International Journal Dental and Medical Sciences Research
Volume 6, Issue 6, Nov - Dec 2024 pp 433-435 www.ijdmsrjournal.com ISSN: 2582-6018

The curious case of obsessional jealousy

Jhilmil Dua, Sucheta Saha, Zeba Khan, Anand Singh
[1,4], Junior resident doctor, All India Institute of Medical Sciences, Rishikesh
[2,3] Senior resident doctor, All India Institute of Medical Sciences, Rishikesh

Submitted: 15-12-2024 Accepted: 25-12-2024

ABSTRACT: Pathological jealousy exists on a spectrum, with obsessional jealousy representing a distinct phenomenon characterized by intrusive, irrational doubts about a partner's fidelity. This case report describes a middle-aged male with repetitive, distressing thoughts of spousal infidelity, preserved insight, and absence of compulsive behaviours. A diagnosis of obsessive-compulsive disorder (OCD) with predominant obsessions was made, highlighting the neurotic nature of the condition. Treatment with sertraline led to significant improvement in symptoms and functioning. This case emphasizes the importance of recognizing obsessional jealousy as a form of OCD to ensure appropriate diagnosis and management, avoiding misclassification as delusional jealousy.

KEYWORDS: Obsessions, jealousy, OCD

I. INTRODUCTION

Jealousy is a heterogeneous condition ranging from normality to pathology, varying indegrees of intensity and persistence, and involving different degrees of insight (1).Although some authors disagree and consider jealousy a "blended" or secondary feeling, (2-4) most believe that akin to anxiety or fear, it is an emotion designed to ensure the survival of the species (5)Pathological jealousy manifests across a spectrum, characterized by/ from excessive possessiveness to taking a delusional form (aka, Othello syndrome). A mid-spectrum entity characterized by repetitive thoughts and preoccupation with doubts about the fidelity of the partner has been described under various heads like "obsessional jealousy" (6), and "jealous monomania" (7). Obsessive jealousy, despite staying within the bounds of neurosis, can present as a diagnostic challenge owing to its atypical presentation. The extreme preoccupation with the thoughts of infidelity and resulting dysfunction could blur the boundaries of insight. We describe a unique case of pathological jealousy elucidating its obsessional nature, a relatively obscure entity.

II. CASE SUMMARY

A 48 year old married male, Mr. X hailing from the state of Uttar Pradesh, studied till MA, shopkeeper by occupation belonging to a Hindu family of MSES presented toour OPD alone. His chief complaints were irritability, decline in work functioning, and poor sleep subsequent to suspiciousness about his wife being infidel to him.

These complaints have been present continuously for the last 1.5 years with deteriorating progression.

1 and half years ago he underwent financial losses in his business which got him concerned about his family's future. He had difficulty initiating sleep, with a delay of1-2 hours due to worries about finances. Over the course of the next month, he started feeling that his wife's interaction with him had somewhat reduced, although he had no evidence to back his thoughts. In the next one and a half months he gradually started having doubts that his wife might be cheating on him. The suspicions continued to increase in frequency but he never confronted his wife regarding this or corroborated with anyone else to confirm. He was distressed about such thoughts as he believed that his wife would never do such a thing. He tried to resist them as well but would not be successful and subsequently felt guilty. He would often have ruminations about how his wife might be talking to other males or was being intimate with others. He was jealous of such men although he could not pinpoint anybody with whom she might be involved. He found himself doubting his wife's intentions every now and then, even if she would be going around with her daily chores. Such thoughts were triggered every time he saw/heard the wife discussing or talking or just minding herself. He then started going home late in the evening, spending most of his day at his shop and with friends to avoid seeing his wife. The thoughts of suspiciousness would bother him even while working or talking to friends. He would be able to distract himself to some extent while at work but in the presence of his wife, he would not be able to resist such doubts. The patient's mood became gradually irritable, and he started

experiencing greater difficulties in initiation of sleep. Around the same time, he started experiencing a feeling of heaviness in his abdomen for 4-5 days, with no precipitating or relieving factors and no change in his bowel habits or appetite. He went to a general physician with these complaints where he was examined, and laboratory investigations were found to be within normal limits He believed in the lab results and the words of his physician but couldn't stop his doubts about having some abdominal pathology. There were no preoccupations with having a major illness, no looking up symptoms in books or the internet, and no instances of multiple investigations being done for the illness or going to multiple doctors, as the patient maintains he "knew" there was no real abdominal illness. The thoughts about his wife's infidelity continued with further deterioration of interaction with his wife ultimately becoming emotionally distant. His interactions with friends and family members including his children reduced as well. He would hardly get 3- 4 hours of sleep, resulting in daytime fatigue and an inability to focus on work.

A past history suggestive of similar thoughts of suspiciousness towards his wife was around four years back and was started on the tablet Sertraline by a private psychiatrist. He had improved but discontinued medications after 2 months because of perceived improvement. As these symptoms were dormant, he did not pay heed to them till their recurrence a year ago. On a detailed mental status examination, he was found to have anxious affect and repetitive ideas of his wife transgressing the boundaries of their marriage by getting involved with other people. He recognized these thoughts to be irrational, repetitive, and intrusive. Distress was reported regarding these thoughts. We made an impression of obsessive jealousy (clubbing thoughts, doubts, and ruminations about infidelity). There were no repetitive images or perceptual disturbances.

As the patient had preserved insight regarding the irrationality of his thoughts as well as an active effort to resist the same, the possibility of delusional jealousy was ruled out. CT scan brain revealed no organic lesions and other blood investigations were within normal limits. A diagnosis of OCD with predominant obsessions (according toICD 10) was made. Y-BOCS was applied, and the score was found to be 20. He was started on Tab Sertraline 50 mg up titrated to 100mg/ day with clonazepam 0.5mg at nighttime for 2 weeks. He was asked to visit with a reliable informant, but he wanted to keep the details of the consultation confidential and was unwilling to involve his wife in the same. On follow up his sleep had improved, and apprehension had come down to some extent. On subsequent follow-ups a total dosage of 150mg of sertraline per day was reached, clonazepam discontinued, and he was found to be improving. Over a period of 3 months, YBOCS score came down to 4.

III. DISCUSSION

Pathological jealousy, whether or not reaching a delusional level, leading to intimate partner violence is a commonly encountered phenomenology. The spouse or family members generally bring the patient to the clinician as patients hardly recognize the same as a problem behaviour. The case that we have described remains unique in that the irrationality experienced was complained about by the patient himself, and not the spouse. The preserved 'insight' is what forms a bold line of distinction between neurotic and psychotic phenomena. A distinctive feature noted in this client is the striking absence of any compulsive acts in the form of repetitive checking behaviours or restricting the freedom and violating the autonomy of the partner as a response to the obsessive thoughts that have been reported in almost all previously documented cases (8-10). Additionally, various etiological factors like organic disturbance (11), primary psychotic disorders, personality types (paranoid, asthenic, and sociopathic), affectivedisorders, and alcoholism, have been described to be associated with pathological jealousy (9,12). Our patient had no organicity nor had any history of alcoholism, strengthening our diagnosis of a primary psychiatric disorder rather than secondary or an induced one. Other factors to be considered are personality disorders, and even though the patient remained our sole informant for the entire follow-up duration, no features suggestive of a paranoid personality were apparent. A study conducted in Italy (2010) concluded that women and single individuals had a lower level of self-esteem and were more prone to obsessive jealousy (10). Contrasting to this our client was a middle-aged married male, which adds to the uniqueness of the case. Obsessive-compulsive disorder is often described as exhibiting a certain avoidance, which has also been reported in a previously described case of morbid obsessional jealousy. Our case paralleled this finding wherein the patient would avoid talking to or seeing his wife, in order to prevent his obsessions from getting exacerbated. As obsessions and compulsions respond to SSRIs (13), our patient was treated with SSRI (sertraline) and the patient responded to the same resulting in a

lesser degree of such irrational thoughts.

IV. CONCLUSION

The phenomenology of pathological jealousy is in itself interesting, but to have anobsessional quality in the same makes such a case fascinating. Non-recognition ofsuch disorders would lead to incorrect management plans, like starting the patient on an antipsychotic agent and increase the risk burden. Such misdiagnosis would lead topoor response to treatment and in turn expose the client to unwanted adverse effectsof antipsychotics, a decline in quality of life, disruption of meaningful relationships,and inability to maintain baseline functionality. Therefore, the recognition of a pathological entity presenting with non-delusional jealousy is of prime importance forour clinical practice and the well-being of our clients.

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