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PSYCHOLOGICAL ASPECTS OF RHEUMATOID ARTHRITIS*

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THE VIEW is gradually gaining ground that rheumatoid arthritis is multicausal in origin. Undue emphasis on any specific factor, such as focal infection, exposure to dampness, heredity, constitution or psychogenesis, fails to do justice to the complexity of the problem. Rheumatoid arthritis, in the view of the authors of this article, is a stress disease and represents a maladaptation to psychobiological stress.

The present study concerning the relevance of emotional factors to the etiology of rheumatoid arthritis has been undertaken because (a) no medical theory adequately accounts for the etiology of this illness, (b) initial hopes of a radical cure of the disease by hormonal compounds have not materialized, and (c) abundant evidence has been submitted in favour of the significance of emotional factors for the onset of the disease, its perpetuation and its relapses.

Our study differs from other psychiatric studies in this area in so far as the siblings of the patients have been used as controls. The focus of the present study has been on one segment of the psychological parameter, namely, on the manner in which patients suffering from rheumatoid arthritis (r.a. patients) deal with their aggressive impulses as compared with their nearest sibling.

BRIEF SURVEY OF LITERATURE

The psychiatric and psychoanalytic literature on rheumatoid arthritis during the past two decades can be summarized as follows:

Nissen and Spencer[13] (1935) pointed out that r.a. patients escape from emotional conflicts through physical or somatic function rather than through fantasy, as schizophrenic patients do.

Thomas[16] (1935) showed in his patients that "a fairly severe emotional disturbance of one kind or another had been present before any sign of rheumatoid arthritis". In his series (31 cases) depressive syndromes are often the important clinical findings. He also found that, in general, the sexual adjustment of rheumatoid arthritics was inadequate.

Booth[2] (1937) mentioned, among other predispositions to chronic arthritis, an urge to be active and an inaptitude to pursue this activity on account of a neurotic defensive attitude.

Halliday[6-8] (1937, 1942) found that r.a. patients tend to show marked restriction of emotional expression and that they are apt to show strong elements of self-sacrifice. He noted that compulsive drives and obsessional trends long antedated the onset of the disease.

Gregg[5] (1939) made a survey of arthritic patients in mental hospitals and was struck, as were Nissen and Spencer (1935), by the relative absence of arthritis among psychotics.

Gordon[4] (1939) and McGregor[11] (1939) demonstrated the relevance of emotional factors to the onset, evolution and exacerbation of rheumatoid arthritis.

Cobb, Bauer and Whiting[3] (1939) made a study of 50 r.a. patients by means of evolving life charts to show the chronological relationships between various events in the lives of the patients and their illness. Their conclusions were that "environmental stress, especially poverty, grief and family worry, seems to bear more than a chance relationship to the onset and exacerbation of rheumatoid arthritis".

Ripley, Bohnengel and Milhorat[15] (1943) felt that the problem of how emotional stress is related to rheumatoid arthritis remains unsettled, but that the field is worthy of further investigation.

Blom and Nicholls[1] (1954) studied a series of children suffering from rheumatoid arthritis. An outstanding feature in the personality structure of these children was a conflict arising from their inability to achieve emotional separation from their mothers.

Meyer[12] (1956) showed that the outbreak of rheumatoid arthritis appears to follow events which upset the equilibrium between the aggressive impulses and their control.

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Few psychoanalytic reports on r.a. patients are available. Groddeck (1928) reported a case of "a woman with spinal arthritis in whom the disease seemed to be a defence against the heterosexual role" (quoted by F. Alexander). Alexander also quoted a case of MacFarlane's in which the symptoms of arthritis had the double meaning of a punishment for the patient's hostile competitive feelings towards men and atonement for her favourite activity – dancing – of which her father disapproved.

Johnson, Shapiro and Alexander[9] (1947) studied 33 r.a. patients of whom 29 were female. They concluded that the majority of these patients learned to discharge hostility through masculine competition, physical activity and servitude, and also through domination of the family. When these methods of discharge are blocked, the increased muscle tonus resulting from inhibited aggression and defence against it precipitates the illness. The authors felt, however, that since these factors are commonly found in patients who do not suffer from arthritis, additional etiological factors would have to be postulated.

Ludwig[10] (1954), reporting on material collected from eight psychoanalytically studied patients seen for several hundred hours each, found a personality pattern which was constant for all the patients studied. Yet the personality pattern observed has also been noted in patients with other psychosomatic disorders and is closely similar to that described by Kardiner in individuals with chronic traumatic neuroses incurred in war. Ludwig states: "The outstanding feature is marked impairment of ego function, manifested by extreme dependence, insecurity, feelings of inadequacy, difficulty in the usual methods of mastering or coping with the environment and with other people, and severe blocking of the external expression of emotion with internalization of feeling and autonomic activity." Ludwig stresses in his writings the presence of depressive features in these cases, but is inclined to classify them psychodynamically in the schizophrenic group and to compare the chronic r.a. patient with the catatonic schizophrenic patient.

MATERIAL AND PROCEDURE OF EXAMINATION

It is generally agreed that it is an almost insurmountable task to find a suitable control series in psychosomatic research because on comparison of two groups, however carefully the control series is matched, there are inevitably uncontrollable variables which defy statistical calculation.

We felt that by comparing two siblings of the same sex (where possible), and as near in age as possible—one suffering from rheumatoid arthritis and the other free from this illness—we reduced the number of variables to a minimum. We realize, of course, that even such a comparison of siblings does not eliminate genetic dissimilarities and different prenatal and postnatal conditions, and also that the healthy sibling, though free from the illness at the time of the examination, may develop it at some future date.

The patients who form the basis of this study represent an unselected sample of r.a. patients attending the out-patient clinic of the two teaching hospitals of McGill University, i.e. the Royal Victoria Hospital and the Montreal General Hospital. A few were private patients of the attending staff. In all patients the diagnosis of rheumatoid arthritis was well established. Altogether, 25 patients were seen. Of these 25, it was possible to see 18 corresponding siblings, and therefore we are reporting only on these 18 pairs. Both the patients and the siblings were seen first by a medical social worker who took a social history and made arrangements then for them to have an interview with a psychiatrist and a psychologist. The psychiatric evaluation consisted in taking from the patient and from the sibling a detailed psychiatric history with special attention to relevant emotional factors related to the onset of the illness. A detailed history was taken of different periods of their lives, i.e. early childhood, childhood, latency period, puberty, adulthood, and menopause and post-menopause when applicable.

The patients and their siblings were subjected to from three to ten one-hour interviews. On completion of the examination a personality formulation was drawn up, using the psychoanalytical frame of reference. Another formulation of their personality was obtained independently through psychological techniques including the Rorschach and the thematic apperception (T.A.T.) tests.

As stated before, the present article is focused on the manner in which the patients and their siblings dealt with their aggressive impulses.

DESCRIPTION OF PATIENTS STUDIED

The age of the patients studied ranged from 20 to 60. Ten were women and eight were men. Six patients were in their 50's, seven in their 40's, three in their 30's, and two in their 20's. In most of the pairs the control sibling was the nearest sibling of the same sex. The difference in age between the siblings was one to three years in 14 pairs, and five to seven years in four pairs. In four pairs the control sibling was not

TABLE I.—DEGREE OF INVALIDISM OF THE PATIENTS STUDIED

	Patient	*Age*	*Sex**	*Marital† status*	*Duration of illness (years)*
Group 1					
Total invalidism; chronic evolution	B.C.	42	F	M-D	12
	I.D.	54	F	S	30
	A.T.	54	F	S	34
	M.D.	50	F	S	10
	F.K.	59	F	M-Sep-W	9
Group 2					
Semi-invalidism; patient self-sufficient within limits, e.g. able to earn or to keep household	J.A.	55	F	M	5
	F.K.	43	F	S	10
	S.C.	40	M	M	13
	R.B.	24	F	M	5
Group 3					
No serious handicaps between recurrent attacks	L.D.	47	M	M	7
	B.T.	24	M	S	1
	M.L.	50	M	S	20
	R.L.	37	F	M	6
	A.T.	47	M	W	25
	R.S.	47	F	M-W-RM	3
	L.G.	31	M	M	2
	S.B.	32	M	M	18
	G.M.	42	M	M-Sep	20

* F = Female; M = Male.
† M = Married; D = Divorced; S = Single; Sep = Separated; W = Widow; RM = Remarried.

of the same sex. In two of these four families there were only two children; in the third family the difference in age between the patient and his nearest sibling of the same sex was too great; and in the fourth family the nearest sibling of the same sex was not available. The duration of time between the arthritic patient's first attack and the time when he was seen varied from one to 20 years. As the severity of the illness is not necessarily proportional to its duration, we have classified our patients in three groups, taking into account the severity of the illness and the degree of invalidism (Table I).

Because the patients were first seen during convalescence or, at any rate, when free from acute symptoms, very few of them were on active treatment at the time of examination. The nature of the treatment given was purposely disregarded in our study because (a) it had greatly varied in many patients during the long span of their illness, and (b) none of the therapeutic procedures, apart from cortisone, are known to influence the patient's state of mind directly. Two patients were on cortisone when seen.

A. GENERAL FINDINGS

(a) *Motor Activity and Aggression in Childhood and During Puberty*

Motor activity, if not overactivity, and impulsiveness were found to be dominant characteristics of the childhood and puberty of the r.a. patients. According to their accounts, they had often been regarded as overactive babies. Many of them had shown a good deal of initiative early in life. This need for motor activity was found to be later canalized into active participation in sports and games, not infrequently at the expense of interest in learning and intellectual pursuits.

In some of these individuals, motor activity assumed a disorderly pattern amounting to unruly behaviour. Three of the r.a. patients had been delinquents and had been sent to a reformatory school. Three others—obvious exceptions to the rule—were quiet, shy and inhibited. However, their manifest behaviour was in marked contrast to their competitive and aggressive fantasies. In these three cases control over aggressive drives seeking outlet in motor action seemed to have been acquired at a very early age.

The corresponding group of siblings—those not suffering from rheumatoid arthritis—showed opposite tendencies in their childhood and during puberty. They were, as a rule, quiet, shy, reserved, and conforming children. Many of them recalled that they had been envious of their active, lively and impulsive brothers and sisters. They displayed definitely less energy than their r.a. siblings as active participants in sports and games or any other type of motor activity, but

greater interest in such sedentary activities as reading or drawing.

Both groups tended to describe one or both parents as strict and rigid. Yet, whereas the arthritics were apt to regard parental demands as excessive and to react to them with impulsive defiance, the non-arthritics either uncomplainingly and unprotestingly accepted similar demands or bypassed them in an unprovocative manner. In most cases the future r.a. patients had got into trouble with their parents while their corresponding non-arthritic brothers and sisters got along with them happily.

(b) *Motor Activity and Aggression in Adulthood*

As r.a. siblings progress from puberty to adulthood, noticeable changes take place. Aggressive, offensive and unruly behaviour may still prevail for some time. Yet gradually and increasingly, as the demands of adulthood arise, restraint in motor discharge is accomplished not infrequently in an obsessional manner. Four of the patients studied presented symptoms of an obsessive-compulsive neurosis; others—the majority—displayed definite obsessive-compulsive character traits.

Among the character traits observed are obsessional striving to be punctual, tidy and perfectionistic. (Opposite traits of character were found in a minority.) Obsessional doubts and brooding are common manifestations of their inability to face a situation demanding immediate action. The externalization of aggression is replaced by self-sacrificing or forgiving attitudes as a reaction formation against display and acting out of aggressive drives. Over-emphasis on and concern about security provided by financial or material values is commonly found, and although many of them are actually poor the misery of poverty is aggravated by the symbolic meaning of money values.

Conversely, a shift from inhibition to disinhibition took place in the group of siblings not suffering from rheumatoid arthritis. After having been shy, self-conscious, obedient and accommodating as children, they gradually developed poise and self-confidence as they grew up. They learned to stand up for their rights, and rather than use reaction formations, as did their arthritic brothers and sisters, they dealt with their aggressive impulses by means of sublimation.

Occasional outbursts of rage were more common and more violent in the r.a. group than in the controls. Yet, while the non-r.a. siblings may flare up and "forget it", the r.a. siblings were apt to be harassed by feelings of remorse and guilt, and subject to obsessional ruminations. It almost appears as if, in deep layers of their mind, they had in fantasy inflicted such grievous harm on the objects of their aggression that their need for self-punishment and for restitution was imperative. Consequently it can hardly be surprising that even on a conscious level they had a greater tendency to curb their aggressive outbursts than had their non-r.a. brothers and sisters.

(c) *Clinical Example*

The D. family was composed of four members: the father, the mother, Paul (born in 1913, brother of the patient), and Jean (born in 1914, suffering from rheumatoid arthritis since 1943). The mother died in 1916; she committed suicide during a depressive psychotic illness. After his wife committed suicide, the father left his two children under the care of the grandparents, Paul being placed with the paternal grandparents and Jean with the maternal grandparents. The father took very little interest in the children afterwards. Two years later he remarried.

Jean. Jean, the patient, was two years old when her mother died and when she was placed with her maternal grandparents who, as she said, were old-fashioned. She felt very lonesome. There was no closeness and no display of affection in the home according to her account. She remembers having felt self-conscious about not being well dressed. She soon became a very disturbed child. Because she was destructive and because she stole, the patient, when 12 years old, was taken to the Mental Hygiene Clinic by her grandmother with a view to placing her in a reformatory school. It had been noted that she enjoyed sewing and embroidering, and that despite her unmanageable behaviour she excelled in these activities. At the Mental Hygiene Clinic, the patient was considered a child of superior intelligence with a mental age superior to her chronological age. However, her scholastic record was very poor. In view of the unsatisfactory situation at her grandparents' home, she was kept at the reformatory school for two years—"the best years of my life", she said. While there, she changed from an aggressive, destructive and delinquent child into an obedient, conforming child. After leaving the reformatory school she became an efficient worker. As she grew older she earned her living by sewing and embroidering. Her work record was good; she was a conscientious, meticulous worker. When she was 19, still hankering for a home and all it stands for, she married. Her husband was an irresponsible

person, unable to provide for the household. He was an habitual drinker and a compulsive gambler. The marriage ended in failure.

Jean's illness started when she took steps to obtain a legal separation. As she felt this to be an aggressive act against her husband, it provoked in her intense feelings of guilt and anxiety.

Comments: Owing to the early death of her mother and owing to her upbringing in the unsatisfactory environment of her grandparents' home, Jean was deprived of parental care and love early in life. Her response to this deprivation was, at first, a longing for an affectionate relationship. Afterwards, it is justifiable to assume, feelings of resentment and of vindictiveness motivated her aggressive and delinquent behaviour. Her antisocial behaviour came to an end at the reformatory school. The facts that she had become an inoffensive individual in adolescence and that she carried out her work activities in an obsessional, perfectionistic manner indicate (a) that her previously outwardly directed emotional economy had been turned inwardly, and (b) that, unrecognized by herself, she had found a new means of obtaining affection, namely, by hard work and flawless performance. Jean, by now, is an obsessional, ruminative person, brooding over her problems, hardly able to externalize aggression which is flimsily concealed by her attitude of resignation and forgiveness.

An impulsive, overactive, destructive, uncontrollable child had been transformed into a peaceful, law-abiding adult with marked obsessional characteristics.

Paul. Paul, who is a year older than Jean, was brought up by his paternal grandparents. Though, like his sister, he was also deprived of parental affection at an early age, he apparently received from his grandparents, and especially from an aunt, sufficient love and affection for his requirements. Because he lived with his father's parents, he saw his father quite frequently. When Jean was seen at the Mental Hygiene Clinic and was described by the maternal grandmother as an impulsive, destructive child, the paternal grandmother was also interviewed and described Paul as "a lovely child, an angel". Despite efforts on the part of the family to prevent the children from seeing each other, they met fairly frequently as they lived in the same district. According to Paul, Jean was a "tomboy" . . . "she could climb an appletree, she could fight and skate like any boy". She was very aggressive with Paul; he said that he received "a good walloping" from her. He was a shy, timid and sensitive boy.

As Paul grew older, especially at puberty, he became less inhibited and more active in his teenage gang which he led in some semi-delinquent activities. As an adult, he gambled, drank heavily and engaged in promiscuous activities. His marriage, like that of his sister, ended in failure. Paul obtained a divorce and remarried some years afterwards. His second marriage is moderately successful. Within recent years he has managed to keep out of serious trouble.

Comments: Paul, like his sister, showed marked signs of emotional immaturity; like her, he went short of affection as a child, though he felt, and probably was, less frustrated than she was. The paternal grandparents and his aunt were fairly satisfactory substitutes for his parents. He had enough contact with his father to allow him an identification of some sort.

The clinical example selected shows a striking difference in motor activity between these two siblings. Jean started her life by being a hyperactive, impulsive child suffering from an acting-out disorder, and eventually became an obsessional person. Paul, by contrast, started off by being an inhibited child and eventually became an impulsive individual suffering from an acting-out disorder. The extreme tendencies shown in this pair of siblings (overactivity in childhood and inhibition of motor activity in adulthood for Jean, and the reverse for Paul) was a tendency found to a variable extent in most of the pairs studied.

B. Details of Findings in 18 Pairs—Discussion

As has been shown, the most significant difference between the two groups of siblings studied has been the manner in which they dealt with their aggressive drives. The r.a. patients were inhibited in display of aggression (before their illness) whereas, by and large, no such inhibition existed in their non-arthritic brothers and sisters. As might be expected, the degree to which the two groups differed in this respect varied to some extent in the 18 pairs studied.

The difference between the two groups was particularly striking in three pairs of siblings. In these three pairs the emotional life of the r.a. sibling was reduced to obsessional ruminations of an aggressive content without any outward display of aggressiveness. The three corresponding non-arthritic siblings, by contrast, could be classed as impulsive neurotics. None of the three siblings who acted out their aggressive impulses neurotically suffered from psychosomatic illness or showed evidence of conversion hysterical somatization of conflict.

Twelve other non-r.a. siblings were found to be more capable of discharging their aggression outwardly than were their brothers and sisters who suffered from rheumatoid arthritis. The degree of this capacity to discharge aggression outwardly ranged from gross to minimal qualitative and quantitative differences.

The greater the inhibition of expression of overt aggressiveness in the non-r.a. siblings, the greater was their tendency to develop and to display obsessional features and psychosomatic symptoms. Of the 12 non-r.a. siblings in this group, three were suffering from migraine, one from obesity, one from essential hypertension, and one from ulcerative colitis.

In the remaining three pairs in whom no appreciable differences could be observed, inability to verbalize thought and feeling made a reliable comparison well-nigh impossible.

The findings thus far reported allow the following preliminary conclusions:

1. Persons who suffer from rheumatoid arthritis are characterized in their premorbid personality by a marked inability to give overt expression to aggressive drives.

2. Such inhibition is not noticeable, or at least not to the same extent, in their non-arthritic siblings.

3. Non-arthritic siblings who, similar to their arthritic brothers and sisters, are inhibited in expression of aggressiveness frequently suffer from psychosomatic ailments other than rheumatoid arthritis.

4. Psychosomatic ailments, such as eczema or migraine, not infrequently precede the onset of rheumatoid arthritis.

5. The choice of psychosomatic disorder, i.e. migraine versus rheumatoid arthritis, is probably determined by a multiplicity of factors of which one is the severity of the personality disorder. Siblings suffering *only* from migraine were somewhat better organized in their personality structure than those suffering first from migraine and afterwards from rheumatoid arthritis.

C. PSYCHOLOGICAL TESTS

Thirteen pairs out of the total of 18 were studied by means of psychological tests. An I.Q. was taken to allow a better comparison of the projective tests, particularly in cases where the siblings were of very different intellectual levels. The projective tests administered were Rorschach and T.A.T. For a variety of reasons only the Rorschach findings will be reported.

With a view to establishing the possible comparative difference between the patients suffering from rheumatoid arthritis and their non-r.a. siblings, we studied two points in the Rorschach: (1) the way in which psychic energy is liberated (whether in accordance with introversive or an extroversive tendency), and (2) the degree of restrictive control (repressive or constrictive control).

In eight pairs out of the 13 pairs studied there was a gross difference between the two groups under comparison. In all of them the patients suffering from rheumatoid arthritis showed pronounced signs of introversion with a repressive control, whereas their non-arthritic brothers and sisters showed a pronounced tendency towards extroversion. As the chief means of discharging his psychic energy, the r.a. sibling seemed to turn to his own inner life, and as a means of control he used repressive mechanisms. The non-r.a. sibling in this group of eight pairs, on the other hand, seemed to succeed easily in releasing his energies when required by external demands (promptings from without), and he used fewer repressive mechanisms.

In three of the remaining five pairs the personality differences were very slight. Both groups showed about the same degree of introversion or extroversion, and they all used repressive controls to the same extent. In two pairs the non-r.a. siblings showed introversive tendencies, but in these two pairs the siblings suffering from rheumatoid arthritis showed such strong repressive mechanisms that they completely hid any indication of a preponderant tendency to introversion or extroversion.

The psychological studies of these 13 pairs, when correlated with the clinical findings, closely corroborated the clinical assessment. When psychological testing showed minimal or no differences between the r.a. and non-r.a. siblings, the latter were found to be suffering from a psychosomatic illness other than rheumatoid arthritis.

It may be objected that the differences in Rorschach findings were due to the fact that one group of the subjects under investigation was suffering from an incapacitating illness whereas the other group was unrestricted in motor activity by illness. This argument is hardly valid because only two of the arthritic patients who were given the Rorschach were total invalids and three were semi-invalids. The other eight siblings in this group were capable of normal motor activity. Also, in the control group the siblings suffering from a psychosomatic illness other than rheumatoid arthritis present the same

signs of introversion with repressive control, though motor activity is unimpaired.

D. Correlation of Psychiatric Findings with the Onset and Evolution of Rheumatoid Arthritis

The natural history of rheumatoid arthritis varies a great deal. The illness may occur once in a lifetime and never again. It may appear in periodic attacks separated by asymptomatic periods with more or less residual damage, or it may take a chronic evolutive course from the beginning with irreversible change.

Attacks of rheumatoid arthritis are frequently precipitated by an overwhelming situation in which the conscious or unconscious urge to discharge aggressive impulses is counteracted by conscious or unconscious fear of the consequences and guilt over wrongdoing. The overwhelming situation is very often the loss of a highly valued, yet ambivalently regarded, person, the r.a. patient being unable to tolerate the aggression revived in the grief reaction.

The severity of the illness seems to be proportionate to the severity of the impairment in the capacity to express aggression.

In those r.a. patients in whom the illness took a chronic evolutive course from the beginning, it seems that the precipitating events were such that the emotional economy failed irreversibly, i.e. the previous homœostasis could not be re-established.

Representative of this type of chronic invalidism is the case of Miss H., aged 50. Since the beginning of her illness in her early 20's, she has been unable to support herself. The onset of her illness was precipitated by the death of her father. After his death she became unusually dependent on her mother. The mother's death, ten years after that of the patient's father, led to an acute exacerbation of the previously unspectacular dragging disease. Subsequently, again and again—in vain—she tried to find substitutes and replacements for her lost parents and for the security and love which they represented. Rejection—emotional desertion and desertion through death—by any of these substitutes was invariably followed by acute exacerbations of her rheumatoid arthritis. All available treatment has failed to bring tangible relief or remission in the course of her illness.

Different psychodynamics prevailed in those patients whose illness was characterized by *recurrent* attacks separated by relatively asymptomatic periods. These patients seemed to be able to re-establish, totally or partially, the mechanisms of defence which were operative before the overwhelming precipitating events occurred.

Representative of this type of case is Mr. C., aged 40. At the time of examination Mr. C. had suffered from rheumatoid arthritis for nearly 12 years. Though handicapped a great deal by his illness, he has not been crippled by it to such an extent as to interfere seriously with his capacity to earn his living. As a child he was aggressive, rebellious and stubborn to the point of being obstreperous. Afterwards he learned to control his aggressiveness, and was in fact inhibited to some extent in motor expression and in his ability to stand up for himself. The onset of his illness was precipitated by an increase in responsibility at work which he felt unable to face and by a serious accident which happened to him when he was performing his new duties. After the first attack of his illness was over, he asked to be demoted despite the substantial loss in income involved. Subsequently he returned to the previous level of his employment, on which he was able to function without much difficulty. He responded with violent feelings of anger to any situation which he regarded as a blow to his self-esteem, but did not attack his opponent either in action or even in words. He said to the interviewer: "I would really fight were it not for my handicapping illness." His illness, it is true, prevented him from using physical force, but obviously it did not prevent him from expressing his aggression verbally. The illness provided him with a convenient rationale for his inability to externalize aggression.

E. Therapeutic Implications of Findings

The contribution which the psychiatrist can make to the treatment of r.a. patients obviously varies with the state of the patient.

1. In the acute phases of the illness the role of the psychiatrist is necessarily limited. A person with acute pain, with swelling of the joints and a high temperature, is a poor candidate for psychiatric investigation. Exceptions to the rule are those patients whose illness has been precipitated by an acute and severe emotional disturbance. In such cases a psychiatrist may be called in to assess the patient's emotional state and to deal with the emotional crisis which may have arisen. This can usually be achieved by a series of brief interviews aimed at reassurance rather than at interpretation of deep-seated conflicts.

Typical of many other patients is the case of Mrs. L., aged 50, who was seen in an acute stage of her illness. When asked by the social worker employed

on this project whether mental upsets had something to do with the recurrent attacks of her illness, she replied: "The history of my illness fluctuates with my husband's illness."

The following history was obtained by the psychiatrist:

Mrs. L.'s husband has been seriously ill for the last three years; the possibility of cancer has been considered. He is an unskilled labourer. Even when he was still employed, Mrs. L. used to work as a charwoman to augment his meagre wages. According to herself, she had been a cheerful woman able to face adversity of any sort up to the time when her husband took ill. With the onset of his illness she became depressed and soon afterwards she was unable to work. Suicidal ideas appeared. A recurrent dream in which she sees her husband abandoning her for another woman has disturbed her greatly.

Shortly after the onset of her husband's illness, she started to suffer from rheumatoid arthritis.

Her grief can be understood in the light of her history. She was brought up in a poor family and was one of many children. At the age of 19 she married, very much against her wishes, a man of her father's choice. She was very unhappy in this first marriage despite relative material security; one reason for her unhappiness was her husband's jealousy. He died after they had been married for seven years. Soon after his death, she fell in love with her present husband, whom she married against her family's wishes. Her husband may not have given her financial security but up to the time of his illness he had given her emotional support which she badly needed. The possibility of losing him grieved her deeply; yet, at the same time, unrecognized by herself, she also resented what was to her a "desertion".

Psychotherapy during the acute phase of her illness consisted largely in reassurance. Arrangements were made to alleviate her precarious financial situation. The doctor who attended her husband put her mind at ease regarding her husband's condition. Gradually she regained her lost sense of security. When the acute phase of the illness was over, psychotherapy was shifted to a deeper level.

2. Measures prescribed during the recovery phase of the illness with the aim of restoring motility often fail. The failure of routine rehabilitative measures may be due to the fact that the motor handicaps are functional rather than structural in nature. Motor inhibition in patients suffering from rheumatoid arthritis, as has been pointed out above, is related to their inability to tolerate the upsurge of aggressive impulses. Analysis, even if only partial, of the emotional conflicts underlying the motor inhibition improves the chances of recovery and may prevent permanent disablement on functional grounds.

Illustrative of this kind of mechanism and its resolution is the case of Miss C., aged 50, who has suffered from rheumatoid arthritis for the past two years.

Six months before she had been hospitalized because of an exacerbation of her illness. When the acute symptoms subsided, the internist advised her to resume her work as a seamstress. This she refused to do owing to persisting aches and pains. Because, in the opinion of the internist, her handicaps were functional rather than structural in origin, psychotherapy was recommended.

When Miss C. came to see the psychiatrist she unburdened herself freely but failed to establish any connection between her emotional difficulties and her physical illness.

She had lost her father early in life and had spent most of her life with her mother, who had died during the year preceding her illness. Her ties to her mother had been very close. In fact, she had devoted herself to her mother to such an extent that she had never considered the possibility of marriage while her mother was alive. Though her mother had obviously been a millstone around her neck, the patient spoke of her in none but adoring terms. Her attitude towards her physician was a similar one. She could not find enough words of praise for his skill and kindness. Likewise, all physiotherapists with whom she had come into contact during her prolonged illness, according to her account, had been paragons of their profession. It was easy enough to recognize that this attitude of exaggerated gratitude and praise covered up a deep sense of resentment which could be better understood by an exploration of her relationship to her mother. It soon became evident that the mother had been over-possessive and over-protective towards the patient, whom she used as a crutch to lean on after her husband had died. It also became evident that, unrecognized by herself, the patient used her doctors as mother substitutes. Advice given to her to return to work was experienced by her as a rejection to which she responded by a display of helplessness and, rather illogically, by expressions of exaggerated gratitude and praise. Her conflict over aggressiveness in relation to her mother was too deeply buried to be exposed to the full; yet, as a result of the psychotherapy, the patient gained some insight into her hostility towards her physicians and physiotherapists whom she highly praised.

After the fourth interview, she was able to return to work but not before she could persuade the psychiatrist to accept a gift which was seen, but not interpreted, as a token of reparation for the aggression which she had been enabled to verbalize. Her aches and pains were still present but were less intense and less frequent than before.

3. Intense psychotherapy seems to be indicated for patients in whom emotional problems are found to be of crucial importance for the etiology and evolution of the disease. The type

of therapy to be given would obviously depend on the nature and severity of the personality disorder, on the insight of the patient and his willingness to undergo treatment, and on the treatment facilities available.

4. In all patients suffering from rheumatoid arthritis, awareness and understanding of the emotional problems underlying the illness and resulting from it on the part of all members of the therapeutic team seem to enhance the prospects of successful treatment.

SUMMARY AND CONCLUSIONS

1. The motor activity of 18 patients with rheumatoid arthritis (r.a.) has been compared with the motor activity of their nearest siblings free of the illness. The comparison shows that the r.a. patients are overactive as children but inhibited later in life (before their illness), whereas their siblings who are free of the illness start life with normal or inhibited motor activity and seem to be able to use their motor apparatus successfully for instinctual discharge later on in life.

2. Motor overactivity early in life in the r.a. patients seems to serve as an outlet for aggressive drives in a socially acceptable or unacceptable form. After puberty, overactivity is progressively abandoned as an inadequate means of expression of instinctual drives as well as a psychological defence against them. Deprived of discharge of instinctual tension in movement and impulsive action, the r.a. patients take recourse to aggressive fantasies which give rise to feelings of guilt and anxiety.

3. The intensification of these incompletely recognized, intolerable, aggressive fantasies (and the concomitant guilt and anxiety) by disturbing events in the patient's life history often precedes and probably precipitates the onset of rheumatoid arthritis.

4. The comparison of the Rorschach findings in 13 r.a. patients with the findings in the 13 nearest siblings free of the disease corroborated closely the clinical assessment.

5. The severity of the illness seems to be proportionate to the severity of the impairment in the capacity to express aggression.

6. The psychotherapeutic implications of these findings are discussed with clinical examples.

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RÉSUMÉ

L'activité motrice de 18 malades souffrant de rhumatismes chroniques inflammatoires fut comparée à celle de leurs plus proches frères ou soeurs. La comparaison a montré que ceux-là étaient hyperactifs pendant l'enfance et devenaient inhibés avec les années même avant de tomber malade, alors que ceux-ci au contraire commençaient par une activité motrice normale ou inférieure, et semblaient capables plus tard de se servir de leur appareil moteur pour satisfaire leurs impulsions. Cette hyperactivité du début chez les rhumatisants semble servir à l'extériorisation de tendances agressives sous une forme socialement acceptable ou inacceptable. Après la puberté, cette hyperactivité décline progressivement et ne sert plus comme un moyen d'expression des poussées instinctives ni comme défense psychologique contre elles. Privés de ce moyen de libérer leur tension instinctuelle par le mouvement et les actions impulsives, les malades atteints de rhumatisme ont recours à des fantasmes agressifs qui, par la suite, donnent naissance à des sentiments d'angoisse et de culpabilité. L'intensification de ces fantasmes agressifs intolérables et mal identifiés, de concert avec l'angoisse et la culpabilité qui les accompagnent, bouleversent la vie du malade, précèdent souvent et peuvent même déclancher le début de l'arthrite. Ces constatations cliniques furent corroborées par l'interprétation des épreuves de Rorschach de 13 rhumatisants compararée à 13 de leurs plus proches frères ou soeurs. La gravité de la maladie semble proportionnelle à leur incapacité à exprimer l'agression. Les auteurs se servent d'exemples cliniques pour discuter les implications de ces données.

TRAVELLING TO AUSTRALIA?

The General Secretary will be glad to be notified of the plans of any member of The Association who is contemplating a trip to Australia early in 1958. The Tenth Session of The Australasian Medical Congress will be held in Hobart, Tasmania, March 1-7, and The Association has been invited to nominate a representative.