the patients and the partners*

When the employment status was considered, 36 (66.7%) patients were employed (Figure 03). Among the partners, 33 (61.1%) partners of patients were employed. However, 10(55.6%) of unemployed patients and 7 (38.9%) of unemployed partners had another source of income. Monthly income of the patients ranged from SL Rs. 1,250.00 to Rs. 690,000.00 with a mean (SD) of 36,172.41 (14,035.84). Monthly income of the partners ranged from SL Rs. 2,500 to SL Rs. 460,000 with a mean (SD) of 27,210.53 (15,586.95).

**Discussion**

The current study reported the frequency and sociodemographic characteristics of patients with delusional jealousy from a descriptive cross-sectional study that was carried out with fifty-five delusional jealousy patients from National Institute of Mental Health, University Psychiatry Units of National Hospital of Sri Lanka and Teaching Hospital Karapitiya and a private psychiatric clinic in Colombo, Sri Lanka.

Majority of the patients reported to the four mental health settings were new cases of delusional jealousy. Lesser number of followed up patients was reported in the outpatient clinics.

**Table 1:** Educational profile of the patients

Level of Education	Frequency			
		Patients (%)	Partners (%)	
Postgraduate degree	1	1.9	1	1.3%
Basic degree	3	5.6	4	5.3%
Passed A/L	9	16.7	7	9.2%
Passed O/L, attended school till grade 12/13 haven't got through A/L	5	9.3	4	5.3%
Passed O/L	13	24.1	10	13.2%
Attended school till grade 11 but haven't got through O/L	8	14.8	9	11.8%
Attended school up to grade 8-10	6	11.1	12	15.8%
Attended school up to grade 5-7	7	13.0	2	2.6%
Attended school below grade 5	1	1.9	1	1.3%
Did not attend school	1	1.9	2	2.6%

Delusional jealousy was more common in males and people with low educational and economic backgrounds. It was observed in patients in early twenties through seventies; however, more frequent in the thirties to fifties age group. Majority of patients with delusional jealousy were employed or had another source of income. Ethnicity and the religion of the sample reflected the ethnicity and the religion of the population, so that no correlation between ethnicity and religion with delusional jealousy was observed. Majority of the patients were living together with their partners and children in the same house.

Majority of patients were first visit patients. Follow-up consultations were less. It is possible that they are less eager for subsequent visits. Research suggests that continuous care for psychiatric disorders can result in improved treatment outcomes, such as a decreased probability of re-hospitalisation (15-19). In psychiatric patients, continuation and maintenance-phase treatment can reduce relapse and improve medication adherence and outcomes (20). Psychiatric patients who missed outpatient appointments and thus the continuing follow-up were more likely to exhibit poor health and social dysfunction than ones who were regular at outpatient appointments. In addition, former had a greater likelihood of clinic dropout and led to subsequent admissions (21).

Even though, current study does not seek to draw conclusions about the public with regards to the demographic variables of pathological jealousy, it permits such conclusions to be drawn about the help-seeking clinical population of delusional jealousy patients in Sri Lanka. A definite majority of the study participants were males. This finding is different from a comparable study conducted in 1999 as a clinical exploration of morbid jealousy in Sri Lanka which reported morbid jealousy in almost equal numbers in males and females (14). The said study was conducted with patients who reported to a private psychiatric clinic whereas current study focused on three main public psychiatric facilities in the country and one private psychiatric clinic. Only a minority of patients came from the private clinic in our study and thus current study can be more representative of the lower and middle socioeconomic strata. There could have been more admissions and outpatient visits of male patients in public sector for the fact that, jealousy of men was more severe in nature than that of females as men were more likely to attack their partners and often the injuries they inflicted were more serious in nature (22). Therefore, there is a propensity that more males than females sought help or were directed towards treatments by their families.

Most of the reported cases were Sinhalese Buddhists. Therefore, results cannot be interpreted in terms of ethnicity and religion. Similar results were drawn in a previous Sri Lankan study (14). Another study had reported that there was no correlation between ethnicity and pathological jealousy (23). De Silva & De Silva (14) have tried to understand the findings along the lines of proportions of ethnic and religious groups residing around Colombo. However, in the current study, the ethnic and religious proportions in the community were not reflected in the patient proportions. Therefore, it is worth studying in the future as to there exist intercultural discrepancies in the incidence of delusional jealousy and/or help-seeking behaviours.

Over sixty percent of the patients were living together with their partners in the same house which might precipitate a risk of violence towards the partners. A plethora of research support violence associated with pathological jealousy (22). It also carries a risk for homicides (24). Partners as well as over ninety percent, a significant number of children, may well be affected from subjective ambiance associated with delusional jealousy. Previous research highlights how such chaotic household due to ongoing jealous issues of a parent can lead to distress in children (6).

Delusional jealousy was observed across all social strata as measured by the economic level, similar to the study conducted by De Silva & De Silva (14); however, problem was not equally dispersed. It was more concentrated in lower economic levels. Previous studies have reported no significant relationship with jealousy and socioeconomic status (25). Majority of the patients were employed which is indicative of the functionality of the patients, despite of the condition. Thus, this may well be one reason as to why problem is under-recognized and under-reported for “functionality” can be misinterpreted by the public as “normality”.

Similarly, delusional jealousy was also seen in patients with all educational backgrounds. De Silva & De Silva (14) reported the same. However, problem was more intense in people with lower educational backgrounds.

The higher frequency of patients with lower income and education backgrounds may be attributable to the origin of the sample. Of all the patients 85.5% were reported from public institutions providing

mental health services. Therefore, data can be more indicative of lower economic classes. Lower economic and educational backgrounds were analogous.

Findings of the study has important implications in practice, as it can assist clinicians in better apprehending clinical jealousy in the context of a developing country in South Asia, thus making better decisions regarding medical and psychological management and advance care planning of delusional jealousy.

Future research may concentrate on a more in-depth examination of the socio-demographic risk factors of delusional and other forms of abnormal jealousy. A qualitative study may investigate the causes of follow-up failure.

### **Limitations of the study**

This study may not provide a comprehensive overview of pathological jealousy in Sri Lanka. First, delusional jealousy is only a subset of the larger pathological jealousy patient population (26). Second, cases of delusional jealousy reported to tertiary care mental health facilities may not reflect the socio-demographics of low intensity jealousy prevalent in the general population. The study sample was derived from mental health services, therefore their severity was sufficient for referral. Due to the secretive and stigmatizing nature of the symptom of delusional jealousy, it is possible that the frequency of delusional jealousy in our study is lower than the actual frequency. For a comprehensive understanding of pathological jealousy, its prevalence, nature, and phenomenology in the Sri Lankan context, a community survey similar to the one done by Mullen and Martin in 1994 (27) is required.

### **Conclusions**

Our study findings suggest that follow up consultations among patients with delusional jealousy were less. In the current sample, delusional jealousy was particularly more prevalent in males in their 30 s to 50 s, low economic status, and low level of education. Majority of the patients were married and continued to live with their partners and children in the same household. Most patients were employed and functional despite the condition.

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