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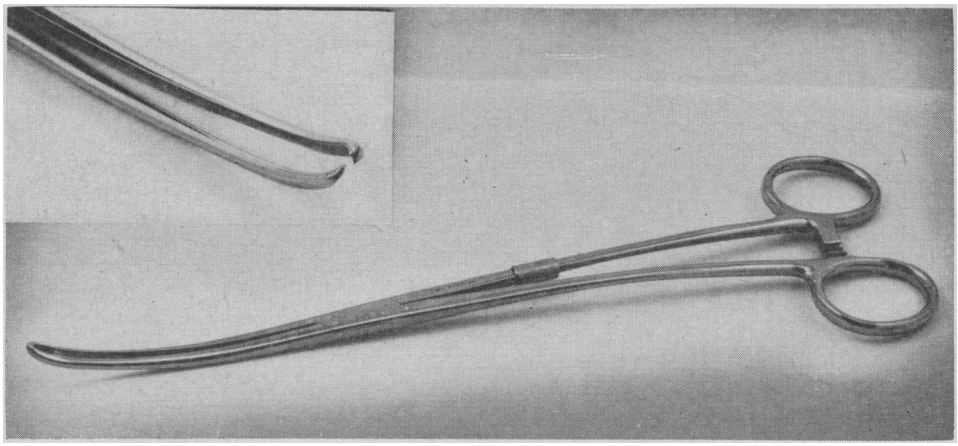

Fig. 1.—Amniotomy forceps.

as in the Allis forceps. Mouse teeth have been placed at the ends of the blades in such a manner that when the blades are closed the teeth are completely hidden, and the ends are smooth and blunt. The forceps is 10¼ inches long and so curved that it can readily be made to follow the volar surface of the index finger through the cervical os. The amnion can be grasped by the fine teeth with ease without fear of damage to the fetal scalp.

Puncture of the forewaters is more readily accomplished if the finger can be swept around the lower portion of the uterine cavity and an area of amnion separated therefrom, but with the instrument described this procedure, although desirable, is by no means necessary.

EMOTIONAL FACTORS AND RHEUMATOID ARTHRITIS

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DESPITE RECENT ADVANCES in the treatment of rheumatoid disease, its cause is still unknown, and there is no cure in the ordinary sense of the word. I would like to point out, therefore, the possible relationship that exists between emotional factors and the onset and exacerbations of the disease, and the importance of dealing with these problems in the total treatment of the rheumatoid patient.

Emotional or psychological factors are usually listed among the etiological agents in standard textbooks dealing with this disease. I think that it is fairly common experience to observe exacerbations or relapses in the rheumatoid condition following emotional stress of various sources. It is perhaps less commonly observed that the first attack of the disease may be preceded or apparently precipitated by similar stress. When such emotional strain has been of an acute nature, circumstantial evidence may point rather strongly to it as a causal factor. I have also been impressed by the frequency with which chronic or prolonged stress may precede the development of rheumatoid disease.

In the first edition of his textbook of medicine[1] in 1892, Osler discussed the etiology of arthritis deformans in these terms: "It is difficult to separate some cases from ordinary chronic rheumatism, but the multiple form has, in all probability, a nervous origin. This view is based on such facts as the association of the disease with shock, worry, and grief; the similarity of the arthritis to the arthropathies due to disease of the cord, as in locomotor ataxia; the symmetrical distribution of the lesions; the remarkable trophic changes which lead to alterations in the skin and nails, and occasionally to muscular wasting out of all proportion to the joint mischief." I do not believe that chronic rheumatoid arthritis is associated with organic nervous system disease, as may be implied from part of the above quotation. I do concur in the suggestion, however, that the "association of the disease with shock, worry, and grief" is so frequent that it may be of more than coincidental interest.

It seems timely to point out, before proceeding further, that the importance of emotional factors has been discounted by many, even after careful appraisal. In Britain the Scientific Advisory Committee of the Empire Rheumatism Council[2] carried out a controlled investigation into the psychological factors in rheumatoid arthritis. "Such factors are widely held to be of importance in precipitating the onset of rheumatoid arthritis. Accordingly both patients and controls were asked a series of questions relating to events occurring before the onset of arthritis that might be expected to produce psychological disturbances. The questions dealt with death, accident, or serious illness in the family, economic embarrassment, broken engagement, or unhappy married life. The

analysis showed no significant difference between patients and controls in the occurrence of these events, and this was true of each individual event as well as in the aggregate; hence the widely accepted view that psychological factors play an important part in the etiology of arthritis is not borne out by this controlled investigation if this view is based on a higher occurrence of such factors in patients as compared with the rest of the population." This concluding sentence must be read in its entirety; the final important modifying clause would seem to allow some room for the possibility of psychological factors being causally related to arthritis. One would like to know, in connection with this survey, more about the incidence of recognized psychosomatic illnesses in the control group; and secondly, one would like to know more about the personality patterns among the arthritic group.

In a group of 43 patients with chronic rheumatoid arthritis under my observation during the past five years, it is thought that a few generalizations can be made regarding emotional stress coincident with or preceding their illness. The onset of arthritis in many instances was associated with loss of support, such as: (a) death of husband or wife; (b) separation from husband or wife; (c) prolonged separation from family; (d) leaving home to become established. It will be noted that these situations could produce acute and short periods of emotional stress on the one hand, or chronic prolonged stress on the other. Regarding the individual personalities it is rather difficult to generalize. However, many of these patients tended to be immature and dependent; they usually tried overly hard to please both in professional and social contacts, and either concealed hostility or expressed it indirectly. Many of them were rather perfectionistic and ambitious. This trait is actually an asset in the treatment program, if controlled, as they are often more zealous and productive in a rehabilitation program than might be expected, considering their physical disability.

Whatever importance can be attached to emotional factors etiologically, there is less doubt as to the need for attention to them as part of the broad therapeutic program. Frequently as much time is needed for dealing with the emotional problems of the patient with chronic rheumatoid arthritis as with the joint or systemic disorders. Of the errors and omissions commonly occurring in practice, one of the most harmful is to infer or say directly to an anxious rheumatoid patient that he has arthritis and "nothing can be done for you". A second common mistake is to tell the worried patient with arthralgia that "it's all your nerves", without a thorough examination and investigation to determine whether or not the "nervousness" is part and parcel of an incipient rheumatoid process, as is so common. Both of these approaches may be construed by the patient as rejection by his physician and may have a harmful effect.

Most of the psychological problems can and should be dealt with by the family doctor or internist, rather than by the psychiatrist. In exceptional circumstances where close co-operation and team work are possible it is rewarding to have psychiatric treatment as part of the combined teamwork approach to the disease. We have also been impressed by the value of casework as provided by social workers trained in the special techniques of professional social casework in a medical setting. As is probably generally known, the successful practice of casework, as in medicine, implies an acceptance of the patient as a person—his interests, desires, strivings and failings; a recognition of his problems; a respect for emotionally determined attitudes towards his illness and the physician; and a willingness to work with the patient in terms of his own way of looking at the world and other people. By decreasing the individual's emotional burdens and increasing his capacity to meet life's frustrations, casework attempts to help the patient make use of his own strengths and the environmental resources. He is thus able to cope with these difficulties more adequately as well as to participate more constructively in the general treatment program.

It has been my experience that, as with recognized psychosomatic disorders, a proportion of patients will benefit as a result of improvement in their psychological attitude. And conversely, many can be helped only a little or not at all, because of too fixed patterns of living and thinking at an age when readjustment is very difficult.

In assessing my group of 43 patients I was interested in the fairly close parallel between the improvement as judged independently by medical standards and the response to casework as judged by the caseworker. For instance, of 13 making marked improvement, 10 were graded as good or fair, and three as poor response to casework; of 15 making moderate improvement, six were classed as good or fair, and nine as poor response to casework; of 15 making only minor improvement, five had a good or fair response and eight a poor response to casework, and two were not referred.

In summary, I think that the emotional or psychological aspect of many rheumatoid patients is of first importance. Whether or not there is an etiological relationship is controversial. However, I believe that rheumatoid disease could be grouped among the psychosomatic illnesses as far as the management of the aggravating emotional problems is concerned.

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