

# Sinhala translation and cultural adaptation of the Short Form of the Multidimensional Jealousy Scale (SF-MJS) and its uses in assessing the proportion and phenomenology of morbid jealousy in a psychiatry clinic in Sri Lanka

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## Abstract

### Background

Morbid jealousy is a psychiatric condition with significant clinical implications, characterized by emotional, cognitive, and behavioural disturbances. Despite its relevance, no validated screening tools exist for the Sinhala-speaking population. This study aimed to translate and culturally adapt the Short Form of the Multidimensional Jealousy Scale (SF-MJS) into Sinhala (SF-MJS-S) and explore the proportion and phenomenology of morbid jealousy.

### Aims

To develop a culturally appropriate screening tool for morbid jealousy in Sinhala and examine its proportion and clinical manifestations.

### Methods

A forward-backward translation process ensured semantic and cultural equivalence of SF-MJS-S. After content, face validity and pre-testing a cross-sectional study was performed among psychiatry outpatient clinics in a Base Hospital in Sri Lanka.

### Results

The study involved 220 participants, with a 91.6% response rate, and the sample was predominantly

female (57.3%) and aged over 30 years (73%). The proportion of MJ by clinical assessment was 25% while the screening tool with Area Under ROC curve of 0.967 (SE=0.013), highest Youden's Index (0.831), optimal cutoff score of 68.5, **SF-MJS-S identified proportion of MJ as 23.2%** with sensitivity of 85.5% and specificity of 97.6%, reflecting excellent discrimination ability. The tool showed excellent internal consistency (CA=0.943), outperforming the original SF-MJS. Sociodemographic factors such as occupational status and previous psychotic spectrum diagnoses were significantly associated with the presence of MJ while no significant associations were found with age, gender, education level, relationship status, or substance use. Most common psychopathology was delusions.

### Conclusion

SF-MJS-S is a reliable and valid screening tool for morbid jealousy in Sinhala-speaking psychiatric patients.

**Keywords:** morbid jealousy, cultural adaptation, screening tool, Sinhala translation, prevalence, delusional jealousy, Sri Lanka, MJS, SF-MJS

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## Introduction

The famous quote from William Shakespeare, "Beware of jealousy, my lord! It's a green-eyed monster that mocks the victims it devours", originates from Othello, a tragedy first performed around 1604. In this play, Othello, an African general in the Venetian army, is manipulated into believing that his wife, Desdemona, is unfaithful, which

leads him to tragically kill her due to his overwhelming jealousy (1).

Humans often associate emotions with colours – sadness with blue, anger with red, and jealousy or envy with green. Shakespeare's "green-eyed monster" symbolized jealousy in its most extreme form (1). This severe jealousy

is referred to clinically as morbid jealousy, a term encompassing various psychopathologies that fall under different psychiatric diagnoses (2). Unlike basic emotions such as anger, fear, happiness, or sadness, jealousy does not have a distinct facial expression but is instead a complex blend of these basic emotions (3).

The Oxford Dictionary defines jealousy as “feeling angry or unhappy because somebody you like/love is showing interest in somebody else” (4). Though commonly used interchangeably, ‘envy’ and ‘jealousy’ are different concepts. Envy involves the sadness of lacking what others possess, while jealousy refers to the fear of losing or having to share something or someone of value (5).

In 1989, White and Mullen classified jealousy into three categories: normal reactive jealousy, pathological reactive jealousy, and symptomatic jealousy, with the latter two being associated with morbid jealousy (6). Pathological jealousy, a more intense and disruptive form, often arises in intimate relationships, where irrational suspicions of infidelity prevail, whether or not these suspicions are supported by any factual evidence (7). The hallmark of morbid jealousy is the persistence of these irrational thoughts, feelings, and behaviours, even when confronted with contradictory evidence (8).

Morbid jealousy is not a single set of symptoms but rather a multidimensional phenomenon, incorporating irrational thoughts, emotions, and extreme actions (9,10). It can manifest as delusions, obsessions, or overvalued ideas, all revolving around the perceived infidelity of a partner (11). Within the ICD-10 classification, morbid jealousy may either be diagnosed specifically or as part of a broader psychiatric condition, making it a common challenge in the management of mental health patients (12).

## Epidemiology

The precise prevalence of morbid jealousy remains unclear. However, while typical romantic jealousy is often functional and short-lived, morbid jealousy is more commonly associated with mental illnesses, both psychotic and non-psychotic (2). Non-psychotic forms of morbid jealousy are more widespread, though they frequently overlap with other categories (13). In a study from the UK in the 1980s, “Murder into Manslaughter”, morbid jealousy accounted for 17% of homicide cases (14). A Canadian study found that 20% of spousal homicides were attributed to jealousy, with men being the primary perpetrators (15). Shepherd’s research on 200 ‘sane’ murderers identified 46 cases where jealousy was the key motive (11). Similarly, Somasundaram’s study of “Men Who Kill Their Wives” found that 13 out of 41 murderers had sexual jealousy, and 4 had morbid delusional jealousy (16). Furthermore, morbid jealousy is a major contributor to domestic violence, with one

Colombian study identifying jealousy as a factor in 35% of intimate partner violence incidents (17).

Morbid jealousy is estimated to affect 10% of individuals with schizophrenia, often contributing to higher relapse rates due to emotional distress, which results in poorer clinical outcomes (11). Studies on gender differences in the prevalence of morbid jealousy show mixed findings, with some suggesting a higher prevalence in men, while others report similar rates between genders (18,19). One study found that 27% of men and 15% of women were affected by morbid jealousy (15).

## Measuring morbid jealousy

Many attempts have been made to quantify morbid jealousy using various scales. Both self-reported and interviewer-administered measures have been developed. Well-known self-reported scales include the Interpersonal Jealousy Scale (IJS; Mathes et al., 1981) (17), the Multidimensional Jealousy Scale (MJS; Pfeiffer et al., 1989) (10), and the Infidelity Dilemmas Questionnaire (IDQ; Buss et al., 1992) (20). More recently, the Romantic Jealousy in Relationships Scale (JRRS) was validated in 2023 with a Turkish sample to assess jealousy in relationships (21).

The MJS, developed by Pfeiffer and Wong (1989), divides jealousy into three main dimensions: cognitive, emotional, and behavioural. The cognitive dimension assesses an individual’s thoughts about a partner’s infidelity, whether real or hypothetical. The emotional dimension gauges emotional responses such as distress or irritability, while the behavioural dimension examines how jealousy manifests in actions. The MJS has proven reliable in measuring morbid jealousy and serves as an essential tool for further research in this area (10).

The MJS has been translated into multiple languages, and its validity and reliability have been repeatedly confirmed (22-25). In Australia, a shortened version of the MJS, called the Short Form of the Multidimensional Jealousy Scale (SF-MJS), was developed, maintaining the original’s cognitive, emotional, and behavioural dimensions while enhancing its reliability and validity (26). A systematic review by Woods (2016) identified both the MJS and SF-MJS as the most effective tools for measuring romantic jealousy (27). The SF-MJS which contained 17 items instead of 24 items in MJS was translated and validated in various languages (28). There is a gap in tools for measuring morbid jealousy in Sri Lanka, particularly in the Sinhala language, which limits its detection in local clinical and community settings (28).

## Justification

Jealousy is a complex emotion, but morbid jealousy stands out for its irrationality and intensity, often leading to destructive behaviours. As stated repetitively in

literature and real life the threats to relationships are real and emotional reactions to those threats are profound (29). It is commonly encountered in general adult psychiatry, geriatric psychiatry, and forensic psychiatry. Comprehensive assessments, which include evaluating the risks to both the individual and others, followed by appropriate management, are crucial for handling these cases (2). There is a bidirectional relationship between morbid jealousy and psychiatric disorders, where morbid jealousy can worsen existing conditions and vice versa, complicating diagnosis and treatment, which can lead to treatment-resistant cases and increased strain on mental health services (30).

Morbid jealousy can have detrimental consequences, such as interrogating the partner, stalking, or violent behaviours even homicide or suicide (31). In addition, the emotional toll on the individuals, their partners and third parties (alleged lovers, children) often lead to secondary mental health issues, resulting in functional, socioeconomical deterioration. Recognizing morbid jealousy and providing treatment can help prevent these negative outcomes on health system, legal system and economy of a country (11).

Early detection of morbid jealousy is vital for improving clinical outcomes and minimizing harm (2). However, detecting morbid jealousy is often challenging due to cultural and social factors. In Sri Lanka, where monogamous relationships are the norm, the absence of specific words in language to describe the emotions, thoughts, and behaviours associated with morbid jealousy may contribute to underreporting and under-diagnosis. A Sinhala-language screening tool would facilitate the identification of morbid jealousy that might otherwise be overlooked in busy clinic settings and other population samples (18).

This study intended to develop a screening tool to identify morbid jealousy in Sri Lanka. Sinhala translation and cultural adaptation of the Short Form of the Multidimensional Jealousy Scale (SF-MJS) was then used to assess the prevalence of morbid jealousy in patients attending a psychiatric clinic at a base hospital in peripheral Sri Lanka. Additionally, the phenomenology of pathological jealousy (delusion, obsession, or overvalued idea) was assessed as it is invariably related to personalised management strategies of affected individuals (2). Identifying morbid jealousy in clinical practice will help to prevent its detrimental effects on individuals, by concomitantly supporting the management of related psychiatric conditions which can ultimately alleviate the burden on Sri Lanka's healthcare services (2, 18).

## Methodology

### Objectives

The study aimed to translate and culturally adapt the Short Form of the Multidimensional Jealousy Scale (SF-MJS) into Sinhala (SF-MJS-S) to assess morbid jealousy (MJ). Additionally, it determined the proportion and phenomenology of MJ among psychiatric patients attending a base hospital in Sri Lanka.

#### Phase 1: Translation and Cultural Adaptation

The SF-MJS was translated into Sinhala using the forward-backward translation method by two bilingual translators. An independent reviewer synthesized the forward translation, and two other bilingual translators performed the back-translation. A second reviewer compared the original and back-translated versions for inconsistencies. Content validity was assessed by a panel of five psychiatric experts, while face validity was determined by five non-experts. The final version underwent pre-testing with ten psychiatric inpatients, leading to minor modifications for clarity and cultural relevance (32).

#### Phase 2: Assessment of MJ Proportion and Phenomenology:

A descriptive cross-sectional study was conducted at the Base Hospital, Mahiyanganaya, Sri Lanka, over a two-month period (June-July 2021). Patients attending the psychiatric clinic with clinic numbers ending in even digits were selected. Inclusion criteria were adults (18-60 years) in a romantic relationship of at least eight weeks (33). Exclusion criteria were inability to communicate in Sinhala, visual/hearing impairment, severe learning disability, acute psychiatric conditions, or incapacity to provide consent, personal acquaintance with the principal investigator. Sample size calculation was based on a previous study conducted to detect the MJ in an inpatient unit in Sri Lanka which has found 17.1% prevalence rate (34).

Participants completed the self-administered SF-MJS-S, followed by an interviewer-administered questionnaire collecting sociodemographic data and psychiatric history. The principal investigator, blinded to SF-MJS-S scores, conducted clinical assessments using ICD-10 criteria to confirm MJ and classify its phenomenology (delusions, overvalued ideas, or obsessions) (12). Data were analysed using SPSS 21. Chi-square tests assessed associations between MJ and sociodemographic variables ( $p < 0.05$ ). The Receiver Operating Characteristic (ROC) curve analysis was performed to evaluate the performance of the screening tool by plotting the true positive rate (sensitivity) against the false positive rate (1-specificity) across a range of total scores and Youden's

Index (sensitivity + specificity – 1) was calculated for each score to identify the optimal cutoff score (35). Reliability was evaluated using Cronbach's alpha, and validity was assessed via Pearson correlation coefficient. The clinical diagnosis of MJ is considered as the gold standard for comparison with SF-MJS-S results.

## Results

This study aimed to culturally adapt and assess the validity and reliability of the Sinhala translation of the Short Form of the Multidimensional Jealousy Scale (SF-MJS-S) for detecting morbid jealousy (MJ) in a psychiatry clinic sample. The first phase involved forward and backward translation, ensuring conceptual and cultural representation of the scale. In the second phase, a cross-sectional study was conducted at a base hospital in Sri Lanka with 220 participants, with a response rate of 91.6%.

The sample included 73% of participants aged over 30 years and 126 were females (57.3%). Among participants, 76.4% were married, 55% had been in a relationship for over five years, 34.1% had less than year 11 education and 45.9% were unemployed. In terms of psychiatric diagnoses, 47.3% had mood disorders, 20.5% had psychotic spectrum disorders, 15% had neurotic spectrum disorders and 17.3% had other conditions, including organic, personality, and substance use disorders. Substance use was reported only in 41.4% of participants, with alcohol being the most used substance (20.9%) while 10.5% had polysubstance use.

SF-MJS-Sinhala was scored in a Likert scale for each dimension- cognitive, emotional and behavioural from 1 to 7 with minimal to maximum scores of 17-119. The mean for the total score was **54.3** (SD=23.89). The cognitive scale (scores 5-35) mean was **10.9** (SD=7.8) while emotional and behavioural scales (scores 6-42) means were **28.9** (SD=10.06) and **14.4** (SD=10.4) respectively. The emotional jealousy mean score was nearly double that of the behavioural jealousy, suggesting a stronger emotional component in MJ presentations.

An Area Under Receiver Operating Characteristic (ROC) Curve of 0.967 (with a standard error of 0.013) showed 96.7% higher chance or excellent discrimination ability of the tool to discriminate between individuals with and without MJ. After maximization of Youden's Index (0.831), score 68.5 considered as the cutoff (69 or more as positive for MJ) with sensitivity of 85.5% and specificity of 95.8%; SF-MJS-S identified the proportion of MJ in the sample as 23.2% while gold standard clinical assessment identified proportion as 25% (n=55, 95% CI=19.4%-31.3%).

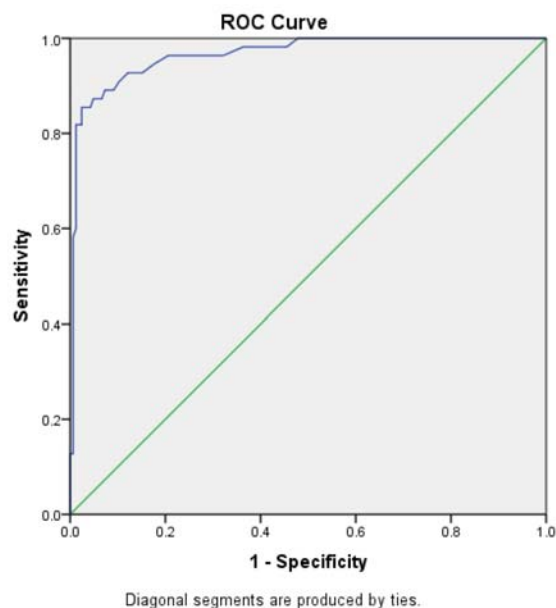


Figure 1. ROC curves.

Table 1. ROC curve coordinates with the total scores for the tool

| Positive if Greater Than or Equal To <sup>a</sup> | Sensitivity | 1 - Specificity |
|---------------------------------------------------|-------------|-----------------|
| 50.5000                                           | .964        | .297            |
| 52.0000                                           | .964        | .279            |
| 53.5000                                           | .964        | .224            |
| 54.5000                                           | .964        | .206            |
| 55.5000                                           | .945        | .176            |
| 56.5000                                           | .927        | .152            |
| 57.5000                                           | .927        | .145            |
| 58.5000                                           | .927        | .121            |
| 59.5000                                           | .909        | .103            |
| 60.5000                                           | .891        | .091            |
| 61.5000                                           | .891        | .085            |
| 62.5000                                           | .891        | .073            |
| 63.5000                                           | .873        | .067            |
| 64.5000                                           | .873        | .061            |
| 65.5000                                           | .873        | .048            |
| 66.5000                                           | .855        | .042            |
| 67.5000                                           | .855        | .036            |
| 68.5000                                           | .855        | .024            |
| 69.5000                                           | .818        | .024            |
| 70.5000                                           | .818        | .012            |
| 71.5000                                           | .764        | .012            |
| 72.5000                                           | .727        | .012            |
| 73.5000                                           | .691        | .012            |
| 75.5000                                           | .673        | .012            |
| 78.5000                                           | .600        | .012            |
| 80.5000                                           | .582        | .006            |

Table 2. Youden Index calculation for the scores

| Cutoff Score | Sensitivity | Specificity | Youden Index      |
|--------------|-------------|-------------|-------------------|
| 60.5         | 0.891       | 0.909       | 0.800             |
| 61.5         | 0.891       | 0.915       | 0.806             |
| 62.5         | 0.891       | 0.927       | 0.818             |
| 63.5         | 0.873       | 0.933       | 0.806             |
| 64.5         | 0.873       | 0.939       | 0.812             |
| 65.5         | 0.873       | 0.952       | 0.825             |
| 66.5         | 0.855       | 0.958       | 0.813             |
| 67.5         | 0.855       | 0.964       | 0.819             |
| 68.5         | 0.855       | 0.976       | 0.831 ✓ (Highest) |
| 69.5         | 0.818       | 0.976       | 0.794             |
| 70.5         | 0.818       | 0.988       | 0.806             |

The internal consistency and the reliability of SF-MJS-S was assessed using Cronbach's alpha (CA) and found as 0.943 for the whole scale while having 0.906, 0.932, 0.924 for cognitive, emotional, and behavioural subscales respectively. When the bivariate correlation for all the questions of the SF-MJS-Sinhala were assessed, all the questions were found to have values less than 0.05 or statistically significant and indicated all questions in the scale were valid.

Psychopathological subtypes of clinically detected MJ were examined using ICD-10 criteria. Delusional jealousy was the most prevalent subtype (12.3%), followed by obsessional (6.8%) and overvalued ideas (5.5%).

The associations between the sociodemographic factors and presence of MJ were assessed using Chi square test for the SF-MJS-S scores.

Table 3. Frequency distribution of the study population by MJ and sociodemographic characteristics

| Characteristics    | MJ Negative |       | MJ Positive |       | Total<br>(n=220) |      | Significance                                   |
|--------------------|-------------|-------|-------------|-------|------------------|------|------------------------------------------------|
|                    | No          | %     | No          | %     | No               | %    |                                                |
| Age category       |             |       |             |       |                  |      |                                                |
| Less than 40 years | 90          | 71.4% | 36          | 28.6% | 126              | 100% | X²=1.404                                       |
| More than 40 years | 73          | 78.5% | 20          | 21.5% | 93               | 100% | df=1<br>p=0.236<br>OR=0.685<br>95% CI=0.36-1.2 |

(Continued)

| Characteristics          | MJ Negative |       | MJ Positive |       | Total<br>(n=220) |      | Significance                                                                       |
|--------------------------|-------------|-------|-------------|-------|------------------|------|------------------------------------------------------------------------------------|
|                          | No          | %     | No          | %     | No               | %    |                                                                                    |
| Gender                   |             |       |             |       |                  |      |                                                                                    |
| Male*                    | 70          | 74.5% | 24          | 25.5% | 94               | 100% | X <sup>2</sup> = 0.001<br><br>df=1<br>p=0.982<br>OR=0.993<br>95% CI=0.53-1.8       |
| Female                   | 94          | 74.6% | 32          | 25.4% | 126              | 100% |                                                                                    |
| Level of education       |             |       |             |       |                  |      |                                                                                    |
| O/L or less*             | 102         | 72.3% | 39          | 27.7% | 141              | 100% | X <sup>2</sup> = 1.006<br><br>df=1<br>p=0.316<br>OR=0.717<br>95% CI=0.37-1.37      |
| A/L or more              | 62          | 78.5% | 17          | 21.5% | 79               | 100% |                                                                                    |
| Occupational status      |             |       |             |       |                  |      |                                                                                    |
| Employed*                | 96          | 80.7% | 23          | 19.3% | 119              | 100% | X <sup>2</sup> = 5.128<br><br>df=1<br>p=0.024<br>OR=2.026<br>95% CI=1.09-3.75      |
| Unemployed               | 68          | 67.3% | 33          | 32.7% | 101              | 100% |                                                                                    |
| Relationship status      |             |       |             |       |                  |      |                                                                                    |
| Married*                 | 125         | 74.4% | 43          | 25.6% | 168              | 100% | X <sup>2</sup> = 0.007<br><br>df=1<br>p=0.931<br>OR=0.969<br>95% CI=0.47-1.98      |
| Unmarried                | 39          | 75.0% | 13          | 25.0% | 52               | 100% |                                                                                    |
| Duration of relationship |             |       |             |       |                  |      |                                                                                    |
| Less than 5 years*       | 73          | 75.3% | 24          | 24.7% | 97               | 100% | X <sup>2</sup> =1.046<br><br>df=1<br>p = 0.829<br>OR = 1.070<br>95% CI = 0.58-1.97 |
| More than 5 years        | 91          | 74.0% | 32          | 26.0% | 123              | 100% |                                                                                    |

(Continued)

| Characteristics      | MJ Negative |       | MJ Positive |       | Total (n=220) |      | Significance                                                                       |
|----------------------|-------------|-------|-------------|-------|---------------|------|------------------------------------------------------------------------------------|
|                      | No          | %     | No          | %     | No            | %    |                                                                                    |
| <b>Substance use</b> |             |       |             |       |               |      |                                                                                    |
| No*                  | 99          | 76.7% | 30          | 23.3% | 129           | 100% | $\chi^2 = 0.046$<br>$df=1$<br>$p = 0.373$<br>$OR = 1.320$<br>$95\% CI = 0.71-2.43$ |
| Yes                  | 65          | 71.4% | 26          | 28.6% | 91            | 100% |                                                                                    |

There was a statistically significant association between occupational status (The Pearson Chi-Square value was 5.128 with 1 degree of freedom, and the associated p-value was 0.024 which was less than the commonly accepted threshold of 0.05.)

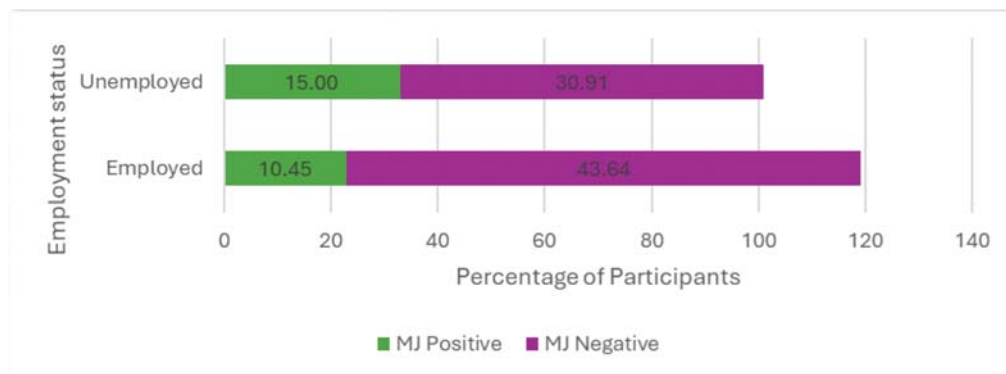


Figure 2. MJ and employment status.

Further having previous mental health diagnosis in the psychotic spectrum showed a statistically significant relationship with presence of MJ. Pearson Chi-Square value was 13.415 with 1 degree of freedom and the p-value was 0.000 suggesting that the relationship between psychotic spectrum mental health diagnosis and morbid jealousy is significant. (OR=0.286, 95% CI= 0.143-0.571)

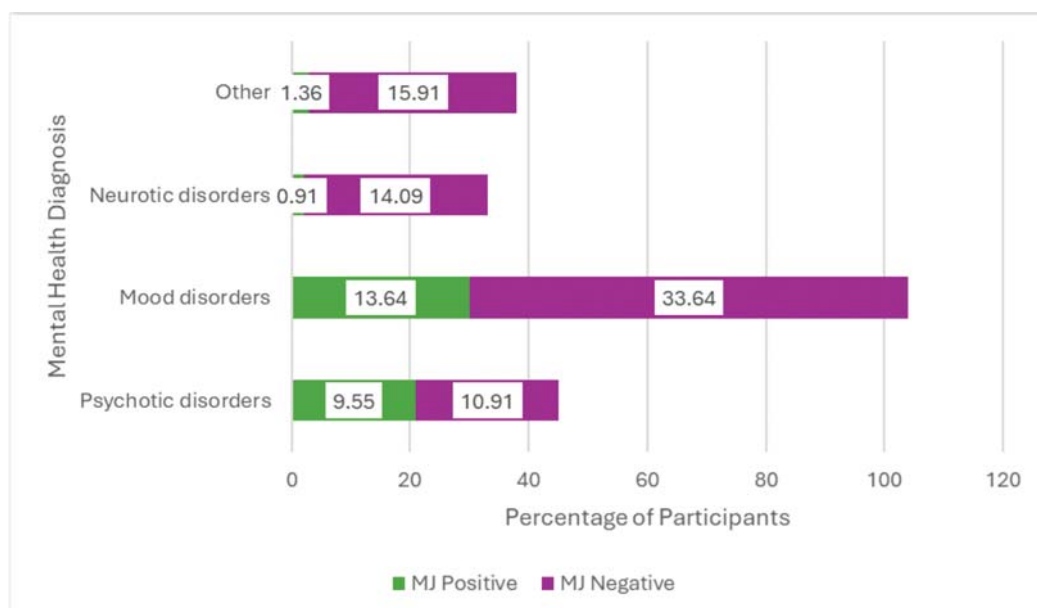


Figure 3. MJ in existing MH diagnosis.

There were no correlations between presence of MJ with age, gender, level of education, relationship status or duration and substance use of the participants. ( $p > 0.05$ ) but MJ was more commonly reported among females, in those who did not use substances, had educational level as O/L or less and married.

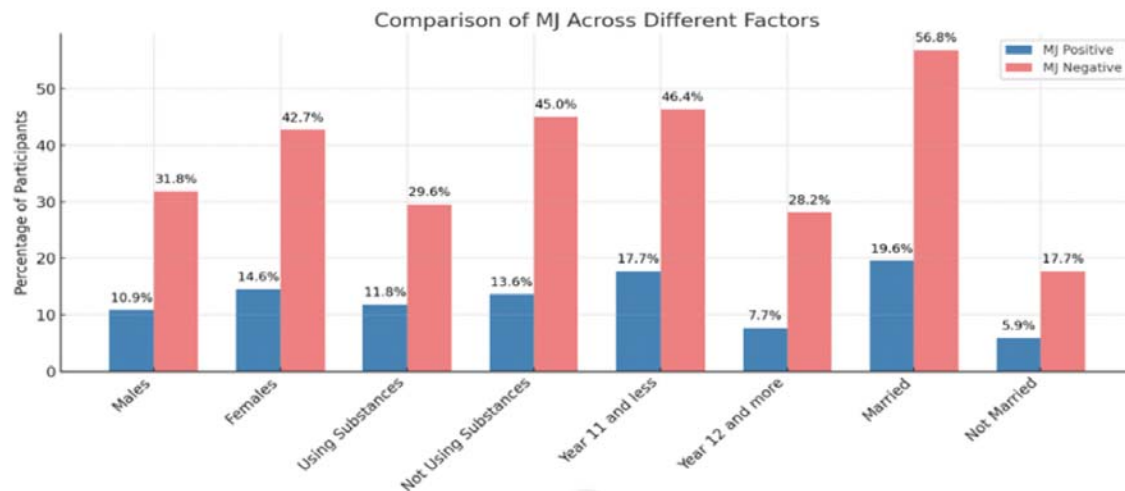


Figure 4. Comparison of MJ across different factors.

## Discussion

Romantic jealousy is defined as “feeling angry or unhappy because somebody you like, or love is showing interest in somebody else” (4). Pathological jealousy, or morbid jealousy (MJ), is a severe form of jealousy observed in intimate interpersonal relationships, leading to significant distress and impairment (7). It is characterized by irrational thoughts, emotions, and extreme behaviours, making it a multidimensional construct (9).

The current study aimed to validate and culturally adapt the Short Form of Multidimensional Jealousy Scale-Sinhala translation (SF-MJS-S) for identifying morbid jealousy in Sri Lanka. Additionally, the study examined the proportion of morbid jealousy among psychiatric outpatients and its associations with sociodemographic and clinical factors.

A cross-sectional study involving 220 patients at a psychiatry outpatient clinic in a base hospital in Sri Lanka examined the proportion of morbid jealousy (MJ) using both the SF-MJS-S screening tool and clinical assessments. Refining the SF-MJS-S cutoff score of 69, enhanced the area under the curve (AUC) to 0.967, which corresponded to 85.5% sensitivity and 97.6% specificity in detecting MJ and SF-MJS-S identified the proportion of MJ as 23.2%, while clinical evaluation confirmed MJ in 25% of cases (95% CI: 19.4%-31.3%). The close alignment between the SF-MJS-S screening tool and clinical assessment in identifying MJ suggests that the refined cutoff score effectively captures clinically

relevant cases. This reinforces the reliability of the culturally adapted tool in detecting MJ and highlights its potential utility in psychiatric practice. A previous Sri Lankan study conducted at the National Hospital, Colombo, reported a prevalence of 17.1% (34), slightly lower than the current study. Variations in study populations may account for this difference. A case-control study in Sri Lanka by Karunaratne et al. (2017) found an MJ prevalence of 4.8% (36), whereas an Indian study reported a prevalence of 7.59% in psychiatric outpatients (18). These results suggest that MJ may be more prevalent in Sri Lanka than in India, possibly due to socio-cultural factors and further studies could design to identify the causes.

The SF-MJS-S demonstrated excellent internal consistency and reliability, with a Cronbach's alpha of 0.943 for the overall scale. Each subscale-cognitive, emotional, and behavioural-also exhibited high reliability, with Cronbach's alpha values exceeding 0.9. Bivariate correlation analyses confirmed the statistical significance of all scale items, further supporting the SF-MJS-S as a valid tool for assessing morbid jealousy. In comparison, the original study by Elphinstone et al., which evaluated the SF-MJS in 326 participants, reported Cronbach's alpha values of 0.77 for the cognitive subscale, 0.81 for the emotional subscale, and 0.70 for the behavioural subscale (26). The higher reliability coefficients observed in the SF-MJS-S version suggest its enhanced robustness and suitability for use in the Sinhala-speaking population.

The mean for the total score of SF-MJS-S was **54.3** (SD=23.89). The cognitive, emotional and behavioural scales means were **10.9** (SD=7.8), **28.9** (SD=10.06) and **14.4** (SD=10.4) respectively. The means for emotional jealousy was nearly double that of the behavioural jealousy, suggesting a stronger emotional component in MJ presentations thus it can be applied in its management (5). Among psychopathology of clinically confirmed MJ cases in this study, delusions were the most common (12.3%), followed by obsessions (6.8%) and overvalued ideas (5.5%). A German study by Soyka et al. reported a 1.1% prevalence of delusional jealousy among psychiatric inpatients (37). Similarly, Singh et al. found that delusional jealousy was the most prevalent psychopathology, followed by overvalued ideas and obsessional jealousy (18). A study by Padmal De Silva, "Jealousy in couple relationships: Nature, assessment and therapy" emphasised the need to assess the phenomenology of MJ and how treatments should be tailored accordingly (5).

In this study no significant associations were found between MJ and age, gender, education level, relationship status, relationship duration, or substance use. But MJ was more commonly seen among females than males, in individuals not using substances, who have lower educational achievements and married in this study. There was a statistically significant association between occupational status and MJ according to the findings in this study. Furthermore, when considered the previous mental health diagnosis as being in the psychotic spectrum showed a statistically significant relationship with MJ even though most common diagnosis among the study population was mood disorders (47%), psychotic spectrum disorders being in the second (20%). Previous studies have yielded mixed findings regarding gender differences in MJ prevalence. One study reported equal prevalence among men and women (19), while another found MJ in 27% of men and 15% of women (6). An Indian study noted a 2:1 male-to-female ratio in MJ prevalence (18). Another Sri Lankan study by De Silva and De Silva found no significant gender differences, with most MJ cases occurring among married individuals and delusional jealousy being the most common presentation. The current study replicated these findings, but unlike De Silva's study, it identified a higher MJ prevalence among individuals with lower education achievement levels (19).

A significant association was observed between previous mental health diagnoses and MJ, particularly among individuals with psychotic spectrum disorders. Indian studies have reported MJ most frequently in schizophrenia, followed by depression (18). A Sri Lankan study by Kapugama et al. (2013) found schizophrenia as the most common diagnosis among individuals with MJ (22.36%), followed by unipolar depression (19.73%), alcohol-related disorders (17.10%), and bipolar mania

(15.78%) (34). Another study done in Germany has replicated the findings in this study as MJ most common among the psychotic spectrum disorders compared to other mental health diagnosis (38).

## Conclusions

These findings highlight the importance of culturally adapted screening tools in detecting MJ, as one in four psychiatric patients may be having it. Using SF-MJS-S in busy clinical settings can enhance screening efficiency and identify individuals who may not seek help due to socio-cultural as well as knowledge barriers. However, certain limitations should be considered. This single-site study relied on self-reported measures and was conducted during the COVID-19 pandemic, restricting participant recruitment to 220 (91.6%). Additionally, the clinical sample may represent the extreme end of MJ presentations, while many MJ cases remain undiagnosed in the community. Further studies using SF-MJS-S in both clinical, non-clinical populations and urban settings would be ideal. The SF-MJS-S proved to be a reliable and valid tool for screening MJ in Sinhala-speaking individuals. The study identified MJ as nearly one in four psychiatric outpatients, emphasizing the severity of the condition. The high prevalence of delusional jealousy underscores the need for tailored psychiatric interventions. Future research should focus on broader validation across different populations and translation to Tamil to enhance understanding of MJ in diverse cultural contexts in Sri Lanka.

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