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CASE STUDY

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Othello syndrome in extramarital involvement and dilemma of psychiatrist

Abstract

We are reporting two cases of Othello syndrome in the context of extramarital involvement. The symptom improved after treatment with risperidone. Reports exist in literature about extramarital involvement and its management however, there is no report of Othello syndrome in the context with extramarital involvement. This report highlights the need to explore infidelity issues while dealing with extramarital involvement.

Keywords: Symptom. Risperidone. Management. Infidelity.

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INTRODUCTION

Extramarital involvement (EMI) has been defined as "a sexual and/or emotional act engaged in by one person within a committed relationship, where such an act occurs outside of the primary relationship and constitutes a breach of trust and/or violation of agreed upon norms (overt and covert) by one or both individuals in that relationship, in relation to romantic/emotional or sexual exclusivity".[1] While various international studies have reported different prevalence rates, in India, Kamasutra Annual Sex Survey of 2004, cited by Agrawal and Shah[2] found that 13% people reporting extramarital sex, of which 68% have one and 32% have more than one partner. Males' EMI has been linked with the strained marital relationship, and marital and sexual dissatisfaction within marriage.[3] Married men who report marital sexual dissatisfaction refer to their need for sexual excitement, sexual curiosity, novelty, or variety, and sexual enjoyment as justifications for extramarital sex and as a sense of hyper-masculinity together with natural need for frequent sexual satisfaction.[4] In India, women fear domestic violence and this is the major barrier which they face from exerting control over their spouse's sexual activity outside the marriage.[5,6] Extramarital affairs in males significantly predicted that their wives may be abused both physically and sexually. This often leads to marital breakdown, substance abuse, and suicide.[7,8] Among males, such behaviour may also extend to a multitude of interpersonal difficulties. Interpersonal relationship may deteriorate if a partner harbours psychopathology that intrigue fidelity.[9]

Othello syndrome (OS) is a psychotic disorder characterised by delusion of infidelity or jealousy. It can involve persons besides a spouse or significant other and is a risk factor for violence, homicide, and other criminal acts.[10] OS arises by an intuitive mechanism, fortified by pathological interpretations and fabulations, and altered memories, forming a strong ideo-affective, quasi-logical system of jealousy.[11] When the allegations are clearly false, it is not hard to make a diagnosis. "When the system seems logical, a correct diagnosis can be made according to the intensity of the affective-emotional charge and to the energy invested in the creation of false evidence, as well as the complaints of emotional suffering and possible physical threats reported by the persecuted partner".[11] Obsessive suspicions take the form of jealous ruminations and unwelcome, unpleasant, repetitive, intrusive, irrational thoughts recognised by the patient as ego-dystonic, followed by the compulsive rituals of checking or seeking reassurance from the partner.[12,13] In India, morbid jealousy is more common in middle aged male, middle socioeconomic status, intermediate level of education, and almost any psychiatric illness can be associated with it. Morbid jealousy is often triggered by partner interactions with opposite sex and meeting the partner less frequently.[14] It has

a significant impact over personal, social, and occupational functioning of the individual.[14]

There are no reports of OS in EMI because of socio-cultural factors and associated untoward consequences. Here, we are reporting two cases of OS in EMI and dilemma of the psychiatrist in dealing with such patients. In the Indian context, this case series is unique because this is the first report of seeking help in EMI and due to lack of any guidelines, it led to dilemma in diagnosis and management.

CASE 1

A 24-year-old married farmer without any history of mental illness in the past or in the family was brought by a woman. The patient was irritable and abusing her physically for last one year. On clarification, she revealed that she and the patient had been in an intimate relationship for last five years that started after her husband was bed ridden and required support for daily routine due to complication of alcohol use disorder. Since the patient was her neighbour, he was helping her financially. They would often have sexual intercourse and everything was fine till one year back when patient started suspecting her that she started having sexual relationship with her husband. She would try to convince the patient that her husband cannot perform as all the treatment was ineffective to improve his physical condition and sexual functioning. He would insist her not to sleep in the room in which her husband sleeps. He would call her at night and if she does not pick the phone, he would accuse her that she was involved in sexual activity. He would beat her often for the same and had frequent arguments. Since she failed to convince him, she threatened to discontinue the relationship and pursued him to consult a psychiatrist. Except for the delusion of infidelity towards the extramarital sexual partner only (not with wife), no other abnormality could be elicited. Obsessive suspicion was excluded as thought was non-repetitive, non-intrusive and patient did not think it to be irrational and was not associated with compulsive rituals of checking or seeking reassurance from the partner. The patient did not have any ideas of infidelity towards wife. Sexual functioning was reportedly normal with both sexual partners. No history of substance use, past psychiatric illness, or any mental illness in the family was reported. Physical examination was within normal limits. Mental status examination revealed irritability and delusion of infidelity. As per the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10),[15] a diagnosis of delusional disorder (infidelity type) was made and treated with 2 mg of risperidone and cognitive behaviour therapy (CBT). The spouse was not involved throughout as patient did not want to involve her. We encouraged them to think and decide in long term perspective of continuing or discontinuing the current relationship. They expressed to continue the on-going relationship without divorce; thus, they were explained about the pros and cons of the ongoing relationship particularly with regards to role changes and issues associated with disclosure of relationship and adjustment issues. The patient had been informed about safe sexual practices and chances of sexually transmitted disease. The patient partner also received supportive psychotherapy. Risperidone was continued for six months and then discontinued with no further relapse of symptoms.

CASE 2

A 40-year-old married man was brought by his wife with complaint of alcohol use in binge pattern for last two years. The wife gives an account that the patient would become irritable before each episode. Though they have two children, but there is no sexual relation for last three years. The husband gives explanation to the wife that after two children, he has no interest in sexual activity. After establishing rapport, it was revealed that for the last three years the patient has been having affair with another woman in the neighbourhood and has regular sexual intercourse with her. Her husband had quadriplegia and was dependent on others for daily routine. The patient then developed suspiciousness that the extramarital partner is unfaithful to him and started having sexual intercourse with her husband. He was sure that though her husband cannot perform sexual acts, she may be using any technique to have sex with her husband. On separate occasions when the women with extramarital relation visited the patient, she volunteered to give information. The woman revealed that the patient suspected her to have sexual relation with husband. She refused to have any sexual relationship with her husband for the last five years as her husband has been suffering from quadriplegia and cannot perform thereafter. The woman wanted to continue the relationship as the patient was very helpful and took care of her very well except for the present suspiciousness. Obsessive suspicion was excluded as thought was non-repetitive, non-intrusive and patient did not think it to be irrational and was not associated with compulsive rituals of checking or seeking reassurance from the partner. Mental status examination revealed delusion of infidelity towards extramarital sexual partner only (not with wife). The patient did not have any past or family history of mental illness. Sexual functioning was reportedly normal. A diagnosis of alcohol dependence syndrome with delusional disorder (infidelity type) was made as per ICD-10.[15]

The patient was treated with chlordiazepoxide 100 mg in three divided doses and tapered off by 20% every three days. Multivitamin supplement and thiamine 100 mg/day was also given. He was started with 2 mg of risperidone and CBT. Throughout the treatment schedule, the spouse was not involved in assessment or management. Since they wanted to continue the on-going relationship without divorce, they were explained about the pros and cons of ongoing relationship particularly with regards to role changes, adjustment issues. Family skills training was given and the female partner also received supportive psychotherapy. The patient had been informed about safe sexual practices and chances of sexually transmitted disease.

DISCUSSION

The two cases reflect the context of two individuals who had pursued relationships with partners outside their marriages. Commonality in these two case reports was a conscious decision to pursue relationships with individuals outside their marriages despite social pressures. In Indian contexts, these case reports are interesting due to two reasons- 1) OS in the context of EMI, and 2) diagnostic and treatment dilemma faced by psychiatrist. OS is a range of irrational thoughts, emotions, and behaviour with dominant theme of partner's

sexual unfaithfulness based on unfounded evidence. It occurs more among adult illiterate unemployed males and can co-occur with variety of other psychiatric disorders such as alcohol use disorder.[16] EMI is not uncommon in India;[2] however, there is no report of OS in EMI. In Indian setting, no reports of this syndrome is seen in EMI mostly due to the cultural factors. Being a collective and strong monogamous society, extramarital relationships are unacceptable in Indian society. Sexual matter is still a taboo in India. Disclosure usually results in social boycott, stigma, and deprivation from psychosocial support.

In highly conservative cultures, any evidence of autonomous or independent activity by a partner may be interpreted as evidence of infidelity.[9] It is even proposed that jealousy is the product of culture and childhood experiences, insecurity, inadequacy, dependence, and past experiences also play a key role[17,18] and is a leading cause of homicide in India.[19] The cognitive model proposed that OS is due to systematic distortions and errors in their perceptions and interpretation of events and information.[13]

One of the dilemmas in these cases were whether the patients warrant a diagnosis of OS. Whether extramarital relationship should be considered as a committed relationship which fulfills the requirement to make the diagnosis? Similarly, can partners who are married and having sexual relationship be considered as OS in the context of EMI? We considered a diagnosis of OS because of two reasons. First is due to the irrational nature of belief amounting to delusional significance; secondly, the relationship was stable and strong enough that the duo wanted to continue the relationship despite knowing the consequences. In addition, the response to treatment was also more supportive of OS.

Other dilemma is with regards to the involvement of the spouse in the management. Since the patients did not want to disclose the relationships, it was decided not to involve the spouses. There is no clear treatment guidelines to deal with such a situation. Though "anti-infidelity" or "pro-infidelity" treatment approaches can be incorporated, we adopted the neutral stance throughout and advocated that extramarital affairs are inherently neither good nor evil but a fact of life. However, it left the therapist with the feeling that he has helped in maintaining the extramarital relation rather than resolving the issue that led to this relationship. We also acknowledged that our intervention would hardly have any consideration of the patients' spouses' or children's perspectives. The overriding concern that permeated therapy focused on the importance of minimising any harm or emotional "fallout" to all the parties involved: the patients, their spouses, their families, and their affair partners.

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REFERENCES

1. Blow AJ, Hartnett K. Infidelity in committed relationships I: a methodological review. J Marital Fam Ther. 2005;31:183-216.
2. Agrawal J, Shah A. Couples therapy and extra-marital involvement: principles and practices. Indian J Soc Psychiatry. 2009;25(3-4):78-88.
3. Mitsunaga TM, Powell AM, Heard NJ, Larsen UM. Extramarital sex among Nigerian men: polygyny and other risk factors. J Acquir Immune Defic Syndr. 2005;39:478-88.
4. Smith DJ. Man no be wood: gender and extramarital sex in contemporary southeastern Nigeria. Ahfad J. 2002;19(2):4-23.
5. Bhattacharya G. Sociocultural and behavioral contexts of condom use in heterosexual married couples in India: challenges to the HIV prevention program. Health Educ Behav. 2004;31: 101-17.
6. Jejeebhoy S, Koenig M. The social context of gynaecological morbidity: correlates, consequences and health seeking behaviour. In: Jejeebhoy S, Koenig M, Elias C, editors. Investigating reproductive tract infections and other gynaecological disorders. United Kingdom: Cambridge University Press; 2003:30-81.
7. Rao ABSVR, Sekhar K. Divorce: process and correlates, a cross-cultural study. J Comp Fam Stud. 2002;33:81-104.
8. Srivastava AK, Arora P. Suspicious deaths in newly married females- a medico legal analysis. J Indian Acad Forensic Med. 2007;29(4):63-7.
9. Kingham M, Gordon H. Aspects of morbid jealousy. Adv Psychiatr Treat. 2004;10:207-15.
10. Silva JA, Derecho DV, Leong GB, Ferrari MM. Stalking behavior in delusional jealousy. J Forensic Sci. 2000;45:77-82.
11. Batinic B, Duisin D, Barisic J. Obsessive versus delusional jealousy. Psychiatr Danub. 2013;25:334-9.
12. Hoaken PC. Jealousy as a symptom of psychiatric disorder. Aust N Z J Psychiatry. 1976;10:47-51.
13. Tarrier N, Beckett R, Harwood S, Bishay N. Morbid jealousy: a review and cognitive-behavioural formulation. Br J Psychiatry. 1990;157:319-26.
14. Singh SK, Bhandari SS, Singh PK. Phenomenology and predisposing factors of morbid jealousy in a psychiatric outdoor: a cross sectional descriptive study. Open J Psychiatry Allied Sci. 2017;8:129-35.
15. World Health Organization. The ICD-10 classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization; 1992.
16. Qureshi NA, Al-Dossari DS, Al-Bedah AM, Salem SO, Al-Habeeb A. Delusional jealousy: a brief literature review and a case report of 'unfaithful husband' with sociocultural repercussions. Int Neuropsychiatr Dis J. 2016;6(2):1-18.
17. Bhugra D. Cross cultural aspects of jealousy. Int Rev Psychiatry. 1993;5:271-80.
18. De Silva D, De Silva P. Morbid jealousy in an Asian country: a clinical exploration from Sri Lanka. Int Rev Psychiatry. 1999;11:116-21.
19. Somasundaram O. Murder in Tamil Nadu (a study of murder trials of 1968). Indian J Psychiatry. 1980;22:288-94.

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