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## Helping families cope with morbid jealousy

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In situations, where a married man harasses his spouse out of irrational jealousy, and rejects all offers for therapeutic or psychiatric help, the other family members often turn for help from family physicians and therapists. The article starts with a short review of the connection between morbid jealousy and domestic violence. It is suggested that in such situations the practitioner will become the family's consultant/advocate and offer them principles for optimal coping. These principles are: realistic expectations, team work, acceptance of feelings and refusal to argue over facts, non-collaboration with and non-reinforcement of suspicions and lastly, setting limits and defining consequences.

Key words: morbid jealousy, crisis intervention, domestic violence, families, consultation.

What do you do when a family seeks help for one member who refuses to acknowledge that there is a problem, and subsequently refuses all suggestions for medical or psychological intervention? We are talking about a parent or spouse who suffers from morbid sexual jealousy. His (and in rare cases, her) symptoms are not severe and life threatening enough to justify forced hospitalization or summoning the authorities. And yet we know that escalation is possible and that jealousy is a risk

factor for domestic violence, in some extreme cases leading to homicide. Following is an e-mail I have received from a son whose father suffered from morbid jealousy:

> I live in a small community in the northern part of the country. During the last year my father started showing signs of obsessive jealousy towards my mother. He often goes to her place of work to check whether she is really there. He also wakes up in the middle of the night and starts interrogating her and driving her crazy, indicating that she was unfaithful to him and so forth. He won't leave her alone and this is hurting all of us. I would like to add that my Dad had a slight CVA [cardiovascular accident] four years ago, and since then he occasionally sinks into depression. What are the ways to treat such a problem? I must mention that my father is a traditional religious person. There are many things in mental health that he objects to and he is convinced that he is OK. What should we do?

Not being able to interview and evaluate this individual's state of mind, we could only assume that he is manifesting morbid jealousy, a term that covers a range of emotions, irrational thoughts, combined with extreme unacceptable behavior. In such a state individuals are preoccupied with their partner's alleged sexual unfaithfulness without any actual evidence (Cobb, 1979).

Whereas non-morbid persons might become jealous in response to specific-objective indications and would listen to reason when satisfying explanations are given, in morbid cases, the belief remains unshaken in the face of contradicting information, and the list of supposed lovers may keep growing (Vauhkonen, 1968).

Psychotherapists would usually advise referring such an identified patient to a mental health practitioner and consider psychotherapy and/or medication. Anticipating resistance to this idea, they might suggest that the couple or the whole family should go for family therapy, making the family (rather than the individual) the client and thus making it easier for him/her to participate. Another option could have been suggesting that the wife gets therapy to empower her in dealing with this crisis. Therapists with a community orientation might even recommend involving some person of authority; in the above case, of a family with a religious-traditional style of life, a rabbi would be a good candidate.

Yet, all of these recommendations are often useless, as the jealous person usually rejects such ideas, being convinced that he or she is completely sane and proper. In addition such a person will do his best, using smooth talking or threat, to prevent the spouse from getting help. The spouse is often unassertive; dependent and clinging onto the traditional role of being married and a good parent; without an ability to imagine and work towards individuation and separation. In addition, spouses will avoid disclosing their hardship out of loyalty, shyness and wanting to save the family's good name.

Involuntary psychiatric hospitalization is rarely an option, as the person doesn't seem to pose a threat to self or others, especially in the early stages of the family's ordeal. In addition, such people might be functioning very well in all other areas of life and feign surprise when questioned about their suspicions. Therapists who do not work in psychiatric or forensic settings often refuse, or are not used, to treating people who do not come to them willingly. Gone are the days when the wife would have been given medication to put in her suspicious husband's afternoon coffee.

The situation presented here confronts us with serious ethical issues. We must act with partial information, not based on detailed interviewing; without informed consent of the identified patient; and on top of that, without any evidence-based guidelines on therapeutic intervention. Not only that, in light of their professional socialization, therapists are reluctant to give advice on how to deal with someone who is not their client. Refusing help is also a decision with ethical implications, as the situation can deteriorate even further. This might be a good place for readers of this article to pause and ask themselves how they would have respond to such a request for help.

As this is a practice oriented article, I will continue with a short literature review on jealousy and domestic violence and than suggest some priciples for helping families in such cases.

## Sexual morbid jealousy and domestic violence

The two subjects in the sub-title above are vast and are each extensively covered in the professional literature. As we are only dealing with their intersection, the reader is referred to Kingham and Gordon's (2004) comprehensive review on morbid jealousy and to Wallace (2004) for discussion of legal, medical, and social perspectives on domestic violence.

Almost a quarter (23%) of all women (and 15% of all men) aged 16–59 were found in a British survey to be victims of domestic violence and to have experienced an assault from a former or current partner (Mirrlees-Black, 1999). The victims came from varied social classes, family situations and areas of residence. The domestic violence offenders were of heterogeneous background as well.

Morbid sexual jealousy has a critical role in producing intimate partner violence (Block & Christakos, 1995; Stets & Pirog-Good 1987). Stets and Pirog-Good found that sexual jealousy increased the probability of using and receiving physical violence among dating women by 240 and 215 percent, respectively. Morbid jealousy combined with domestic violence can deteriorate into homicide, especially when borderline personality organization and paranoid ideation are involved (Dutton, 1994).

Silva, Ferrari, Leong, et al. (1998) found in a US sample of 20 individuals with delusional jealousy (of which 19 were males and one was female), that 13 had threatened to kill their spouse because of alleged infidelity, and that 9 of them had actually attacked their spouse. In their UK series, Mullen and Maack (1985) found that more than half of morbidly jealous subjects have physically assaulted their partner, and yet none of them come to the attention of the criminal justice system.

A U.S. Department of Justice study of spouse murder defendants (Langman & Dawson, 1995) found that out of 540 cases, 20% of the husbands and 10% of the wives had been killed in a fit of jealousy over the mate's real or imagined infidelity. Dell (1984) had found that in the UK sexual jealousy/possessiveness accounted for 17% of all cases of homicide in the UK.

Mowat (1966) studied, in a British forensic psychiatric facility, 110 morbidly jealous subjects who had killed or committed serious assaults. In 85% of thee cases, the victim had been the partner. Mooney (1965) reported that 14% in a sample of morbidly jealous individuals had made ‘homicidal attempts,’ most of them against their partners.

Gilchrist et al. (2003) identified in their sample several risk factors for domestic violence including witnessing domestic violence in childhood, disrupted

attachment patterns, high levels of interpersonal dependency and jealousy, attitudes condoning domestic violence and lack of empathy. They also found that almost half the sample (48%) was alcohol dependent. The investigators differentiated between four sub-groups of domestic violence offenders, three of which exhibited antisocial and narcissistic characteristics in different combinations. The fourth group was quite distinct, consisting of borderline/emotionally dependent offenders who had high levels of jealousy and volatile relationships, high levels of interpersonal dependency, high levels of anger and low self-esteem. It stands to reason that the father-husband who was described in the e-mail quoted above, most probably belongs to the very sub-group we have just described.

## Families under the impact of morbid jealousy

The data above was presented in dry terms of statistics and types of domestic violence. It is a different thing to understand the story in terms of the emotional experience that families undergo, including the sexually jealous individual, his partner and their children. Families in such situations are in great pain.

*The sexually suspicious individual* is ridden with agonizing suspicions, and suffers no less than a person who experiences an actual infidelity. He experiences a mixture of anxiety, rage and cascading suspicions. Every action he takes to ascertain whether sexual infidelity occurred reinforces his hidden absurd assumptions; every reassurance the partner gives brings short relief but again reinforces the investigatory and blaming behaviors.

*The victim-partner* is often torn between love and resentment. Jealousy goes hand in hand with possessiveness and attempts at isolation and control. The partner of this person is abused, suffering from interrogations, blaming and

threats and in severe cases a gradual escalation into intimidation, physical assault, and as was documented above, into homicide. Some suspicious individuals "sober up" intermittently, to ask for forgiveness and promise that the abuse will stop, which makes the sometimes emotionally and economically dependent partner refrain from leaving this terrible constellating,

*The children* young ones as well as adults, suffer from traumatic scenes in which they witness heated arguments and physical violence. They live in anxiety, not knowing when the next episode will take place. They are helpless and feel conflicting loyalties to their parents, sometimes being forced to take a position regarding "who is right."

As the mental health agents are often helpless themselves, the family is left in limbo. Looking at the situation in positive terms, we could say that helping the family cope optimally has a good chance of preventing further complications and make it easier to tolerate the burden.

## Suggested principles for family coping with morbid jealousy

The accumulated experience with such situations has led to formulation of some principles, which of course have to be adapted to the specific situation. After verifying that the suspicious person does not agree to try any form of psychotherapy, he or she is informed that the family is invited to meet a mental-health agent. They are advised to say that they will all be very happy to go together, but will also go without him and that he has an open invitation to join them at any time in the future. Rather than serving as the family's therapist, I become their consultant/advocate. I meet with the family to help them learn and apply an agreed upon policy. With the above-mentioned family, I served as a pro-bono corresponding consultant (due to the

distance, scarcity of mental health services in their area, and their lack of experience with such situations).

The five principles are:

- Realistic expectations.
- Team work: mutual support and coordination among family members.
- Empathy: acceptance of feelings; refusal to argue over facts.
- Non-collaboration with and non-reinforcement of suspicions.
- Setting limits and consequences.

To illustrate these principles, I'll quote relevant sections from my letter to the family's son:

> *Realistic expectations*: The consultant makes it clear that given the existing circumstances, the person cannot be helped and that morbidly suspicious ideation is very resistant to change. We can only aim for decreased intensity and frequency of suspicious outbursts. Curing the problem is not our goal, but rather learning to live better with it.
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> *Team work:* "...The children and mother and any other involved family member should meet together to discuss the situation and agree that they will update each other and coordinate their actions. For this purpose they will meet together as often as needed. As mother is alone on the 'battle field,' she must get a lot of support by home visits and frequent phone calls."
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> *Empathy:* "Regarding your Dad, you can all agree with his feelings, never with the facts as he sees them: 'You must be suffering…It must be awful after all these years not being able to trust your wife'…'I respect your

feelings…we can not argue with them'… 'The only facts are that you suffer and you make mother suffer too.' 'Your feelings are your business; we will understand if you do not want to stay in such a marriage and will help you separate if you so wish, but when you make Mom miserable, that becomes our business.' "

*Non-collaboration:* "Mother needs instruction on how to answer Dad. This necessitates rehearsals and role-playing. One of the siblings can play Father, letting Mother experiment with different responses. She should never answer questions of fact (whether she has a lover, or met someone). Giving answers to a suspicious person, and especially when it seems reassuring and calming, just reinforces his tendency to ask again and again. Instead, your mother should talk about her own feelings: 'your suspicions hurt and insult me…it is terrible to live with someone who can't trust me. 'When you talk like this, I feel that I live with a stranger…The more you behave like that the more it gets difficult to love and respect you.'"

*Setting limits:* "All of you must decide on rules of accepted behaviors, and make the rules and the consequences of their infringement clear to your dad. For example: It is forbidden to wake your mom at night or go to her place of work. You have to decide what would happen if your dad does it anyway. These messages have to be transmitted with a combination of respect and firmness, with expressions of love to both your parents."

"Possible results could be to have one of the children stay a night with the parents or have Mom move in with you for a day or two. All sanctions should be time limited and delineated in advance. It should be made clear

> that in cases of physical abuse or threat you will involve the police immediately. Dad should understand that this is not just the couple's issue, but rather a family one. Alone mother could be conceived as weak. Dad will hesitate however to confront a united family."

## The principles' rationale

The considerations behind each one of these recommendations are quite obvious. It is their combination which is special: Empathy is offered. The family moves from helplessness to empowerment. The power structure in the family is changed. Maladaptive behaviors are not reinforced. Aggressive acts are restrained.

The family I've quoted has just started organizing along these guidelines. In a prior occasion it was a friend who consulted with me. He is an only son who is very dedicated to his older (78 and 72) parents. His father started to accuse his mother of having an affair with a neighbor in his twenties. The couple's life deteriorated into arguments, yelling and crying. Witnessing all this and being expected by each parent to be on his/her side, my friend was at a loss. A psychiatrist suggested hospitalization, but the son being especially attached to his father, could not bring himself to agree. In our conversation I explained the above principles. Two years later, after his fathers' death, he told me that these ideas enabled him to understand his father much better. His mother, far from being an adulteress, was simply a difficult woman. My friend felt that his ability to be empathic with his dad's feelings and supportive with his mom's distress enabled the parents to live together in a bearable relationship.

In concluding such a presentation, it would have been expected to suggest that controlled studies of the problem are needed. Unfortunately, due to lack of cooperation of the identified patients, this is not applicable. It would be beneficial to have other publications on practitioners' experiences in dealing with the dilemma.

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