British Journal of Healthcare and Medical Research - Vol. 12, No. 01
Publication Date: February 25, 2025
DOI:10.14738/bjhr.1201.18160.
Thomson, W. (2025). Jealousy - The Green-Eyed Monster and Its Relationship with Depression, and Personality. Causal or Coincidental? British Journal of Healthcare and Medical Research, Vol - 12(01). 235-240.

Jealousy - The Green-Eyed Monster and Its Relationship with Depression, and Personality. Causal or Coincidental?

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ABSTRACT

This research is an example of theory and therapeutic practice converging. Using experiential and subjective ideation gained as a therapist and then as a researcher to test and evaluate hypotheses. Furthermore, this research is a continuation of Thomson (2019) and earlier research Thomson (1996, 2011) which investigated the nature and consequences of a depressive illness. There is no one accepted theory of depression. To extend the research profile a questionnaire: The Self-Defeating Quotient; SDQ, (2016, 2017). The SDQ is an anonymous self-administered questionnaire. The bottom-up approach was used to start with the patients themselves by using the SDQ to obtain data concerning the underlying factors in a depressive illness. Jealousy and neuroticism were found to be significantly correlated with a depressive illness. Results: Jealousy was found to be significantly correlated with depression. Factor analysis played a significant but unexpected part in defining the emotion jealousy in a cohort of depressed patients. Additional variables found to be associated with jealousy were family, family time, and education: The implication being that these foundational variables may have causative connections with jealousy and depression. The inference for treatment is briefly discussed alongside the implications following previous findings on the mortality of a depressive illness. Summary: The results found in this pilot study ideally justify further verification using a larger sample of depressed patients.

Keywords: Depression, jealousy, factor analysis, Self-Defeating Quotient, personality, treatment.

INTRODUCTION

World Health Organisation (WHO) statistics on mental health disorders estimate the annual cost to the global economy of $1 trillion in lost productivity, with depression being the leading cause of ill health and disability, WHO estimates that more than 300 million people worldwide suffer from depression, an increase of more than 18% between 2005 and 2015. There is no denying that a depressive illness is a grievous condition to suffer. The diagnostic criteria for depression include hopelessness, lack of control, a lack of self-esteem, insomnia, or needing too much sleep, overweight versus underweight.

Pervasive is the feeling of hopelessness and lack of control and self-esteem. A situation where the sufferer may lack either the hope, the energy, the inclination nor indeed the belief that they can get out of the quagmire and that thing will improve. 15% of all depressives will commit suicide in the belief that will be an end to their suffering (Thomson, 1996,2012). A further finding is that depressed patients will die from unnatural death Thomson (1996, 2014). A depressed patient will frequently ask, or even if they do not ask, they will most likely think, “am I going mad?" It is a vicious reinforcing system in which even the stigma associated with a

mental illness diagnosis must be unfairly reckoned with by the patients. The symptoms are all-encompassing, involving behaviour, feelings, emotions, relationships, social isolation, physical ailments, and the financial consequences - confirming depression as a bio psychosocial condition Engel (1980).

The additional symptoms other than those accepted as correlating with a depressive illness, but perceived during personal therapeutic involvement in depressed patients are: the inability to imagine, loss of a sense of smell, and an in some patients, the initial resistance towards a therapeutic relationship. The loss of imagination is an important prerequisite, a necessary part of the toolkit to navigate all the areas of living today. The loss of the sense of smell, was attributed to the dulling of all the senses; explained by the shutting down in depressed patients.

The transference intuitively felt, implies to the envy and jealousy – towards the therapist who joins the list of people whom the patient's feet resentment towards (i.e., it assumed by some patients that the therapist, along with society in general, is privileged and enjoys advantages the patient lacks. The implication being that without experiencing the hardships and disappointments they endure how could anyone play a vital and influential role in their treatment and recovery. The SDQ (Self-defeating quotient) Thomson (2016) to discover more about a depressive illness and the associated correlates. The reasoning was that if there was no agreed theoretical underpinning of a depressive illness then it was a responsibility, a challenge, and interesting to obtain more information from the patients themselves. The established diagnosis criteria used, such as the Maudsley Psychiatric diagnostic schedule of mental illness while it is suitable for the initial consultation for all mental illness, but it is limited when used concerning depression. It was considered too inexact and lacked the detail necessary to treat and 'get under the skin 'of depressed patients. But an important element was involving the patients actively right from the beginning of the consultation, in inviting them to complete the SDQ.

Jealousy is defined as the feeling of dissatisfaction and of being disgruntled; it comes from the word zealous, which means the dislike, and hostility towards others who have something we want or desire. Whereas "envy" derives from the Latin word "invidere," which means to "look askance upon," as in "give someone the evil eye." Its previous uses include "malice" and "spite." So "envy" isn't as benign as some might have it. However, it was necessary to be mindful that jealousy is a potent and negative word and being jealous would be a condition that patients would not want to disclose. Which perhaps explains why it has remained unrecognised. The anonymity of the questionnaire (SDQ) facilitated disclosure. Vining, 1986; Ness, 1990] stated, "Since psychopathology is concerned primarily with brain function and since the brain evolved as the organ for tracking social success then it follows that at some level the social milieu in which we grow and live must enter our research endeavours and theory building. A depressive illness is often associated with various patterns of affect and behaviour's, and very few assessment instruments tap this complexity of ranking behaviour and sense of identity".

THE RESEARCH METHOD THOMSON (2017)

To understand and define the underlying emotions, thoughts, attitudes, feelings, and behaviour of depressed patients the SDQ questionnaire was designed to quantify self – defeating ideation; a bottom-up approach to:

1. Segregate depressed patients from a normal control group

2. Examine if personality dimensions correlate with the SDQ
3. Via factor analysis, discover what the patients were experiencing, via self-disclosure.
4. Identify their treatment needs.

RESULTS

From 36 multifactorial variables, 11 factors were identified, which had a clear interpretation and appeared to represent latent states in depressed patients. The states formed a hierarchical relationship and correlated with personality dimensions, namely Neuroticism and psychoticism. The results suggested that this avenue of investigation could throw more light in the refinement and the understanding of some patients with depression.

Eysenck (1990) stated, "Factor analysis is a statistical technique to reduce many correlations to a few factors which are indicative of the number of dimensions involved, and of their nature. The rotated component matrix helped to determine what the components represent.:
Factor 1: Family time, family, childhood, jealousy, education.

Table 1: factors produced by scoring the SDQ.

Factor 1: Family time, family, childhood, jealousy, education.
Factor 2: Contentment, control, optimism, frustration.
Factor 3: Community, exercise, conservation, neighbours, and elections.
Factor 4: Country, initiative, diet,
Factor 5: Temper, aggression.
Factor 6: Altruism, vandalism, colleagues, work.
Factor 7: Weight, stress, debt, honesty.
Factor 8: Destruction, Adult training.
Factor 9: Drugs, law.
Factor 10: Alcohol, smoking, care,
Factor 11: Problems, philosophy

The factors produced by the SDQ provide a clear picture of negative attitudes, behaviour, and feelings. Factor 1 shows clearly that the family is the necessary foundation in which states and traits are embedded. This may include genetic, developmental, environmental, cultural, and social components. Further, the results suggest that the emotional dynamics are set in motion in which the patient then becomes insular taking little or no responsibility for themselves or for others, with implications that circumstances are to blame not themselves. Of relevance here are also further results obtained from the research which detects a pervasive attitude in these depressed patients who feel "nobody helps me so I will not help or be concerned with others" This attitude holds for broader issues involving the collective responsibility towards the country, and the inability to take any initiative.

The next consideration begs the question: is jealousy an important contributory cause of the depression or is it more likely to be that depression causes the jealousy? It would be perfectly understandable to want the same health and happiness enjoyed by others but denied. It would also be understandable that if being depressed was looking askance at those around who appeared to be living happy, contented lives and living in the light, but the depressed were living in the shadows. The results grouped variable together in factor 1 which appeared

foundational: family, family time, and education. Perhaps indicating the entrenched and important influences which stemmed from childhood.

The results begged answers to questions of treatment. If jealousy is a significant underlying cause of depression, what are the implications for treatment. Carl Jung believed the kernel of jealousy is the lack of love. Indeed, these depressed patients in some cases repel encounters or potential relationships where they might get the support empathy and love which is missing in their lives. As previously hinted the pivotal relationship between the patients and therapist can be undermined by the patient. During therapy it was noticed that there is also an intuitive element of testing out: the therapist can be considered 'as not understanding 'which is either explicitly stated or suppressed by the patient. 'What do you possibly know, or how can you relate or have any idea about my psychic pain. '

Furthermore, they can be reluctant to accept any evidence that they play any pivotal role in the formation and maintaining of relationships. Depressed patients when given the opportunity, appear to group together. They have more in common with the psychopathology of fellow depressed patients. They prefer not to be in the conflicting company of those from whom they feel alienated, those who are not suffering from depression, and living in seeming abundance. This is indeed like any cohesive group, like iron filings attracted to a magnet there is propulsion towards the attraction of interests, gender, politics etc. and in this case depression and all that it entails.

TREATMENT

What would be the treatment of choice to challenge this amalgam of self-defeating ideation? Jamison (1987) suggests that for every patient who complies with their prescribed drug doses, there is another one who takes too little, too much or none. This appears to suggest that while drugs are essential, they are not the preferred treatment of choice for some patients with depression. The use of the SDQ to confront the emotions and behaviour and function which underlie depression suggest that it was drawing on a hitherto untapped source of relevant information. While scientifically collecting and monitoring the data, the prevailing thought was that an opportunity was being missed, and that these patients were being let down. A research process was started, by them agreeing to complete the SDQ but there was no opportunity to progress and use the results during treatment.

Having found the strong association between the diagnosis depression, and the variables, jealousy family, family time, and education, in factor one, the first question was what the treatment implications are: how to utilise the information to help the patients. It needs to be noted that that the word jealousy with its very negative connotations can only be used with caution.

Raising questions such as: What strategy could be applied to address this newly found knowledge? And what is the role of personality? The treatment aim would appear to be replacing what the patients feel they lacked, which others have. Namely achieving this by initially using a diversionary tactic, away from the preoccupation they have with their deprivation. Towards change of direction for the sufferer: re -instituting a belief in the self, facilitating a feeling of security, and looking externally to educational / retraining opportunities if appropriate.

Furthermore, in view of previous research on the mortality of depression Thomson (1996, 2011,2012 having identified jealousy, what impact if any it might have on the unnatural and natural death rate if identified and confronted successfully? Or what relevance of the accompanying variables in factor 1 for the provision of treatment.

It is too speculative to answer these questions without giving due consideration of the interplay between the variables identified and the diagnosis. However, although needing additional supporting research nevertheless this line of research is provocative. And when faced with a depressed patient being mindful that another causative factor might be involved is a contribution towards untangling this pervasive condition with all its many consequences, individually, to families, and of course to nations.

CONCLUSION

The results suggest that jealousy has been overlooked as playing a contributory part in both the causation and maintaining psychopathology, particularly concerning patients diagnosed with a depressive illness. It is hoped that this line of research can continue including a larger sample with refinements following the lessons learnt from this the original pilot study into self-defeating ideation. Shakespeare summarised well and succinctly the subtlety of jealousy. “Oh, beware jealousy, my Lord! It is the Green-Eyed Monster That mocks the meat it feeds on “.

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