CASE REPORT

Morbid jealousy reactivated by mood episodes

Ruziana Masiran,¹ Nik Shaliza Hussin⁴

¹Department of Psychiatry,
Universiti Putra Malaysia,
Serdang, Selangor, Malaysia
⁴Department of Psychiatry,
Universiti Putra Malaysia,
Serdang, Selangor, Malaysia

Correspondence to
Dr Ruziana Masiran,
ruziana78m@yahoo.com

Accepted 3 January 2018

SUMMARY

A middle-aged man who has been enduring financial constraint experienced a period of irritability, increased goal-directed activities and insomnia occurring along with extreme jealousy with his current wife. The episode was followed by depressed mood and non-prominent auditory hallucination. His previous history revealed a forensic psychiatry case of a murder he committed 20 years ago.

BACKGROUND

Morbid jealousy is a rare and often underestimated condition despite its potential homicidal and suicidal risk. With proper psychiatric treatment, affected individuals may improve and ultimately be symptom free. However, certain life stressors may 'reactivate' this condition and symptoms of a mood disorder may co-occur with the underlying jealousy. Here, this rare condition, currently manifesting as a bipolar disorder, is presented.

CASE PRESENTATION

A 57-year-old man who has been on psychiatric follow-up for 20 years met with a motorbike accident 2 years ago. In this accident, he fractured his right ankle which did not heal well and subsequently he took long medical leave. He did not suffer head injury.

Just 5 months prior to his recent psychiatric ward admission, his wife noticed that he became easily irritable and increasingly jealous with her. According to him, he was concerned that his wife might be having an extramarital affair with their neighbour because the male neighbour liked to chitchat with her. Whenever the neighbour starts to talk to her, he felt angry and believed that it was an attempt by the neighbour to flirt with his wife. So he started to restrict her movement and would call her employer up to check whether she was really at work. As a result, his wife began to doubt her safety and even reported to his treating psychiatrist. Around this time, he expressed his concern that his colleagues were jealous with him because he believed that he was much a nicer person compared with them. He was sure that they want to repossess his power and wealth. As he had not been working following the accident, he also began wishing to be medically boarded off his job in order to obtain MYR1 million which he intended to squander it all on his travelling plan. When an adjustment on his treatment regime was suggested to him, he threatened to sue the hospital for the same amount if the doctor changed his medications. He insisted

that only highly credible specialists had the right to meddle with his treatment. At home, his wife noticed that he was becoming more active and energetic; painting the corridor wall of his flat and decorated a public gazebo there. However, he attributed this as his hobby and due to the fact that he felt bored as he was out of work at that time. There were times when he visited his colleagues, his office and he seemed to be more talkative than before. Throughout this time, he could sleep well but sometimes missed his medications. These changes lasted for about a month before he finally turned up for his treatment follow-up and was recommended for admission but he refused. He turned up to see his usual psychiatrist much later and seemed to be more rational. At that time, his wife reported that he was more stable and was taking medications regularly. Therefore, the same treatment regime was continued and he was scheduled for regular monthly follow-ups.

He finally recovered from his fracture and returned to work, but unfortunately refractured his right ankle and underwent surgery again to fix an external fixator over his right leg. This time, he only had a slim chance to return to work and had choose for an early retirement. His condition turned from bad to worse for 1 month prior to admission when he received a letter of instruction to pay his employer up as he had used medical leave more than allowed. He then began feeling depressed, could not sleep well and lost appetite. His wife noticed that he looked preoccupied in his thoughts a lot of time and disinterested in his hobbies. He felt weak, hopeless and thought that death was probably better for him. There were brief episodes of auditory hallucinations where he described as a 'similar voice as in the past', now telling him to die. Fearing that he might harm himself or others, he requested for a ward admission. Other than the above-mentioned symptoms, he denied having any ideas of infidelity, and did not have persecutory or grandiose delusion.

A check on his previous history revealed that his first psychiatric contact was 20 years ago when he was brought in for a psychiatric assessment after he murdered his first wife. At that point, he was found to have harboured delusion of infidelity towards the deceased just a few months prior to the incident. There were circumstances where the deceased's actions meant to him that she committed adultery with his work supervisor. As a result, he frequently had quarrels with her. His other family members had never suspected anything as he was mingling well with them, but his colleagues reported that he was frequently irritable at work. In terms of

CrossMark

To cite: Masiran R, Hussin NS. *BMJ Case Rep* Published Online First: [please include Day Month Year]. doi:10.1136/bcr-2017-223430

occupational function, he was able to perform his work including more overtime jobs that he sought. Later, he also experienced auditory hallucination mentioning that his wife really had the extramarital affair and consequently he received commanding hallucination instructing him to murder his wife. He was conscious when he committed the murder but tried to end his life afterwards by slitting his throat with a kitchen knife, but fortunately survived the incident despite sustaining deep laceration wound across his neck. Subsequent to his psychiatric assessment, he received insanity defence and was incarcerated, while continuing his treatment with a visiting psychiatrist for many years. After serving 7 years in the prison, he was granted pardon by the Royal Ruler and was released into the community with the continuous monitoring and treatment by his psychiatrist. He has only been given chlorpromazine 200 mg and benzhexol 2 mg every night. A record mentioned that he had refused an alteration in his treatment regime. However, he successively managed to rebuild his life, work, remarried and had children.

He has hypertension for the past 5 years. None of his family members has mental illness. He was never addicted to alcohol or drugs. Since his incarceration 20 years ago, he never met his four children from the first marriage. His current wife is a working woman and knew about his psychiatric illness and forensic history. He currently lives with his wife and has three children from current marriage. He was still on medical leave during his ward admission and would be retired soon.

His mental state examination on the day of admission showed a mildly anxious middle-aged man with good eye contact. He spoke relevantly in a low tone. He was depressed and felt hopeless but denied any suicidal or homicidal thought. There was neither perceptual disturbances nor thought disorder. On physical examination, there were two old linear scars across his neck. There was an external fixator over his right lower limb and clean wounds around right ankle. His vital signs were stable.

INVESTIGATIONS

Full blood counts, thyroid, liver and renal function tests were normal. His urine toxicology showed no evidence of use of illicit substances. There were neither brain imaging nor electroencephalographic test carried out for him. He was referred to the clinical psychologist for Personality Assessment Inventory but it was scheduled to be done as outpatient much later.

DIFFERENTIAL DIAGNOSIS

In this patient, the most recent presentation exhibited significant symptoms suggestive of major depressive disorder, with a previous brief episode suggestive of mania. For the recent episode, he felt depressed and hopeless, and had insomnia, anhedonia, loss of appetite and lack of energy. Prior to that, there was a short period of irritability, inflated self-esteem, increased goal-directed activities, increased energy and talkativeness which co-occurred with persecutory and grandiose delusion. It was during this time that he was increasingly jealous with his wife but he denied delusion of infidelity. Based on these two mood episodes, it is very likely that he has bipolar I disorder, most recent episode of depression and psychotic feature.

The diagnosis of delusional disorder—jealous type, multiple episodes—currently in full remission was also looked into. His previous history showed a strong feature of delusion of infidelity towards his wife, which is considered ‘non-bizarre’ as it is among the situations which could actually occur in real life. Even so, the requirement of non-bizarreness of the belief is no longer a requirement in the Diagnostic and Statistical Manual of Mental

Disorders, Fifth Edition (DSM-5), compared with the previous versions. He also had auditory hallucination but it was not prominent and is related to the theme of delusion of infidelity. However, retrospectively, he also reported having irritable mood at that time and was holding more ‘overtime jobs’. Based on these additional information, perhaps there was a phase where he had either a hypomanic or manic episode around the time when he developed the first delusion 20 years ago. Subsequently, he seemed to have undergone remission, only to start having jealousy 5 months prior to his recent ward admission. Having said these, in the most recent episode, there were manic symptoms which fulfilled the criteria for a manic episode according to DSM-5. As a matter of fact, individuals with delusional disorder commonly have mood symptoms occurring secondary to their delusional experiences. In spite of this, mood symptoms in mood disorders are more prominent and meet criteria for a full depressive, manic or mixed episode compared with mood symptoms of delusional disorder which are mild.

Alternatively, schizoaffective disorder is also possible, but longitudinally he did not show a major duration of mood symptoms and he never fulfilled criterion A of schizophrenia. Schizophrenia is another consideration but the delusion was rather ‘well-circumscribed’ and hallucination was non-prominent, making this diagnosis questionable. Additionally, there was no documented evidence of disorganised thought, speech or behaviour. Common findings in schizophrenia like cognitive deficits, negative symptoms and deterioration in function were also non-existent.

TREATMENT

He was started on olanzapine 5 mg and sodium valproate 400 mg two times per day. Due to the risk of treatment non-compliance, fluphenazine decanoate depot was initiated. An atypical depot was actually considered but it was not readily available in the hospital at that time and the patient could not afford it by himself.

OUTCOME AND FOLLOW-UP

He was followed up by his psychiatrist every 1–3 months and every visit was accompanied by his wife. Following his discharge from the ward, his wife reported that he was much calmer and the depressive symptoms resolved. However, he developed somnolence and his olanzapine was changed to 10 mg every night. There were no extrapyramidal side effects. He and his wife were generally happy with his improvement and she helped to supervise his intake of oral treatment.

DISCUSSION

Jealousy is a normal emotional state and a common human response. The patient described in this case report had had a strong sense of jealousy towards his late wife where he had attributed that to his late wife being a housewife and therefore easily lured by men. Although jealousy is a very common emotion, it could turn pathological when it was entirely baseless. From this aspect, jealousy can run along a spectrum where there is an essentially normal jealousy emerging from one’s sense of insecurity to a morbid jealousy, where there are full-fledged psychotic symptoms. This is when the patient had strong false beliefs that his partner was unfaithful, further strengthened by some circumstances which he interpreted as the evidence. These were associated with non-prominent and brief episode of auditory hallucination telling him that the belief was indeed true and hence commanding him to end her life. Although an individual

may present with morbid jealousy, the underlying psychiatric problems may show major illnesses like bipolar mania in up to 15% and schizophrenia 20%, among other diagnoses like depression and alcohol-related disorders.¹

Morbid jealousy may not only be delusional, but also obsessional in nature.² Delusional jealousy is also called Othello syndrome, although the term might not be accurate and so the synonym 'delusional or morbid jealousy' is more commonly used in the literature. Affected individuals would actively search for evidence and as a result, the partner's freedom is limited and their relationship is subsequently impaired.³ There are also other associated features like marital disharmony, verbal or physical violence, and attempted suicide and homicide.⁴ Other than the common psychiatric diagnoses mentioned, this syndrome may also co-occur with personality disorders, substance use disorder and dementia.⁵ In our case, it presented in the most recent episode, as a depressed phase within the context of bipolar I disorder. Similar to the patient's past presentation, suicidal thoughts and attempt are not uncommon in morbid jealousy. When jealousy gives rise to fatal violence against the partner, this may be followed by suicide—an exact scenario taking place in our patient 20 years ago. However, females either as patients of morbid jealousy or as partners of a morbidly jealous spouse

carried the higher risk of suicide compared with males.⁶ Although existing demographic data for this syndrome are sparse, men are largely represented among the persons who murdered due to jealousy, a fact which may be associated with higher occurrence of morbid jealousy in men.⁶

Assessment of morbid jealousy should be approached tactfully. With poor insight, individuals with this condition may believe that it is the partner's alleged infidelity that created the problems rather than tackle their own jealousy. Thorough history incorporating aspects of marriage and intimate relationship,⁷ along with mental state examination, helps in establishing the primary psychiatric illness. In this case, although there was a significant component of jealousy in his presentation, it was coupled with a full-blown episodes of mania followed by depression. With a proper treatment regime which included antipsychotics and a mood stabiliser, psychosocial approaches like couple therapy and psychodynamic psychotherapy may benefit this patient further.

Contributors RM managed the patient during his hospitalisation, while NSH manages the patient throughout his out-patient follow-ups.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

© BMJ Publishing Group Ltd (unless otherwise stated in the text of the article) 2018. All rights reserved. No commercial use is permitted unless otherwise expressly granted.

Learning points

- ▶ Life events may reactivate morbid jealousy and the affected individual may concurrently experience mood symptoms. In this case, former may dominate the picture, hence masking the primary issue in the latter.
- ▶ Early identification and treatment of morbid jealousy as well as the underlying primary psychiatric illness are most important to prevent serious consequences, especially in an individual with a significant prior forensic psychiatric record.
- ▶ Interviews on individuals presenting with jealousy must include assessment of marital relationship, sexual history and history of domestic violence.

REFERENCES

- 1 Kapugama C, Suraweera C, Kotalawala W, *et al.* Prevalence of morbid jealousy among inpatients in a psychiatry unit in Sri Lanka. *Sri Lanka J Psych* 2013;4:38–40.
- 2 Perestrelo JMF, Mota D, Teixeira B. Obsessive jealousy: a case report. *PsiLogos* 2016;14:84–8.
- 3 Marazziti D, Di Nasso E, Masala I, *et al.* Normal and obsessional jealousy: a study of a population of young adults. *Eur Psychiatry* 2003;18:106–11.
- 4 Famuyiwa OO, Ekpo M. The Othello syndrome. *J Natl Med Assoc* 1983;75:207–9.
- 5 Cipriani G, Vedovello M, Nuti A, *et al.* Dangerous passion: Othello syndrome and dementia. *Psychiatry Clin Neurosci* 2012;66:467–73.
- 6 Singh SK, Bhandari SS, Singh PK. Phenomenology and predisposing factors of morbid jealousy in a psychiatric outdoor: A cross-sectional, descriptive study. *Open J Psych & Alli Sci* 2017;8:129.
- 7 Kingham M, Gordon H. Aspects of morbid jealousy. *Advan in Psych Treat* 2004;10:207–15.

Copyright 2017 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit <http://group.bmj.com/group/rights-licensing/permissions>.
BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Become a Fellow of BMJ Case Reports today and you can:

- ▶ Submit as many cases as you like
- ▶ Enjoy fast sympathetic peer review and rapid publication of accepted articles
- ▶ Access all the published articles
- ▶ Re-use any of the published material for personal use and teaching without further permission

For information on Institutional Fellowships contact consortiasales@bmjgroup.com

Visit casereports.bmj.com for more articles like this and to become a Fellow