McGILL UNIVERSITY

THE PERSONALITY OF RHEUMATOID ARTHRITIS PATIENTS

A study of eighty rheumatoid arthritis patients
from the clinics of three Montreal hospitals, 1952

A thesis submitted to

The Faculty of Graduate Studies and Research

in partial fulfilment of the requirements

for

The Master's Degree in Social Work

by

A. Lewis Bennett

Montreal, August 30, 1952.

ACKNOWLEDGEMENTS

Grateful acknowledgement is made to Dr. L.G. Johnson of the Royal Victoria Hospital, to Dr. E.R.Watson and Dr. G. Fiske of the Montreal General Hospital, and to Dr. R.A. Hughes of St. Mary's Hospital, who supplied cases for this study.

My sincere thanks are due Dr. E. Wittkower and Dr. A. MacLeod who made this study possible. Their direction and stimulation in designing the research and their assistance throughout the study was most valuable.

I wish to express grateful appreciation to Dr. J.J.O.Moore, Miss E.R. Younge, Mrs. J. Smith and Mr. R. Marier for suggestions, assistance and criticisms which enabled completion of the study.

To Mrs. R.Sortor, who assisted in arranging appointments with patients, and to Miss Quinn who assisted in supplying cases at Royal Victoria Hospital, I am indebted.

A last, but far from least, acknowledgement is due the patients interviewed by this writer. Their cooperation not only made the study possible but provided whatever pith the reader may discover in the material presented here.

A. Lewis Bennett.

CONTENTS

TABLES

CHAPTER I

INTRODUCTION

This is a study of the personality of rheumatoid arthritis patients specifically concerned with the characteristic ways in which these patients may deal with interpersonal relationships, influences which appear to be involved in the development of such behavior patterns, and the relationship of the illness to the personality manifesting these characteristics.

This is one of four sections of a pilot study which aimed to discover the influences, stresses, tensions and adjustments in the social field of the patient and how these are related to the precipitation, course, outcome, and possible prevention of the illness. This pilot study was conducted by four social workers under the direction of two psychiatrists and a professor of McGill University School of Social Work. It comprises the present study of the personality and studies of the patient's parent family, present family adaptations to illness, and, the illness in various aspects. Each of four social workers interviewed twenty patients diagnosed as suffering from rheumatoid arthritis and obtained information through an interview, the schedule for which was developed in cooperation with the psychiatrists. Each worker's interviews dealt with all aspects to be studied, and each had copies of interview material concerning eighty patients from which each will report one of the four sections mentioned.

This and other pilot studies of specific disease entities are designed to open the way for and to develop and test methods to be used

in a larger study which has the aims of determining adverse environmental factors responsible for mental ill-health and of eliminating them at the source. This major project, which, with the pilot studies, is under the direction of Dr. Eric Wittkower, also includes plans to make parellel studies in rural and industrial communities to learn how the pattern of illness is altered by the type of community life.

Rheumatoid arthritis was chosen as the specific disease entity for this pilot study because it is a fairly common disease; it is recognized as psychosomatic and does not require elaborate diagnostic procedures which may be lacking in out-of-the-way areas.

The present study of personality is thus seen to involve the concept of psychosomatic illness in relation to rheumatoid arthritis; it also relates to a larger study involving broad concepts of the interplay of emotional, social and environmental factors affecting individual and community physical and mental illness. Therefore, background material on the study appropriately includes some definitive discussion of rheumatoid arthritis, including psychosomatic factors, based on findings of previous studies. It will also include discussion of some concepts related to the whole study and the approach to this specific section. Outline of the purpose, scope and limitations of the pilot study and of this particular section of the pilot study and the methodology of these levels of the study will be discussed in Chapter II.

Background for the Study

The Pilot Study

About 2400 years ago Plato observed that it was the great error of his day that physicians separated the soul from the body. Modern interpretations of illness eliminate this error and recognize that physical and psychical factors are present in the symptoms which express the difficulty being encountered in the organism and in its function.

The concept that the organism maintains a balance or equilibrium for most efficient functioning is most easily illustrated by reference to the processes observed as perspiring and shivering which are involved in the maintainance by the body of "normal" temperatures, etc.

This equilibrium controls the interactive functioning of all parts of the organism. Therefore illness may be seen as a disturbance of that balance and the fevers, lesions and other symptoms as evidence of the forces within the organism struggling to restore it.

This concept of a functional equilibrium may be applied not only to the physical and psychical interactions within the individual but, with modifications, to the members of the family as an organic unity, as Richardson [1] has applied it, and to the members of a community.

This reference to equilibrium in the physiological systems and in the psychological field is intended to be somewhat analogous rather than definitive. Krech and Crutchfield [2] state that equilibrating or

---

1. H.B.Richardson, Patients Have Families, (New York;1945),p.76.

2. Krech and Crutchfield, Theory and Problems of Social Psychology, (New York, 1948), pp.66-67.

self-regulating physiological systems are static; they bring about a return to the same stable state - e.g. of temperature or the concentration of carbon dioxide in the blood. Equilibrium in the psychological field is dynamic, " a history of changing equilibria, in which the psychological field restructures constantly, never returning to a state in which it existed before". This restructuring constantly tends to the reduction of tension and a more stable state, though the individual's action to reduce tension may not be aimed at achieving equilibrium. When this restructuring results in equilibrium at progressively higher levels it may be related to growth and health; when it results in equilibrium at lower levels it may be related to regression and illness.

Rheumatoid arthritis is one of the diseases which, it has been suggested, are due to stress, tending to disturb equilibrium in the physical and in the psychological or emotional and social fields. The concept of psychosomatic medicine described by Deutsch as "the systematized knowledge of how to study bodily processes which are fused and amalgamated with emotional processes of the past and present" [1] implies the relationship between these stresses and illness.

Several studies of the psychodynamic background of rheumatoid arthritis have been conducted in recent years. Johnson, Shapiro and Alexander, [2] following their study, described that background as a chronic,

---

1. Felix Deutsch, "The Use of the Psychosomatic Concept in Medicine", Reprinted from the Bulletin of the Johns Hopkins Hospital, Vol.80, No.1. (Jan. 1947), p.71.

2. Adelaide Johnson, et al, "Preliminary Report on a Psychosomatic Study of Rheumatoid Arthritis", Psychosomatic Medicine, Vol. 9, (Sept-Oct. 1947).

inhibited, hostile aggression, exhibited in the early difficulties of relationship with and dependency upon the mother and subsequently in all relationships, especially the sexual. They examined thirty-three patients of whom twenty-nine were female. They found the female patients generally discharged hostility through masculine competition, physical activity, serving and domination of the family. The illness appeared to be precipitated in relation to events or circumstances which increased the unconscious resentment against men, increased hostility and guilt feelings, and intensified the masculine protest reaction as a defense against fear of sexual attack. As these factors are commonly found in patients other than arthritic they suggested the presence of other etiological factors, still unknown, which might be somatic; inherited, traumatic, or infectious. They considered that increase and reactivation of the emotional conflict was a major factor in relapse and that remissions were related to improvement of the conflict situation.

Booth [1] concluded that there was in these patients a predisposition to this illness. He found that they satisfied libidinal drives through physical activity and that, when their vitality was no longer sufficient to meet the demands of their situation in which they were attempting to maintain equilibrium, illness resulted.

Cobb, Bauer and Whiting [2] emphasized environmental stress, especially poverty, grief, and family worry, which they found closely coinciding with onset and exacerbations of the illness.

---

1. Gotthard C.Booth, "Psychological Factors in Rheumatic Diseases", The Practitioner, Vol.143, p.627

2. Stanley Cobb, et al, "Environmental Factors in Rheumatoid Arthritis - A Study of the Relationships Between Onset and Exacerbation of Arthritis and the Emotional or Environmental Factors", Journal of the American Medical Association, Vol.113, No.8,(1939),pp.668-670.

Thomas [1] found a previous history of neurosis and onset of arthritis during a severe emotional conflict to be common to many cases.

Weiss and English, [2] in consideration of the several views, state:

> It is gradually being recognized that the emotions have something to do with the disease but what part they play is not understood. The prevailing view is that if a person develops such a painful and crippling disease, it is no wonder that he is nervous. The opposite point of view would be that the cart is placed before the horse in this attitude - that arthritis is largely due to a response to certain strong emotional influences which arise within the individual and influence the function of the joints. Then there are those who traverse the middle of the road and feel that it is neither wholly one nor the other, but that many factors are at work of which the psychic factor is only one - sometimes important, sometimes not, and sometimes missing altogether. This is our belief.

Rheumatoid arthritis is considered to be the greatest crippler and most significant of the various types of arthritis. The highest incidence is in the most productive years of life and the illness has as concomitant constitutional symptoms low vitality, anemia, fatigue and loss of appetite and consequent loss of weight in many cases. Its course fluctuates through progressive crippling of the joints and frequently involves chronic invalidism.

The most generally accepted programs of treatment include careful management of diet, elimination, rest and activity, treatment of anemia, and cautious removal of foci of infection. The results of treatment and research with cortisone, ACTH, and Compound F have caused most medical authorities to feel that these offer hope for a specific remedy in the future.[3]

---

1. G.W.Thomas, "Psychic Factors in Rheumatoid Arthritis", American Journal of Psychiatry, Vol.93, No.1 (Nov.1936).

2. E.Weiss and O.S.English, Psychosomatic Medicine, (Philadelphia and London, 1949), p.738.

3. Holbrook and Hill, Manual of Rheumatic Diseases, Chicago 1950, pp. 15-16.

The Study of Personality.

The schedule set up to obtain information for the pilot study did not directly anticipate the needs of this section. A picture of personality would have been developed if the pilot study had been reported jointly. In the academic requirement of separate reporting by each of the four social workers the possibility of obtaining this picture was lost. Therefore it was decided to devote one section specifically to the personality of the patient adapting the material obtained as best as possible. Consequently this study must proceed under the disadvantage of information that is lacking in some areas and that is at the best fragmentary.

As the study of personality is exceedingly broad in any case, and as no agreement has been reached by authorities regarding the nature of personality, it was necessary in the beginning to decide on a much narrower focus from which to approach the subject. In view of observations from other research, it seemed advisable to concentrate on the manner in which the rheumatoid arthritis patient handles his relationship to other people.

The possibility of making a satisfactory study of this one behavioral area of personality, and the feasibility of concentrating on the individual's conflict between certain basic drives or impulses, and the demands and influences of interpersonal relationships are indicated by the following definitive statement of personality by Kluckhohn and Murray:

> Human personality is a compromise formation, a dynamic resultant of the conflict between the individual's own impulses (as given by biology and modified by culture and by specific situations) and the demands, interests, and

> impulses of other individuals.... An individual may be over-socialized in one sector of his behavior, adequately flexible in others, inadequately socialized in another behavioral area. [1]

In the literature and from discussion with doctors there appear to be certain commonly recognized characteristics of arthritis patients. This picture of the arthritis patient appeared to be supported by impressions derived from observations of the 20 patients interviewed by the writer. The characteristics referred to are as follows:

(a) That persons who develop rheumatoid arthritis have difficulty in forming satisfying relationships with other people. They are unable to commit themselves fully in any love relationship and remain relatively detached even from those with whom they are intimately related. At the same time they have difficulty in controlling their temper and they try to avoid situations which would require them to exercise foresight and restraint before asserting themselves.

(b) That the inability of these people to accept any situation which deprives them of their independence is very marked and their struggle to maintain their independence is continued throughout the course of their illness.

(c) When faced with a problem these persons have little ability to sit down and think it through, tending rather to resort first to action which is made up of generalized non-goal-directed muscular activity such as general restlessness.

(d) These persons rely to a great extent on muscular activity to provide pleasurable tension release as is borne out by the number of active

---

1. Kluchhohn and Murray, Personality in Nature, Society and Culture, (New York, 1949), p.27.

pursuits in which they engage.

It was decided to examine the material obtained through the interviews from the standpoint of the above formulation.

The principal question posed, then, is: Is there evidence that arthritis patients do have characteristic ways of dealing with interpersonal relationships; and if so what are these?

This question will be approached through more specific questions regarding the patients' performances in several crucial life areas as follows:

How do these patients express themselves in the area of

1. Extrafamilial Relations

    (a) work relations
    (b) social relations

2. Intrafamilial Relations

    (a) parent family relations
    (b) marital relations?

(Note: It is to be further noted that this attempt to arrive at an understanding of the arthritis patient's personality will depend upon material provided by the patient about himself)

Having examined the patients under study in terms of the above characteristics it was felt that some attention should be given to their development throughout the life span. A secondary question, therefore, is: What experiences has the patient met at various developmental stages in his life and how has he reacted to them? (Specifically excluded from consideration here are constitutional factors.)

CHAPTER II

THE STUDY

Purpose

The purpose of the comprehensive study, to which the pilot study is preliminary, has been given as that of determining adverse environmental factors responsible for mental ill-health and of eliminating them at the source. [1]

This broad statement of general purpose becomes more specific in terms of the two parts of the study. The first part would have the purpose of investigating, through pilot studies, a specific disease entity which would allow easy entry into the community, and then, of assessing the value or otherwise of the reparative and compensatory efforts on the part of the individual on the one hand and the community on the other in the attempt to master the situation caused by the illness. The present pilot study is related to the purpose of this first part. The second part would have the purpose of attempting to discover the effect of two different forms of community life on the pattern of illness within the community. The correlation of psychosomatic disorders with the socio-psychological factors would be enabled by analysis of the various psychological stresses in two differing forms of community, agricultural and industrial.

In addition to accomplishing its part of this general purpose, the present pilot study serves per se the important purpose of discovering the problems involved in selecting samples for study, and developing, testing and improving methods and techniques of obtaining and assessing the material to be studied, so that future studies may be more efficiently carried out.

---

1. Supra, p. 2

The purpose of this particular section of the pilot study is to produce a picture of the personality of rheumateid arthritis patients in the aspect of interpersonal relationships, to discover the characteristic ways in which they behave in these relationships and how this behavior is related to the illness. It is also purposed to study the factors which appear to be involved in the development of such characteristic behavior or personality patterns. [1]

Scope and Limitations

The concepts underlying the study indicated the need for a unit of study larger than the individual. A purely arbitrary unit of the total social field was chosen for the initial study. This social unit comprises the family formed by the parents of the patient and includes all the secondary families subsequently formed by the patient and his siblings.

One hundred persons attending the Out-Patient Clinic at Royal Victoria Hospital and diagnosed as suffering from rheumatoid arthritis were to be studied by a team consisting of a physician, a psychiatrist, a psychologist and four student social workers. The physician would study the patient from the standpoint of internal medicine; the psychiatrist, from that of personality structure, ego development and methods of emotional adjustment; the psychologist, from that of intellectual ability and fixed character trends as revealed by various test procedures. The social workers would study the dynamics of the interpersonal relationships of the patient both with regard to his immediate family, occupation, recreation and community activities and compare these relationships with those of his siblings acting

---

1. Supra, pp. 8 and 9.

as controls. They would also attempt to assess the effect of his illness on these relationships, and to study the reaction of the community to him and whether this reaction helps or hinders his recovery.

This phase of the study to be conducted by the student social workers, would be carried out by studying the behavior of the family as it develops over the course of the years, assessing the strength in this family of those forces which tend to keep the various members together, and comparing the strength of these forces in the parent family with those in the families of the siblings. It would also entail study of the incomes, occupations, and occupational stability of each member of the family, and the adequacy of the family income. The attitudes of each member of the family to other members, the attitude of the family to the neighbors and the attitude of the neighbors, as the members of the family see it, would also be studied. Finally, an attempt would be made to have a picture of the social field prior to the outbreak of the illness and to show how this illness changed the social circumstances.

The social workers' study would also attempt to produce a picture of the patient's personality.

Certain limitations were seen in this plan and additional modifications and limitations were involved as the study progressed. The representativeness of the patients to be studied was limited by the fact that they all came from clinics and none from private practice, obviating the possibility of examining the illness in all social and economic strata. Also, only English-speaking patients could be interviewed as the interviewers speak only English.

Insufficient English-speaking patients were found attending Royal

Victoria Hospital arthritis clinic and it became necessary to take patients from St.Mary's and Montreal General Hospital's clinics. It was necessary to accept some who were not presently attending clinic; and finally, due to time limitations, to complete the study on 80 patients instead of 100. However, the random nature of the sample was not considered to be altered by these additional limitations. The interviewers were limited by lack of transportation also and could only see patients who lived in accessible parts of the city.

Interviews took two and a half to three hours each and it was soon discovered that lack of time and the difficulty of interviewing siblings made the plan of using them for controls impracticable.

The requirement that this study must be reported in four separate theses by the four student social workers imposed a further limitation on the unity of the study.

This section of the study includes a cross-sectional view of the 80 patients in their interpersonal relationships, within the parent and present family, and outside the family, namely, in work and social relationships. It includes an attempt to appraise the developmental influences in the patients' behavior patterns and the relationship of personality characteristics to illness. It is limited to study of the expression of aggressive and libidinal drives and the attitude to responsibility and dependency of the patient in these relationships.

The chief limitation encountered in this section has been noted as the inadequacy of material not specifically obtained in relation to the needs of the section. The other important limitation is in the inability

to draw broad and definite conclusions due to the segmental nature of the whole pilot study, and the lack of controls and verification of information given almost entirely by the patient in one interview. The limitation of subjectivity imposed on the material by the interviewer was reduced considerably by having access to the interviews conducted by the other three social workers, each of whom were responsible for 20 patients.

The limitations here noted do not warrant the conclusion that the study cannot be of value or yield enriched understanding of the disease and its social ramifications. Indeed, less reliance on statistical measures and more reliance on intuitive insights developed by the researcher in a loosely structured situation placing primary value on the patient's own concepts may represent modifications in research technique which necessarily result from a better understanding of the dynamic nature of illnesses such as rheumatoid arthritis.

Methodology

The steps envisaged for the total study to be carried out over a period of five years by sociologists, psychiatrists, psychologists and social workers provide a general impression of the overall methodology. Briefly, they are as follows:

1. Survey of work done in this field.
2. Selection of communities to be compared.
3. Information about each of the communities.
4. Establishment of contact with doctors and local authorities in the communities chosen.
5. Canvassing of hospitals and medical men regarding incidence of rheumatoid arthritis.
6. Training of field workers in interviewing.
7. Psychiatric interviews with sample of or all patients suffering from rheumatoid arthritis.

8. Sociological analysis of the communities chosen by field workers and sociologist.
9. Analysis of material obtained and report on preliminary results obtained regarding rheumatoid arthritis by psychiatrists and sociologist.
10. Approach to problems of mental health based on the lessons learned from the psychosocial study of rheumatoid arthritis. [1]

The methodology of the pilot study consists of library research, original investigation, and consultation.

Literature concerning psychosocial and psychosomatic concepts of illness was perused under the direction of the psychiatrists supervising this study. Literature concerning the physical, emotional, social and economic implications of arthritis and reports of previous research on this illness were studied and from these was derived background material for the study such as was discussed in Chapter I. Also, for this section of the study, some reference was made to authorities on personality.

Interviewing was used as the best method for ascertaining the attitudes and unique reactions of the patients to their illness and general circumstances on which information was required. The technique as used in a casework interview to obtain information, to study and to enable diagnosis of social problems was considered to qualify the student social workers for their part of the task. A schedule [2] outlining the essential information was drawn up to guide the interviewers and to assure uniformity of areas covered by information elicited. Interviews were generally directly only to the extent necessary to obtain the required information within the approximate time allotted to an interview.

---

1. E.Wittkower, M.D. "Memorandum on a Research Project in Social Psychiatry." (A directive concerned with this study).

2. See Appendix A.

Consultation proved a very important method by which orientation was developed, problems of management and methodology were handled, and uniformity and integration of procedure in the study were furthered. These conferences of the directors and members of this research team were held at intervals in relation to the development of the project and provided the main channel through which its direction and the integration of its inter-disciplinary nature moved. Further discussion and evaluation of this process will be included in the final chapter of this study, "Critique of Methodology".[1]

It may be pointed out that the steps in this pilot study followed in part those envisaged for the total project. Eliminated, of course, were the steps concerned with community comparison and the major work of the sociologist planned for the larger study.

The methodology of this specific section of the study, the study of the patient's personality, follows.

The principal question, concerning the patients' characteristic ways of handling interpersonal relationships, will be approached through a cross-sectional analysis of factors on the basis of a key card[2] prepared for this purpose.

In connection with the key card, attention is called to a departure from its usual use for extracting and analyzing material. As indicated in Chapter II[3], in view of the better understanding of the complex and dynamic

---

1. Infra, p. 80

2. See Appendix "C"

3. Supra, p. 14.

nature of certain illnesses, and in view of the acknowledged interaction of researcher with the patient in interviewing, increasing recognition is given to the difficulty of applying statistical measures in studying human relationships, as well as to the probable erroneous impressions given in reporting statistical findings. Likewise the tendency is to give increasing weight to the patient's concept of his own situation as spontaneously reported by him in a loosely structured interview, and to the insights developed by the interviewer through disciplined observation and intuition.

Since this study is in itself in the nature of an exploration as to method of research, it was agreed that full recognition should be given these considerations in at least one section of it. The section devoted to the personality of the patient appeared to be most appropriate for this purpose, since this problem requires the maximum integration and interpretation of material.

In this report, therefore, it will be found that, while using the key card for a general guide, a minimum of use is made of numerical analysis and tabular presentation on the basis of it. Quantitative statements are made in approximations, using such words as "few", "many", "most", etc. Where use is made of specific figures, it is with the acknowledgement that perhaps this is more a matter of convenience than accuracy. The emphasis throughout is on the patient as a changing, non-quantitatively-dissectible being, on the subtle and dynamic nature of the illness, and on the reporter's total impressions concerning the two in interaction with each other and with the environment.

This section of the report is presented as avowedly impressionistic in method of analysis and in presentation.

The second question, concerning the study of developmental factors in the personality of the arthritis patients, has been subject to modification. It was originally purposed to present the development of the personality through material from the three companion studies dealing with the parent family, the present family adaptations, and the illness. However, as these studies are not yet complete the writer must, in order to complete this study within the allotted time, present the results of his own less detailed examination of these areas.

The second question therefore, will be approached through

(a) examination of information concerning influences in
    1. parent family and early life.
    2. present family and work adjustments.
    3. illness in the patient.

(b) reconstruction from this of what seems to be a common developmental pattern.

(c) presentation and discussion of two cases which seem best to illustrate this pattern.

Presentation

The first chapter dealt with general introductory material concerning the study. It included references to social and psychosomatic concepts of illness, the general background information and concepts of rheumatoid arthritis, brief introductions to the whole study and to the pilot study, and the approach to this section of the pilot study.

This chapter, the second, has dealt with the study, its purpose, scope and limitations, methodology and presentation.

The third and fourth chapters will deal with the principal question raised, namely, the characteristic behavior of the arthritis patient in interpersonal relationships, the third chapter with extrafamilial relationships, that is, work and social relations, and the fourth with intrafamilial

relationships, that is, parent family and marital relations.

Chapter five will be concerned with the secondary question, the experiences of the patient and the way in which his characteristic behavior pattern has developed. This will be based on information concerning the parent family and early life, present family and work adjustments, and illness in the patient. (These are the areas to be presented in much greater detail in other sections of the pilot study). It will also contain two case histories illustrating the developmental pattern.

Chapter six will present general conclusions of this study of the patient's personality, and its relationship to the illness.

In the seventh and final chapter the methods and techniques attempted and used or considered and rejected in carrying out this study will be considered and some attempt will be made to evaluate their advantages and disadvantages. The problems encountered and methods used or suggested to improve the approach to and carrying out of future studies will be discussed.

CHAPTER III

WORK AND SOCIAL RELATIONS

Every man is in certain respects
a. like all other men,
b. like some other men,
c. like no other man.[1]

This proposition has seemed to be an acceptable and valuable guide to examination of personality factors in the eighty rheumatoid arthritis patients being studied. These patients are "like all other men" in that they all experience basic human needs and tensions; they must all learn ways of satisfying these needs and reducing these tensions; They all attempted to achieve these satisfactions within the same basic human relationships while protecting themselves against unpleasant or painful environmental influences. Bearing in mind that they are "like no other man" in that they are individuals, each unique in constitution, experiences, and resulting features of personality - with singular capacity in relation to environmental influences - it is purposed to discover whether these patients are "like some other men", those within the group under study, in manner and quantity of reactions to certain situations and influences in the basic relationships involved in work, family, marital and social life.

Since these patients are artificially grouped for purposes of study but actually bear no psychological relationship to one another they are not a "group" and it is precisely for this reason that we are justified in speaking of "the rheumatoid arthritic personality" if a characteristic pattern of self-expression is seen to exist among them.

---

1. Kluckhohn and Murray, Personality in Nature, Society, and Culture, (New York, 1949), p.35.

The four relationships in which the behavior of these patients is studied divide readily into those relationships outside the family and those within. The present chapter will therefore treat the extrafamilial relations, namely, those in work and social contacts, though something of the work relations within the family must be included. The intrafamilial relations, namely, parent family and marital relations will be the subject of Chapter IV.

Work Relations

Analytical consideration indicates that the significant characteristics of the work behavior of these patients concern the incidence and type of employment, the changes and advancement in employment, and the attitudes to authority, responsibility and co-workers. Accordingly some discussion of these aspects will be presented with a summary of the characteristics observed.

Incidence of Employment.

It is first noted that all of the 80 patients have been employed at some time, either as housewives or in gainful employment. It is more significant that, while only 27 are male patients, 61 have volunteered information that they were gainfully employed at some time. Most significant, perhaps, is the fact that 24 of the 46 women who married have had gainful employment since marriage and 6 of these are still employed gainfully and as housewives despite illness.

The following table illustrates this high incidence of employment:

TABLE I

DISTRIBUTION OF 80 PATIENTS WITH RHEUMATOID ARTHRITIS, FROM CLINICS OF 3 MONTREAL HOSPITALS, 1952, BY INCIDENCE OF EMPLOYMENT. (a)

Sex	Marital Status	Totals	GAINFULLY EMPLOYED	
			At any Time	At Time of Study
Totals:		80	58	24
F.	M[b]	46	24[c]	6
M.	M	22	22	15
F.	S	7	7	2
M.	S	5	5	1

(a) Subsequent tables refer to this sample.
(b) All females who had been married at any time are included here.
(c) Information not requested but volunteered. Also, this concerns only gainful employment since marriage.

A glance at this table shows that more than half the married females were at sometime gainfully employed in addition to their occupation as housewife. Of the six who still are so employed despite illness, four work full time to support themselves and their families and do all their housework; two, greatly incapacitated by illness, do factory sewing at home and do much of their housework. Some others, not gainfully employed at the time of study, had been so employed during illness.

Information is not available as to the number of male patients who have held more than one job simultaneously.

The lower incidence of employment, and consequent dependency, among the single patients at the time of the study is significant in relation to findings of greater conflict over dependency in marital relations.

A total of housewifely and gainful employment shows 104 jobs held at some time by our 80 patients. This indicates something of the activity, feelings of responsibility and concern for others, the assertion of independence and perhaps the anxiety of these patients. The tenacity with which they follow this pattern in the face of illness is also indicated.

Type of Employment.

No one works outside all contact with people, but these patients have tended for the most part to have jobs which require the least possible contact and cooperation. Several are taxi drivers; two or three are waitresses, and two are nurses. In such jobs catering to others requires only a superficial and temporary contact. Only two patients had jobs in which the ability to make good relationships was essential; and striking changes occurred in both these cases. One[1] was a man of 46:

> This man, employed twenty years as a laborer, became a foreman three years ago. Until that time he had engaged in much recreation and played with his sons "like a boy". His boss wanted more work but his men would not work unless he was watching them. Unable to agree with superior authority or to exercise it easily with his men, he found the job was "getting" him. He hated having to walk around watching the men continuously. Suddenly his feet were crippled with arthritis and he has been off the job for 7 months.

The other [2] was a personnel manager in a hotel. He, too, was suddenly crippled by arthritis and is now an accountant.

Together with these just mentioned, sales clerks, office workers and a barber make up one quarter of the patients. Three quarters are laborers, domestics or housewives, mechanics, factory workers and deck

---

1. Case No. 16

2. Case No. 55

laborers. There is no salesperson relying on his own relationship ability to make a living. Jobs in which responsibility and concomitant anxiety are avoided and in which things rather than people and physical rather than mental effort are involved are thus seen to be held by most patients.

Changes in Employment

Most of the patients' histories show long records of hard work. More than half of those gainfully employed made changes in employment; but, in view of the nature of the major types of employment concerned this is not significant as they remained in the same general class of occupations. Only six patients showed evidence of significant irregularity and irresponsibility concerning employment. Five of these are single and three of them indicate emotional disturbance sufficiently severe or acute to have secured psychiatric treatment for them.

The most significant observation concerning job changes appears to be that several have changed to jobs in which they are their own bosses, such as taxi driving, carpentry work, shoe repairing and other jobs in which they have their own business. They have generally expressed their satisfaction in becoming thus independent; yet some had not made the change until forced or facilitated by illness. In three of these cases an upward alteration in income accompanied the change in employment. Seven patients showed some advance in their position. In two cases this was due to automatic promotion - and one of them, the foreman previously mentioned, was obviously not happy about it. Five patients had taken courses and had improved their positions deliverately and ambitiously. Several had been forced by illness to make changes, and, in three cases, this had resulted in improved financial condition. In all, one quarter of the patients have shown occupational advancement. Only twleve have shown imagination or concern regarding advancement,

though most patients feel their earnings have never been sufficient. Most of them indicate stoical acceptance of the poor man's lot. Most patients had but very elementary education; some had none; few indicated any attempt to increase their formal education. Sixteen volunteered the information that they had been employed before they were fifteen - some as early as nine. Hardships had been experienced and accepted by most. Twelve showed some concern about their record but few of these were critical of their efforts which are generally in keeping with their most popular criterion of hard work.

The most common attitudes to lack of success or advancement in employment was that the patient was playing the cards dealt him by fate. Many regretted they had always had low earnings, a few commented on their lack of education, but none directly blamed themselves for not making greater progress and few attempted to lay the blame on anyone else. They indicated instead that they had worked hard all their lives, suffered hardships stoically or even cheerfully, but luck or the way of the world was against them.

Responsibility

A strong feeling of responsibility-anxiety is manifest in the work habits and attitudes of most patients. They tend to remain on the job during illness, are frequently meticulous and critical about getting work done, perhaps most particularly about leaving nothing undone. It seems that they cannot stand to be criticized and feel that by getting their work done they will avoid being held responsible. Only five hold what could be considered responsible positions. The eager acceptance of hard work and

the avoidance of positions of responsibility are indicated generally, and suggest that responsibility and trouble have been identified in the experiences of these patients who attempt to escape trouble by hard work and avoidance of positions they identify with responsibility.

Attitudes Towards Authority

Little additional information is available concerning the attitude of patients to authority in work situations, except in their own homes. However, those who volunteered such information indicated that employers expected a great deal, and that when they had a difference with a superior they quit the job. The preference for individual enterprise already mentioned might suggest rejection of authority. An attempt to assess all patients through all information obtained indicates the distribution of attitudes to authority shown in the following table. The last two categories are nearly indistinguishable, in that the patients showed a repressed attitude towards authority in some relationships - particularly with parents and doctors - and rebelliousness in others.

TABLE II

DISTRIBUTION OF PATIENTS BY ATTITUDES TOWARDS AUTHORITY

Attitude Towards Authority	Total	Male	Female
Total	80	27	53
Submissive	10	4	6
Independent but Cooperative	16	8	8
Rebellious	18	5	13
Defiant but Repressed	36	10	26

Only two patients appear to have had positions of authority in employment. The inability of one [1] to exercise authority has been mentioned. The other [2] was also suddenly crippled while personnel manager and lost his job. He did not report any difficulty in the performance of his duties. There is considerable difficulty in exercising authority evident in the present family relationships of most patients, however, which will be discussed in the section on "Marital Relationships". [3] Half the patients attempt to influence others to their will by domineering rather than tactful approach; and not more than a quarter of them consider themselves at ease in relation to authority.

Attitudes Towards Co-workers.

There is no evidence that these patients have a critical attitude towards those who work beside them as labourers and factory workers. Criticism is evident in relation to difference of position in authority and is seen in many housewives who not only criticize the work of other members of the family but do over again the work they have done. They also criticize the work of those who come in to help them during illness. They readily state this and that they lose their temper at such times. They commonly take this attitude with their children; but one woman [4] stated she helped the woman who was sent when she was "helplessly" ill and another [5] said she screamed at someone who came in to help and could not do the work to suit her. It was the simple task of scrubbing the floor which she

---

1. Case No. 16

2. Case No. 55

3. Infra, pp. 44 and 45.

4. Case No. 20

5. Case No. 13

afterwards did herself though she had to lie down in order to do it. This type of criticism is apparently related to the patient's feeling of responsibility for doing his own work.

The general attitude to authority and non-expectancy of consideration appears to obviate any worthwhile degree of sharing problems with management. One patient [1] said "It's the overtime that kills you. I worked so much overtime that I was dopey, and I was sick from the cold in the shop, but you can't say anything or they'd let you go." The same lack of communication prevents cooperative handling of problems in the home in which area there is much evidence.

Summary

There is a high incidence of long records of steady employment at hard work among these arthritis patients. They tend to hold jobs in which hard work is required rather than initiative, responsibility or the exercise of authority. These characteristics were seen also by other observers, particularly Halliday [2], and indicate anxiety manifested by unusual drive to perform all expected tasks and more, and stick to the job despite illness. Changes to jobs in which they are less subject to authority, and participation in gainful employment after marriage by more than half the female patients indicates the desire for independence and removal of the self beyond criticism, as well as the expression of aggressive and libidinal drives through excessive physical effort. This observation is further substantiated by the absence of competitive employment among

---

1. Case No. 19

2. J.M. Halliday, "Psychological Aspects of Rheumatoid Arthritis", Proceedings of the Royal Society of Medicine, Vol.35 (Feb.1942),pp.455-7.

these patients. The general tendency to hold on grimly to a difficult job, which involves dependency, unless moved by circumstances to a more satisfactory one, and the general avoidance of responsibility and a repressed difficulty with authority appear to indicate a basic dependency and restricted awareness reinforced by deep anxiety.

Lack of success and advancement is usual and is a natural concomitant of these attitudes in work relations. The general absence of criticism or self-condemnation in this regard is significant, and evidently coincides with acceptance of the philosophy that life is difficult and that he who works hard and is "poor but honest" avoids criticism.

Social Relations

In the light of the basic hypotheses of this study of personality characteristics, [1] analysis of the amount and types of recreation, participation in social activities, the number of friends, and the characteristics of social self-expression reported by these patients will be significant.

The most significant result of this analysis appears to be the finding that sixty-five of the patients considered they had "always been very active", but also had tried to avoid trouble, had few friends and little social recreation or other social activity prior to illness.

Rationalization or projection is almost invariably present in defenses of this social isolation. Forty-six indicated poor control of aggression and temper; but some suggestion or open statement of excessive busyness of self or of moral disapproval of others was usually given with information concerning social inactivity. One patient [2], whose family life was filled with fighting, said of neighbors "I stay away from them. They

---

1. Supra p. 8

2. Case No. 8

want to get into your affairs - and they're always fighting".

Sixty-two of the patients indicate little or no interest or participation in social activities. Lack of time and money cannot be overlooked as reasons for this, but the patient more often refers to the lack of time than of money and indicates he "can't be bothered with people", "the neighbors are rowdy", "they're not fit to say 'Hello' to", they're always trying to get their nose in your affairs", or "they're always fighting" - and in some cases "they're not careful enough about their children". One woman,[1] who said there had always been friction in her own home, did not know the neighbors beside whom she had lived for ten years. Several patients who reported some domestic trouble seemed proportionately eager to remain socially isolated. Two women,[2] separated from their husbands openly stated they felt the stigma of their position for themselves and their children and preferred to stay away from people so they wouldn't be questioned. Both are registered at clinic as "widow". These cases are not exceptions but illustrations. Not only do these persons tend to social isolation but in most cases conditions of relationship difficulties, quarrelling, wife-beating, or alcoholism reinforce the rigid standards which keep other people out of free contact with them. Very few report any participation in church activities though most of them report attendance.

The most common reason given for lack of recreation was lack of time. These patients had always worked hard and had little time for play. As the majority are married women the care of children and household work, which they wished to perform or could not afford to pay someone to do,

---

1. Case No. 56

2. Cases No's 2 and 7.

justified in large measure this lack of leisure time activity. Some regret but more pride seemed to accompany their statements of concentration on hard work and duty. Pleasure in physical activity was reported by several who said they "loved" it, and was evidenced in the earlier activities of twenty-five who had opportunities for recreation. Much walking, swimming, skating and dancing was reported in terms such as "I was always dancing" or "when I was a girl I loved to skate, and I could take a hockey stick and go with the best of them, boys or girls". [1] Of this group a few, who evidently had opportunity, became excellent all-round athletes; one [2] became a leading contender for the world's light-weight boxing title.

Most patients manifest in their attitude to work and in some direct statements the same "love" of this type of physical activity. Industrious use of leisure time in sewing and knitting by the women is common. The almost religious use of every spare minute for cleaning, painting and "tidying up" could bear mention under recreation.

Cultural and thoughtful pursuits are almost entirely neglected by these patients, who prefer activity even when greatly restricted by illness. Light fiction reading and movies are the most frequently reported non-physical recreation. It seems probable that the more intellectual pursuits would bring painful awareness of their own social difficulties instead of the pleasure evidently provided by activity which tends to keep problems out of consciousness. This probability appears to gain substantiation as we look at the patients' reasons for social non-participation.

---

1. Case No. 6

2. Case No. 16

In relationships fifty-four appear to be active rather than passive, Forty-one consider themselves self-reliant and most of them have behaved in accordance with that belief. Thirty-six appear to assert independence out of proportion with their self-reliance and indicating the repression of a considerable dependency need. Fifty-eight indicated or stated more concern for others than for self; and most of them appear to be driven to earn safety in relationships in this way and to escape or eliminate the consequences of their poor relationship ability just as they attempt by hard work to reinforce their insecure work relationships. Most of these have also indicated that they try to avoid trouble and that they have considerable anxiety.

In the light of these traits or tendencies of character and behavior and the lack of aggressive expression in competition in work and recreation it is not surprising to find that over sixty patients tend to bottle up their emotions and their aggressive impulses in particular; nor is it surprising that forty-six of them admit or indicate explosive tempers and forty admit or indicate repression of anger with explosive outbursts in inappropriate or trifling matters. It is significant also that most patients admit that as arthritis curtails their activity they become more irritable and explosive. An old lady, [1] quite crippled, saw this connection in speaking of her former activity. She said "I used to be so energetic - it lets off steam - lets off your feelings".

In the behavior of these patients in social relationships, in their withdrawal from these relationships, in their justification of such

---

1. Case No. 11

behavior and in the activity which apparently covers and substitutes for the lacking social activities, we have evidence of a high and meaningful correlation between the lack of dependency on and participation in society and great need for such dependency and participation. Case No. 7 may illustrate.

> A 72-year old "widow", [1] whose husband beat her and left her for another woman, accepted comparative poverty in working and raising her family. She remained isolated from her friends and neighbors because of her condition for 26 years. Recently, unable to work because of arthritis, she joined an elderly persons friendship club into which she had been drawn through her daughter's efforts. This club is in a different and better community. She became secretary of the club, participates fully in all its functions and will not allow anything to take precedence over her duties in it. Since joining she has been much happier, ceased the treatment at clinic and reports that during the eight months since that time her arthritis has ceased to be progressive or painful.

Summary

In early life these patients tended towards individual and muscular types of recreation rather than to group activities and interests. Prior to illness, in adult life, recreation of any kind was greatly reduced and work and the struggles of family maintainance generally took the place of recreation and social activities. This social withdrawal coincides with and is evidently related to increasing discouragement and hostility developed by failure in adult relationships. By repressing aggressive impulses and devoting himself to work and his family's interests the patient attempts to avoid trouble. The development of a reputation for hard work and for minding one's own business also counteracts criticism and self-condemnation related to social incapacity. Anxiety and hostility appear to be observable evidences of this repression.

---

1. Case No.7

CHAPTER IV

INTRAFAMILIAL RELATIONS

This chapter deals with the ways in which the patients handle interpersonal relationships in the parent family and in the marital relationship. More detailed data and tabular presentation concerning the parent family relationships, not yet available, will be found in the companion study of this area of the lives of these patients.

Parent Family Relations

The most significant factor concerning the relationship of the patients with their parent families is the lack of information given, though this area was specifically questioned. The patients uniformly tended to discuss their parents briefly and in terms of moral approbation rather than relationship. The terms "strict" and "good" were most frequently used and usually together. Most patients had one parent who was quick tempered and accordingly somewhat difficult to approach. This, most often, was the father. However, in several cases both parents were quite strict and mutually reinforced disciplinary rules. Most of the patients indicated a better relationship with the mother who was evidently more approachable and whose word was not so often "final" as that of the father. Actual statements about relationships were very general. "We got along all right" was the most frequent reaction. Forty-eight patients indicated that they got along well with parents and siblings. Most of them felt a closer relationship to the mother and siblings than to the father.

Information was not only meagre but appeared to be in conformity with what the patient thought most acceptable as an impression of family relationships. There is much evidence that relationships were not as

"good" nor family life as "happy" as reported. Examples of this evidence are seen in the story of a patient [1] who said her relationship with parents was good. Later she stated that her mother was dominant, favored the boys, did not cry, as her father did, when patient came alone from Europe to the United States. The mother also forced the patient, then 21, to give money to an unfortunate brother against the patient's will. Another [2] said she was unruly and her mother beat her until the time she was physically strong enough to rebel against this discipline. She ran away from home shortly after, at the age of 15.

Half of these patients did not have both parents present in the home beyond the age of 15. The number of parents now alive and in contact with the patients is not large enough for conclusive discussion. However, if the 20 patients who reported leaving home before they were 18, the 19 who came from Europe without their families, and those who do not have contact with living parents be considered, it seems evident that relationships were at best superficial. One male [3] who stated that his father was a "good man" and "not a hard man" does not know whether his father is dead or alive though he keeps in touch with his younger sister who lives in Scotland and with whom he had a good relationship. The family separated in England after the death of the mother.

It appears that strictness, goodness, and exhortation to diligence and independence, as well as quick-tempered actions were more frequent and

---

1. Case No. 1

2. Case No. 3

3. Case No. 23

prominent in the disciplinary relationships between the parents and these patients than were tolerance and understanding. It is significant that 31 patients have given sufficient of such information to enable identification to be noted between the strict, dominant pattern of parent behavior and that of the patient. And, just as the patient describes the parents in terms of moral standards rather than relationship ability, so, it appears, the patient conceived of the parent more as a measure of conduct than as a person.

In some cases, in which the parent - usually the mother - arranged marriages and carried on most or all of the patient's relationships outside the family, the patient has evidently developed such dependence upon the parent and the parent's pattern of behavior as to be quite incapable of action not completely in accordance with that pattern. One patient [1] who "loved" her mother who had asked her forgiveness for urging her marriage, stated that her mother "loved" work and so did she; also, her mother had taught her to "pretend" feelings of which she was incapable in sexual relationship with her husband.

Summary

These patients verified the findings of Ruesch [2] that "almost all statements made were justified and labeled in terms of good and bad, and in terms of conformance or non-conformance to prescribed rules of conduct" when they attempted to assess their relations with parents. Also,

---

1. Case No. 17

2. J.Ruesch, and A.R.Prestwood,"Communication and Bodily Disease", Reprinted from "Life Stress and Bodily Disease", 1950. Proceedings of the Association for Research in Nervous and Mental Disease, 1949, Vol. 29.

as Ruesch found, they indicated "a prevailing sense of obligation towards the parents, while thoughts of aspirations for things other than what the family had been able to provide seemed to make these patients uneasy".

Generally they indicated that parents were "strict" and "good", and some quick-tempered. However, the record of leaving home in early adolescence, of continuous difficulties with parental control and sibling rivalry, the great distances they put between themselves and their parents, and the general lack of communication with parents, as well as this inability to describe adequately any relationship with parents indicates the restricted nature of such relationships. Identification of the patient with the strict, dominant parental pattern gives some measure of the effect on the patient and of the quality of the relationship. Loss of a parent by death or separation was a cause of added anxiety to half the patients while they were still adolescents.

Marital Relations

Marriage may be fairly considered the crucible in which the ability to establish satisfactory relationships is most severely tested. Sixty-eight patients, 22 male and 46 female, participated in 77 unions and the results indicate their ability to create a happy marital union to be low. Forty-three are now living with a marital partner. Thirty-two of these were not questioned regarding conjugality; but of 11 questioned only 7 were living in conjugal unity. The assumption that there is insufficient satisfactory sex expression among these patients might well rest on this evidence. However, as the writer specifically questioned his 20 patients, 4 men and

16 women - which ratio of men to women coincides with that in the incidence of rheumatoid arthritis - more specific evidence is available.

Of these 20 patients, 11 live with marital partners, 7 are separated and 2 are widowed. Only 7 live in conjugal unity and all 7 stated that intercourse is infrequent, while 6 said it was unsatisfactory. One male, formerly a tuberculosis patient considered his sexual adjustment satisfactory.

Of the 16 females, 8 considered that they were "cold". They did not wish or enjoy intercourse, and their husbands complained of the frigidity which they admitted; 6 were terrified and disgusted; two thought their sex relations had been satisfactory -(the husband of one had deserted 26 years ago with a "loose"woman; the husband of the other had been dead for 40 years).

Eight of these women had been beaten by their husbands, four so seriously during pregnancy that they had miscarriages or stillborn children. Despite all these discouraging factors 15 reported 80 pregnancies and 68 births. One [1] could have no children because of womb displacement. Though most of them disliked intercourse and feared pregnancy, they stoically accepted the role and responsibility of child-bearing; and it seems probable that, in addition to ignorance of contraceptive methods, the desire to make up for what they lacked in ability to relate by doing their full duty and undergoing hardships as wives and mothers was a considerable motivating influence.

Several of these women reported that their husbands commenced or greatly increased their consumption of alcohol after marriage. The woman

---

1. Case No. 3

who could have no children,[1] and who had divorced her third husband, expressed terrific resentment against men, and said that her first husband who had been unfaithful during their honeymoon drank himself to death in three years. Her father "drank like a fish" and deserted her mother when the patient was 12 years of age.

This woman, though denying her own sexual maladjustment, selected a second husband much older than she ("he was a beast"). Another,[2] badly beaten by her first husband who left her, formed a common-law union with a man crippled with rheumatism and subject to epileptic seizures. She was happy in taking care of him until his death 10 years later. One [3] who disliked intercourse and quarreled much with her husband when he was the aggressor in the sexual act states that intercourse takes place, since arthritis, only when she initiates it and this is more satisfactory. A young woman [4] who married in complete ignorance of sexual matters had 7 children in 14 years while "terrified" of intercourse and pregnancy. Since illness her doctor advised and provided a contraceptive; her attitude to intercourse is improved - also her arthritis. Of three widowed two did not remarry. Of 5 separated 4 remained so; and the other returned to that status after 10 years of common-law union ended by her partner's death. One divorced from third husband remained so.

Two of these women reported physical abnormalities of sex organs creating some difficulty. One reported quite extensive masturbation after marriage. One had pleasure in being caressed but not in coitus.

---

1. Ibid.

2. Case No. 15

3. Case No. 9

4. Case No. 20

There is considerable evidence that marriage was an unconsidered escape from conflicts and difficult situations in many cases. It is noted, concerning the conditions of marriage, that, of 10 who married between the ages of 15 and 19 years, 9 left home and a situation of conflict with heavy discipline and hardships. One had left home at 15 years and was married at 16 years. Also of these 10, 6 married at the age at which their mothers had married. One was pregnant before marriage. One stated that her mother, of whom she was terrified, forced her to marry, at the age of 16. Of the 6 who married after the age of 20, 2 were in situations of reported conflict at home; 1 reported extremely strict parents; 2 were in service, their mothers dead; and 1 was an orphan.

The 4 males married between the ages of 26 and 33 years. One,[1] married immediately after both parents had died of cancer and he had contracted arthritis, was separated after 6 months. Three out of 4 live in conjugal relationship with their spouses as compared with 4 out of 16 females. A major factor in this difference is that these men and their partners are equally accepting of the sexual relationship, which they recognize as something less than their own concept of what is normal or ought to be. In our culture it is not customary for wives to make demands concerning conjugal rights or to complain about insufficiency of sexual expression. Two of these males state that they were "never highly sexed". One[2] was formerly tuberculous and learned to "take everything easy"; and his wife is a cool, independent woman, older than he, who was advised because of an accident

---

1. Case No. 19

2. Case No. 18

before marriage that she ought not to have any children. The other [1] stated that neither he nor his wife were highly sexed; gratification was marred by fear of pregnancy and absence of any efficient contraceptive method and practically eliminated by his wife's nervous and lethargic condition since she had an hysterectomy five years ago. The third [2], an oriental, did not marry until a year after he had arthritis. He states that because of his illness he no longer seeks gratification through sexual relations. Accordingly, he says he has no interest in his wife as a woman. But he is definitely the head of the house and the only one permitted to complain about anything.

This detailed consideration of the sexual adjustment of 20 patients randomly assigned to this writer indicates the maladjustment, frustration and lack of sex expression in the marital relationships of these patients. Emanating from these basic conditions, distorted expressions of frustrated love, dependency and sexual energy are found, as might be expected, in relationships involving the marital partners and families of most of these patients. The writer and the psychiatrist have noted in questioning these patients, particularly the females, that, though they may be reticent about sexual adjustment and closely related problems, when the subject is opened the usual result is a torrent of information revealing such problems and the degree of repression under which they have existed. At the same time the aspects of family relations and activity into which adjustment has ramified and the peculiar adjustive and substitute forms of expression are frequently indicated. Of the remaining 32

---

1. Case No. 16

2. Case No. 12

patients who live with marital partners but who were not questioned concerning sexual adjustment, 5 stated voluntarily that it was unsatisfactory.

Relationship between two people implies dependency of one upon the other for the gratification of desires, the satisfaction of needs and the reduction of tensions. The infinite number of relationships, of varying intensity and depth, into which human beings are forced or enter voluntarily for the satisfaction of needs show an equally great number of degrees of dependency. The parent-child relationship implies complete dependency of the child upon the parent for all the physical necessities of life, and for affection, education and socialization. It also implies dependency of the parent upon the child for the satisfaction of emotional needs. Friends are mutually dependent for understanding; members of organizations, for various kinds of support; acquaintances, for feelings of social or communal well-being. The marital relationship implies mutual dependency for self-expression as man and woman, as parents and family head and as the nucleus of a social unit. This relationship involves dependency for satisfactory functioning and role-playing at the most intimate, intense, responsible and permanent level. In our culture, and because of the needs and conditions in her role as wife and mother, it appears that the female partner must accept the more obviously or physically dependent role for the relationship to function most adequately and to give the partners the greatest mutual and individual satisfaction; and both partners should be mutually dependent emotionally.

Twenty of our 80 patients indicate fair reconciliation to dependency in their relationships. Half of these are married males, who may be

considered over-dependent in relation to a comparatively dominant wife. Of 46 married females, about 35 indicate rejection of dependency in relationship and dependency per se. Several of these are in conflict; but the majority are evidently the dominant partners. Some take the dominant positions directly, stating they are the ones who make the decisions and manage the household and family; others work and sacrifice themselves so extensively for the family that all members depend upon them implicitly. One woman attempting to indicate there was no dominance in her family said there was "peace at any price". Another[1] said "There is no boss; he asks what I think and does whatever I say". She also stated the children ask her advice. Some, less naively, justify their independence by comments on the difficulty in understanding their husbands, their husbands' drinking, abusiveness, laziness, inefficiency and helplessness.

It has already been indicated that inability to achieve sufficient dependency to permit adequate sexual adjustment is a central factor in the poor marital relationship which features most of these cases. Several women suffering subjection separated from their husbands; some maintain physical separation within the home, in some cases aided by illness in doing so; others, few in number, have accepted dependency. The largest group has been able by various means to dominate the relationship and to be independent. But this independence is not satisfying their dependency needs.

A common complaint is that they have to carry more than their share of responsibility and work, that their husbands and children do not help,

---

1. Case No. 50

and that they must do it themselves rather than ask repeatedly and uselessly. They note that the neighbours know of their need but do not offer help. They complain that they have given their lives for their children's welfare, and the children forget them and do not even keep in touch with them when they are ill or in need.

Equally common, however, is the behavior which negates these complaints in refusal of help when proffered. Household work done by husband and children is criticized and frequently done again by the patient. Cooperation is not usually sought or recognized. "I get so mad when I can't do things for myself"; "no one can do things to suit me"; "I can't stand to see anyone else doing my work"; "my husband is useless, he doesn't know how to do anything; "I just scream when the children try to do anything - they can't do it the way I want it done"; "they sent someone to help but I had to do the cleaning over again", are statements typical of the attitude towards help. It has been indicated in consideration of employment that more than half of these women have taken over in part or wholly at times the role of breadwinner outside the home.

Many of these women complain also that their husbands do not discuss affairs, business or current news with them. They also admit disagreement with the opinions or judgments of their husbands on such matters and that they "never give in" when an argument arises. They do not attempt to adjust or adapt themselves to behavior admired or suggested by husband or family but usually take the attitude that "I am the way I am - I can't change". One woman [1] who frequently disagreed with her husband, being aware of the nature of her illness, forced a separation from him in

---

1. Case No. 62

order that she would not be dependent on him.

Detailed ordering of their children's lives is a common extension of their own pattern and perhaps an attempt to fulfil their own minor ambitions; but it appears to be a field where more complete domination than they maintain over their husbands is possible. One woman [1] who controls her husband's pay and almost all of her son's, insisted on having the bank account of the son, who was 20, arranged in such a way that he could not draw any money without her knowledge. Though this was impossible, she went with him to the bank and argued with the manager about it.

Self-sacrificing service to the children and to the husband commonly appears to express the patient's concern for others, in lieu of mutually dependent love relationships, and to enable domination as well as to justify great physical activity and inability to work cooperatively with other members of the family. This pattern of behavior is illustrated in the following case:

> This woman,[2] dominated by her husband who left her, lived in common-law union with a man crippled with rheumatism and subject to epileptic seizures. She nursed him, worked to support him and their two boys, and headed what she considered a very happy family. Since his death, and though crippled with arthritis, she still does the thinking and worrying for the boys who are still largely dependent upon her. Though supported by welfare services she still manages to meet the needs of these boys, who are over 20, sufficiently to maintain a dominant relationship with them.

Though 8 of 80 patients live with children since and because of illness, the general trend is toward little contact after children have become independent. Patients frequently relate how much they did for their

---

1. Case No. 1

2. Case No. 15

children who did not reciprocate. One patient [1] stated this and the story of family relationships very succintly:

> "I never liked men and when I married and found I didn't like it I made the best of it. I respected my husband and did my duty having children. "I made the children my life while I had them. I worked so hard for them. You raise a big family and they're no good to you."

It appears that one of the possible purposes of illness is to reinforce or to recreate the superficial relationship, which has existed through duty and necessity, by the new duty and necessity related to illness and which did cause 8 of these children to live with parents again.

Only half of the married males appear to be dominant in the marital relationship. Those who are dependent justify their position by considering dominance to be "fifty-fifty" in their relationship; or the attitude of "I make the money and the wife looks after everything else" is expressed. They usually consider that they have enough to do, and that the wife is quite capable. This greater acceptance of dependency among the males seems directly related to the cultural position of the male with regard to sexual adjustment. Culturally accepted as the aggressor or initiator in the sexual relationship, he has little conflict in this area or over demands made upon him, and consequently less need to assert independence and dominance to overcome fear of dependency and its results. Reinforced by his position as nominal and legal head of the family; he has less concern and perhaps less realization if the actual situation is otherwise. It is customary for a wife to be largely responsible for management of family and household affairs; and when she definitely usurps something of his role there is usually something of apology or recognition of her husband's nominal position.

---

1. Case No. 6

Though the male role thus involves less conflict over dependency in the marital relationship, there is some evidence among these male patients of the same rigidity of behavior and inability to compromise seen in the females. A patient [1] said, "I will not stand for disagreements. If my wife does not agree with me she must show a logical reason for her opinion, then I would concede the argument". As he also indicated a belief that women cannot argue logically, there is little doubt as to the outcome of the arguments.

This is similar to the more direct and more frequent statement made by females that they usually break off the discussion if the husband's argument seems too strong. "I could never give in" or "I never give in" is perhaps the expression most frequently used to describe their attitude to arguments, dependency, illness and other difficulties. It appears that most arguments end in quarrels in which the precipitating matter - usually trifling in itself - is lost and the difficulties of relationship are made emphatically manifest.

Summary

The marital relationships of these patients are generally inadequate and unsatisfactory because of unsatisfactory sexual adjustments. A strict moralistic attitude to sex expression and consequent ignorance, fear and psychologieal incapacity appear to underlie the dominating independence of the female patients and of the wives chosen by some of the male patients.

The female patients have been subject to abuse and self-condemnation because of this frustration and generally react by more

---

1. Case No. 12

moralistic attitudes and self-sacrifice. The inability to be dependent and the need to perform the duties of a wife raise a serious conflict in which the patient seldom gives in and which is or may be resolved by illness. Enforced dependency in the marital relationship appears to increase the patient's dominant attitude towards the partner in other aspects of family life and towards the children. Extreme anxiety about removing any chance of criticism is manifested in a very compulsive attitude towards maintainance of the home and the behavior of the children. The male partner reacts by abuse, drinking or neglect, and sometimes by submission.

Male patients indicate the same inhibited attitude towards sex and lack of capacity for expression, though their conflict at the conscious level is more concerned with dependency needs per se.

CHAPTER V

DEVELOPMENTAL FACTORS IN THE PERSONALITY

> Characteristic modes of tension reduction are learned by the individual as a function of his past experiences of success or failure with them and of the opportunity for employment of them within the confines of his particular culture. Personality may be described as the pattern of relative importance of these various modes of adjustment to tension which uniquely characterizes the individual.[1]

This statement, and that of Kluckhohn and Murray already quoted,[2] emphasize the validity of examining the life experiences of the patients in order to discover influences and factors involved in the development of certain characteristics now observable in their personalities.

Examination of the developing personality begins logically with early life and the parent-child relationship, which may be unhesitatingly described as respectively the most important developmental stage and influence in the life of the individual.

The following statements by Sullivan [3] concerning personality development in childhood indicate that importance and are most revealing of the process observed in the experiences reported by most of the patients:

---

[1] Krech and Crutchfield, OP.Cit. p.73

[2] Supra p.7, "Human personality is a ... dynamic resultant of the conflict between the individual's own impulses and the demands, interests and impulses of other individuals".

[3] Harry Stack Sullivan, Conceptions of Modern Psychiatry, (Washington, 1947), pp.9-10.

> As one proceeds into childhood, disapproval ... becomes more and more the tool of the significant adult in educating the infant in the folk ways ...This process, coupled with the prohibitions and the privations he must suffer in his education, sets off the experiences that he has in his education and gives them a peculiar coloring of discomfort ... the basis of what we ultimately refer to as anxiety ... Not only does anxiety function to discipline attention, but it gradually restricts personal awareness... through control of personal awareness the self itself from the beginning facilitates and restricts its further growth... tends very strongly to maintain the direction and characteristics which it was given in infancy and childhood. For the expression of all things in the personality other than those which were approved and disapproved by the parent and other significant persons, the self refuses awareness...

In contrast with the etiological factors of rheumatoid arthritis the psychodynamic or personality factors involved may be more accurately recognized,and, as they are common to other than arthritis patients they may be interpreted through such general conceptions of psychology, personality, and psychiatry as those quoted above.

Parental Attitudes

Moral approval or disapproval was seen to be used by these patients instead of some measure of love in assessing interpersonal relationships [1]. "Strict", frequently modified by "good but strict" was the indication given by most of our patients as the central impression they had of parental influence.

This impression was most often associated or identified with the mother and emphasized by the passive or active approval of the father, by his own submission to it or by his rebellion expressed in rage, alcoholism or withdrawal which branded him as fearful, worthless or undependable and made the mother appear self-sacrificing, dependable and good by comparison.

---

1. Supra, Chapter IV, p.34

In some cases both parents cooperated in enforcement of the strict pattern of discipline; and in a few cases the father was indicated to be the dominant and strict paternal figure, with the mother passive. A frequently noted combination was the strict, industrious mother and the somewhat withdrawn father who seldom entered the disciplinary picture. This was described by one male patient [1] thus:

> Mother looked after everything including discipline. There was no tension and no quarrelling. Father was a hard worker. He drank a bit; mother nagged but he said nothing. He seldom spoke to us but when he did it counted.

The dominant mother and the pleasant, tolerant father were described by a female patient: [2]

> There was no tension; mother ran the show and father accepted it. I used to love to work with my father, getting the cows in the wet and cold and turning the separator when my arms were sore and I could hardly reach high enough to turn it. I worked since I was 7. I was happy to work on the farm; but at 16 mother put me out to get something else. I don't understand why. I was lonesome away from home - but mother decided everything. She always favored the boys.

Another female patient describing another type of parental combination said: [3]

> There were never any quarrels in our home. Mother was a very good Christian woman who played the organ in the church. She was very strong on right and wrong, minded her own business. She was sick for 5 years and died when I was 12. Father was quick-tempered, but a good man and hard worker. (Patient recognized her inability to relate and said also 'mother died of anemia - I have it too' and ' I have a quick temper - like my father')

---

1. Case No. 19

2. Case No. 10

3. Case No. 2

A male patient said of a dominant father and passive mother: [1]

> My father is so domineering that no one will live with him since mother died. They both favored my older brother and sister. I used to try to talk to father but he always made me out stupid. He always paid attention to my brother - it's not fair you know.

A female patient aged 77 recalled a strict mother and an alcoholic father who deserted when patient was 12. With resentment strongly evident in her eyes and voice she said: [2]

> My mother was very strict; she beat me a thousand times but I went on being naughty. My father drank like a fish. He left home after my brother was born...Men are all beasts and they are so stupid - it is easy to fool them.

This woman's identification with her mother's behavior and her lack of success in the marital adventure was noted previously. [3]

The parental background of these patients is seen to be one in which affection and relationship are not expressed between the patient and his parents. Siblings commonly appear to the patient to have made better adjustments to the parent personalities, which of course adds to the feeling of isolation and inferiority in the patient. The "goodness", strictness, self-sacrifice, violence of temper, and disapproval so prominent in parental behavior forces the patient, as a child, to greater preoccupation with self-condemnation and attempts to gain the desired approval through acceptance and emulation of the parental pattern. They are unable to bring about the desired relationship; and instead, a heightened state of anxiety is developed, with personal awareness restricted to problems of relationship, libidinal and aggressive impulses.

---

1. Case No. 18

2. Case No. 3

3. Supra, Chapter IV, p.39

The expression of these needs and impulses seems focussed upon physical activity which helps to lower the emotional pressure, and upon the strict morality, diligence, hardships and self-restriction of the parental pattern, which might bring approval, and which at any rate lessen the opportunities for criticism by others or the self. This pattern of behavior added to the inability to depend on parents for expression of these needs produces a pattern of self-sufficiency in behavior further disguising the actual dependency needs thus more completely frustrated than ever. A great desire to escape responsibility is developed through the child's being held responsible, constantly, by the parents and his own anxiety.

Childhood Reactions

This pattern of anxiety-motivated behavior is accentuated by the traumatic emotional experiences and stresses in all fields of personality. Of these an almost incredible number and complexity have been seen involving these patients throughout their lives and attending each developmental stage or change in their career. More will be shown of this in connection with the relation of personality and illness. In addition to deprivation and hardships in childhood it is very significant that 37, almost half, of our patients had their emotional security further reduced by the loss of one or both parents before they reached the age of 15. Of these 17 lost fathers, and 13, mothers by death. Separations accounted for the others. Temporary separations, not included in this figure, threats of separation and severe disagreement which characterized the parental background of others and increased their anxiety would swell this number

greatly. It must also be noted that the attitude of the patient was to minimize or completely deny any emotional rights in the family picture as admission would tend to increase his self-condemnation and feeling of inferiority. His wish was to picture himself and his family in a light which would obviate criticism; factual statistical information and indirect mention supplied much of the material which qualifies the usual initial statement that the family was "happy as most" and the parents "good but strict".

Adolescence

In this conflict between the impulses and demands of the individual and the demands of his parents, of which the result is the personality of the patient as a child, the tide of battle runs strongly against the child. However, as these patients became aware of the strength and status of approaching adulthood their repressed impulses and hostility threatened to even the forces and decide the issue. Their habitual acceptance of the parental right, self-condemnation, developing restless reaction to frustration, and the long repressed desire to escape seem to be reasons why escape rather than continued battle was the result of this conflict in most cases.

Escape from the parental influence appears to have been literally necessary only in the female's situation. Whereas males were less subject to rigid restrictions related to sex and could consider themselves more independent while single and enjoying actual dependency on the family by remaining at home during early adulthood, as most of them did, the situation of the females was quite different. Their frustration was increased by added restrictions related to their sex and the moral attitude of parents,

who generally considered marriage the goal of their ambitions for their daughters and guarded them towards that end while male children were allowed more freedom. Many females were forced to work and to contribute to the family income through employment away from home; thus increasing responsibility and independence and further frustrating dependency needs.

In adolescence these females evidently equated their developing difficulties in interpersonal relations with the strictness of parental control, escape from which meant the solution of their problems.

Marriage was the most frequent form of escape and runaway marriages and marriage without the knowledge or consent of the parents was not uncommon. Marriage placed them in the dependent position they desired and at the same time gave opportunity for the assertion of independence.

Marriage

The conflict over dependency and the serious difficulties these women encountered in sexual adjustment, child-bearing and in the whole marital relationship, made them sympathize with their mothers perhaps for the first time and follow the mother's pattern of continuous activity, self-sacrifice and hardship to reduce tension and self-condemnation aroused by their failure to make a satisfying relationship with the marital partner. "Now I understand what mother went through" and many comments to that effect were made by these patients. The completeness with which many followed the pattern of the mother is illustrated by the statement of one woman [1] whose husband had beaten her and left her, that when sexual adjustment with her husband had been bad her mother had taught her the trick of making him think she had emotional participation in coitus which she had not.

---

1. Case No. 17

In the detailed discussion of the marital relationship already presented [1] considerable evidence was shown as to the inadequacy of the undeveloped and inhibited sexual adjustment of these women and the disillusioning and traumatic experience it proved to be for most of them. It was also indicated that patients of both sexes did not find gratification of sex or dependency needs, and were generally incapable of the give-and take fundamentally necessary to satisfaction in the intimate nature of married life. Accordingly, the frustration of needs and the ending, or continuing in dissatisfaction which characterized this relationship in many cases may be stated with some certainty to have developed and intensified the characteristic behavior patterns and anxiety which we have observed inhibiting and altering the course of self-expression and increasing the general relationship difficulties of these patients.

An illustration of the direct relationship these patients commonly saw between escape from parental influence and marriage, and of their disappointment in the result and resignation to the conception that married life is full of hardships is seen in the following statement by a 29 year old woman [2] who had been married 10 years, had four of five children living, admits poor sexual adjustment, domestic and financial difficulties and constant illness of some of the children.

> Mother used to slap me - now if anyone says I can't I want to. Father was very unfair in punishment; he kept us in. He was too strict; he wouldn't let us go to a show. I ran away and got married the same day. I should have had my head examined. A person needs to be young and carefree for a while.

---

1. Supra, Chapter IV, p. 38

2. Case No. 13

This woman considered the punishment which restricted activity "unfair". In connection with her mother's punishment it might be noted that she now has a great fear of people getting hurt.

The Search for New Surroundings

Another common and important characteristic of the personality of these patients in this developmental stage involving the need to escape parental control and to overcome the difficulties that control had placed in the path of adjustment in early adulthood is that of actual escape from home, the place of birth and even from the culture which they evidently associated with the control pattern.

Three quarters of these patients were not born in Montreal and 36 came from outside the western hemisphere. Of the 36 who came from the Old World, 19 - 5 male, 14 female, came without their families and 12 of these came alone. It is also significant that 8 females came alone, only one of them having a sibling already in this country.

An excerpt from the story of one woman [1] who came from Roumania clearly shows the motivation and common result of this type of attempt to gain freedom of expression and to test the ability to make relationships in a new environment:

> When this patient was 18 she came to the United States. When she left home her mother, who had always favored her brothers, did not seem to mind, though her father cried when she left. She worked hard as a domestic and suffered from sore legs. She had intercourse for the first time and found that she didn't like it. She returned to Roumania after 3 years. She had been very lonely. Her mother again resumed control and forced her to give her money to her brother. She married and came to Canada. Her marital relationship has been unsatisfactory and her life dull and full of hardships.

---

1. Case No. 1

Employment

The patient's hope of emancipation and of gaining a satisfactory independence through earning his own living has likewise been dimmed by experience. It has been shown [1] that these patients tend to hold jobs which involve hard work and low pay. Such jobs do not entail the responsibility which might bring criticism; and they do not provide much satisfaction or opportunity for self expression. Whatever conflict he may have with the hardships and rigidity in the parental attitude to work may express itself in work relationships with the resulting loss or change of jobs during the first years of employment. Then, it seems, anxiety and the compulsion to repeat and resign himself to the work status of his parents takes control. In order to avoid the expression of hostility he avoids aggressiveness; in order to avoid self condemnation and criticism he works hard and avoids positions of responsibility. He, therefore, must, in most cases, work for someone else and is greatly dissatisfied because he wishes to be his own boss.

Forced by conscience and the need to conform, these patients generally became steady, and diligent workers while actually wishing to move about and have a more adventurous life. The need to avoid responsibility and aggressiveness kept them in routine poorly paid jobs. But the stoical acceptance they indicate in these ambition frustrations is tinged with bitterness which adds to their social difficulties, their anxiety and the stress of their existences. The detachment and stolidity of facial and vocal expression which generally characterizes the personality of even the younger patients who have recently developed arthritis or have had partial

---

1. Supra, Chapter III, p.25

or complete remission indicate the depth of bitterness or hostility they contain and the anxiety and repression with which they contain it.

Illness As A Stage In Development of Personality

The illness may be described as a stage in the development of the personality of the patients. It may also be described as that which proves the depth and strength of the characteristic patterns of behavior in the personality.

The Traumatic Situation

Three quarters of the patients reported some stressful events or conditions chronologically related to the coming of illness. These stresses ranged from the death of a loved one to intense anxiety over marital discord, sexual maladjustment, illness of self or children, loss of fortune and extreme difficulty and conflict in work or personal relations. In additional cases hardships, poverty and life-long conflicts existed but [redacted] were not reported by patient or counted by the interviewer as being directly related to the onset.

The most common and significant reaction to stress, whether it was the result of financial loss, illness, or the marital conflict involving physical beatings, desertion separation, or continuation in extreme unhappiness, was reported by such phrases as "I never give in" or, "I am the way I am and I can't change". Such stress may be said to have crystallized any fluidity in the characteristic patterns of behavior evident in these personalities. In this test the patient lost or gave up money, personal relationships, marital partners - anything except their patterns of response

to the environment. Halliday [1] has noted this personality characteristic which he describes in terms of an extract from Henley's poem, "Invictus":

> In the fell clutch of circumstance
> I have not winced nor cried aloud;
> Under the bludgeonings of chance
> My head is bloody but unbowed.

Certainly these words, dramatically strong though they are, do not over-emphasize the attitude of these patients which demands that they be equal to any set of circumstances. Foremost examples of this attitude are the women who, unable to attain satisfactory relations with marital partners, were beaten so that they had stillborn children and foetal displacements resulting in death for the child and intense suffering for the mother. Most of these patients continued to live with the abusive marital partner and to accept this abuse as merited or at least expected and a release from self-condemnation.

That this stoical or masochistic acceptance of suffering and hardships is closely related to self-condemnation is clearly illustrated in the case of a 48 year old woman [2] who had left her husband after five years of married life, not because he beat her but because he beat their only living child:

> I never enjoyed intercourse; I get a thrill out of being kissed and petted. When we were married I didn't know anything; I was afraid and shy. I wanted him to wait 2 or 3 days but he wouldn't. He jumped on me the first night and I began to hate him from that day. It was two weeks before he managed to have intercourse with me. I never enjoyed it; I was too proud to ask him to wait for me. My mother taught me the trick of making him think I felt like he did. I guess there's something wrong with me, eh?. He was sadistic - liked to make people cry. He used to

---

1. J.L.Halliday, "The Psychological Approach to Rheumatism" Reprinted from Proceedings of the Royal Society of Medicine (Nov.1937). Vol. XXXI, p.169.

2. Case No. 17

> wake me up at night and beat me. I had 4 pregnancies and only the second one lived. Two were breech births and the doctor had to break their necks to save my life. He said they were displaced by the beatings I got. The fourth time I fell over a chair and lost the baby at six months. The doctor said I should leave him (the husband). He could beat me, but when he started to beat M----- (their son) that was enough. I left him.

Whether this patient left her husband because of his abuse of her and the unsatisfactory sex adjustment or because he beat the child - or these and other reasons - she obviously avoided self-condemnation by ascribing her desertion to the need to protect an innocent person, the child.

A detailed consideration of stress in relation to illness is not part of this particular study. However, it is significant concerning the personality that arthritis appeared when stresses had evidently raised tension to a point beyond the ability of the personality to cope with or reduce it by increasing physical activity, temper outbursts and other substitutes for rational adjustment to the causes.

Reactions in Illness.

While it is true that the self or personality of the patient admits no change because of stress or illness and there is little evidence of any basic alteration, it is also true that certain changes are forced upon the arthritis patient in and by his physical incapacity and by the effect of that illness on his environment.

The patient attempts to be independent and to carry on work as usual. But this is not possible; and it is the writer's impression that the patients who were most able to accept dependency to the necessary degree are among those with less severe and arrested arthritis.

It would seem to be of great importance that the only behavior changes observed resulting from arthritis operate to reduce tension. Some of these changes and effects are:

forced dependency	-	meets the long frustrated need, cuts down excessive physical activity, and, is known to be acceptable to others, thereby reducing self-condemnation.
lowered sex urge and demands	-	reduces frustrated need for expression, reduces demands of marital partner, who must consider illness reduces criticism, by self and partner, of evasion of or dissatisfaction in sex "duties". Increases dominance and reduces fear in sex relationship.
self-employment	-	enables more real independence and weakens anxiety about inferiority.
pattern altered by authority	-	Doctor's advice about worry, birth control, rest, diet, recreation, etc. enables patient to escape hardships without guilt. Also authority is highly respected and patient follows advice with usual attention to "duty". Rigid pattern forced to some flexibility. Social agencies and other influences may be known for the first time.

The rigidity of the patient's personality may minimize or may not permit these changes. Indeed, the majority of the patients when forced into dependency, for example, increase their anxiety about and assertion of independence and few will permit even physical alterations for their comfort in their dwellings or accept with equanimity the help of anyone. However, the writer has noted such changes and modifications as those mentioned here in 5 of his 20 cases and is impressed by the remissions and moderations in arthritis which have accompanied these moderations in conflict, anxiety, attitudes and behavior patterns.

Summary

The background of parental influence of these patients was seen to be generally very strict, inhibiting and conflict-provoking, repressing libidinal and aggressive impulses and lacking in close relationship.

In childhood the conflict between repressed needs and impulses and the desire to gain parental approval resulted in anxiety, restricted awareness, physical activity, desire to escape responsibility, and general restlessness.

In adolescence the advent of physical maturity increased the need for self-expression and the conflict with parental restriction. Escape was generally sought through leaving home at an early age for marriage or work in keeping with the pattern of restricted awareness and expression through precipitate physical action based on anxiety and restlessness rather than reasoning.

Inability to relate, to accept dependency and competition, brought failure in these attempts at emancipation and adjustment to society. Failure decreased ability for normal adjustment and increased anxiety, acceptance of the parental pattern, self-condemnation, and expression through physical activity.

Failure also involved increasing stress in the midst of which the characteristic ways of meeting difficulty were evidently insufficiently effective and arthritis appeared. In most patients the stresses they had encountered had seemed to cause greater anxiety, self condemnation, strictness, hostility to human relationships and aversion to change.

Arthritis forced and enabled certain moderations in the tension developed in these stresses and conflicts. Illness moderated or eliminated sexual conflicts, stress of social relationships, guilt and criticism about these and dependency. It enabled the patient to demand or withdraw without criticism. Patients who were able to accept and make use of the support

thus afforded by their illness and treatment and the increased consideration from their environment to moderate their response to life have generally had corresponding moderation in arthritis.

The tenacity of the characteristic personality pattern is seen, however, in the general resistance to change and in the inability to accept and use the opportunities and justifications offered by the illness to provide and support dependency and other personality needs of the patient.

Illustrative Case Histories

Two case histories, one of a male patient, the other of a female have been chosen for presentation in some detail to illustrate the characteristic personality pattern observed in the eighty arthritis patients, and the factors involved in the developmental pattern as presented in this chapter.

Each of these cases will be summarized, and followed by a brief discussion:

[1]

Case of Mr.D. This patient is a 46 year old man, who is married and has four children.

His father was a blacksmith who married for the second time at 46. The second wife was a nurse, aged 34, who married him after nursing him through pneumonia. Three children were born of this union, the patient being the second. Siblings were a brother 2 years older than the patient and a sister 6 years younger.

The patient remembers his father as a powerful man who was quiet and took little interest in his second family. He was a hard worker, and saved enough to support himself and wife during 18 years of retirement prior to his death at 86 of pneumonia following an operation for cataract. While he looked after finances his wife looked after everything else and he did not interfere.

Discipline was considered unfair by the patient. He stated 'We were pretty obedient but my brother and sister got away with a lot - I was the one in between. Mother took sides with them and was unjust'. (Here patient quoted an example and an example of injustice he had suffered at school).

---

1. Case No. 16

At 17 he left school, tried office work which he disliked along with several other jobs, took up boxing - he had always been determined to get even with his big brother when he grew up - and became a prominent boxer. (his brother was now forced to marry; and the patient no longer wanted to get even.)

After 6 years of boxing he quit after a bad beating. He worked in the harvest, on boats and in various jobs. Then he became a third officer on a boat and got 'fed up' with the responsibility of this job. He began to work for the railway before the depression, and retained that job as a laborer in the shop until made a foreman 3 years ago. He married in 1931 at the age of 25 years. He had known his wife 6 months. She had been subject to the same 'unfairness' at home and they were good pals. They were not deeply in love nor interested in sexual expression - marriage was suddenly 'a good idea' (evidently related to his sympathy for her poor home adjustment.)

He stated, 'I never had another woman. Our relationship is good but the depression was hard on us. She may have thought, as I did, that it would have been better for us to have remained unmarried. Neither of us are highly sexed and intercourse has not been important. Fear of pregnancy made it less satisfactory; and since she had an operation (hysterectomy) five years ago she has no urge at all. We have four children, and our girl of 20 would not think of going to a show without asking me if it's all right. I used to play out on the road with them, played hockey, ball and everything like a boy until 3 years ago. Then the job began to get me. As foreman I had the boss on my neck complaining about the work and the men wouldn't work unless I walked around and kept an eye on them'.

Seven months ago, when this patient was 46, the age at which his father married his mother, he was suddenly stricken with arthritis in the legs and was unable to walk. This happened when he had taken a few steps away from the home of his sister where he had been on one of his infrequent visits. He was now unable to 'walk around and keep an eye on the men'.

As a boxer he 'learned to control his temper, and never shows any emotions; when angry his arms shake. His sleep is much disturbed with nightmares of fighting and of life before marriage. He had fainted several times during his illness.

Despite his resentment of doctors and hospitals, related to his father's death in hospital and his mother's profession and resentment of doctors, his arthritis has responded to treatment and he has been told he may go back to work soon. Since that announcement he has taken greater interest in his psychiatric condition, and, it appears this may become an alternative escape from the responsibility of the foreman's job.

The age at which this patient's parents married, the fact that it was a second marriage for his father, the circumstances of the marriage, the profession of his mother, and the fact that he was the 'in-between' boy with an older brother and younger sister are all factors which may be seen as possible sources of difficult relationships in his home background.

During childhood this patient was impressed by his father's powerful physique and his remoteness. He was afraid of his brother and his mother who, he felt favored both his siblings. An early evidence of anxiety is clearly seen in one of his stories:

> One time I had some marbles. I told my brother I didn't have any because I knew he would take them from me. Later, when he saw me playing with them he said they were his. Mother made me give them to him. She took his word - it was an injustice.

He was so emotionally concerned with the fact that the marbles were so justly his that he could not see that his anxiety which caused him to lie had caused his mother to accept his first statement denying ownership. This appears to be a simple illustration of the way in which many patients are responsible for their own failure in relationships throughout life, acting unwisely as a result of anxiety.

This patient manifested the same difficulty in adolescence, as well as the restlessness that is characteristic and which took him from job to job and about the country avoiding jobs involving physical inactivity. The bad beating he took in the ring evidently caused him to resign himself to the inferior status he had experienced in relation to his father and brother and had tried to escape. "Fed up" with his authority and responsibility as third mate on a boat he came home, took a job as shop laborer and married.

He had evidently been able to express both his aggression and pleasure impulses through much physical recreation and work, with adequate adjustment until the job of foreman was given him with the concomitant increase in anxiety.

Characteristic repression of sex, strictness in family life and social withdrawal were evident. He did not go out or have any friends to visit or invite. A movie was his occasional recreation.

His face was unusually expressionless even when speaking of emotionally charged incidents, and his voice was equally controlled. His dreams of fighting, in which he is hurt but is never able to hurt his opponent, and his dreams of life as a boy and before marriage, if freely interpreted, would seem to indicate the way in which his emotions are expressed since his mode of living and his lack of physical activity eliminate these possible avenues of expression.

Treatment has caused a remission of arthritis; but this man's conflicts are unresolved and his anxiety is so great that it is manifest in these disturbed dreams to such an extent that a psychiatric condition appears likely to reinforce the arthritis in keeping him from the foreman's job.

This man spent more than an hour telling of his treatment and the lack of consideration shown him by doctors who had treated him as "a guinea pig". He did not wish to be interviewed because no one had helped him, and he did not wish to help them by being studied. However, when the interviewer had explained many of the reasons for experimentation in treatment, giving him the consideration he desired, he asked the interviewer to

come again and offered to go to the interviewing psychiatrist to do what he could to help - indicating he felt he might get more help, and that he wished to please the interviewer.

Case of [1] Mrs. S.

This is the case of a 32 year old married woman, who has 7 children.

This woman's mother died at the age of 21 when the patient was 2 years of age. Death occurred after the birth of the patient's only brother. The patient was placed with the maternal grandmother and her brother was placed with the paternal grandparents. The father who was 23 soon married again, but did not take his children to live with him.

The patient lived, until she was 14 years of age, with her grandmother who was 'the boss of the house, worked very hard, never told us anything, was very active, worked at home and at the Post Office, went to meetings and card parties. She was strict but gave me everything. I was spoiled. She was a wonderful woman. She had asthma. She died at 76, when I was 14, and then I was on my own'.

The grandfather, mentioned only in response to a question, was a fisherman in the summer and worked around the house in the winter. He was very passive and easygoing.

The patient worked as a domestic until she married at 18 years of age. She said 'I didn't know anything about sex and I was scared. I was so terrified and tense and never enjoyed intercourse - my husband called me "the old ice-box". I was terrified before the children were born. I've had seven children in fourteen years and sometimes I think it is no wonder people and animals go mad and do terrible things. Sometimes I could throw the children out. I feel as though I were in a cage. I like the children but it gets to be too much. I work after them all the time and can never get out. I used to do all the painting and papering and cleaning to keep the place nice and I did it at nights after they were in bed. My husband is so useless! Whenever he tried to help me he just made a mess and I had to tell him to get away and I did it myself. Once someone threw a rock in the window and he ran to get help, leaving me here unprotected. I picked up a baseball bat and was ready to let them have it. This is a tough district. The children have been beaten up and once a neighbor came in to start a fight about the children. I split her lip, tore half her clothes off and told her she was lucky to be able to get home. I let them

---

1. Case No. 20.

have it - no use saving it for your old age.'

After the seventh child was born the patient was terrified about the possibility of having more. At this time she received news of the sudden death of her only brother whom she had not seen for ten years. Then arthritis appeared and she soon became helpless. The children had to help dress her. She had to let her husband do much of the work and she noted that he had learned to do it well.

The doctor at the clinic who said all his patients were one happy family was so good to her. Once when she had been suffering at home he said she should come whenever she needed relief. This consideration was wonderful. The doctor had also suggested her husband should have more consideration, get someone in to help, etc. He had also advised and provided a safe contraceptive so she need not worry about more children unless she wished them. Since that she has been able to lose her terror of sex relations and her relationship has been better with her husband. Treatment of arthritis also began to result in improvement.

A later interview revealed this patient much improved, doing all her own work, shopping, running for street cars, making new curtains and sewing until her fingers were bleeding because she couldn't be bothered with a thimble, starting to wash a ceiling at night and then getting dressed to go out to a show. (This woman who has much hostility and apparently the drive of her very active grandmother, had evidently been unable to accept or rightly interpret all the doctor's advice which included instructions with regard to work and rest.)

The death of this patient's mother before the patient was three, the fact that her father never wanted her sufficiently to take her to live with him after he remarried, and the strict, religious, active, dominant, selfsacrificing grandmother and dependent grandfather with whom she lived until the age of 14 appear to be the factors responsible for the extreme hostility she manifests. The passivity of the grandfather, the fact that her grandmother was small and evidently did not use much physical force in discipline, and the passivity of her husband may be factors enabling her to manifest more of this hostility than is common among these patients.

At 14 this patient was on her own, which seems to indicate the

CHAPTER VI

CONCLUSIONS

On the basis of evidence provided by the patients included in this study, we are justified in stating that arthritis patients do have characteristic ways of dealing with interpersonal relationships.

The main characteristics of the picture of the arthritis patient drawn from the findings of previous studies, from current medical conceptions, and from the writer's contact with these patients, have been shown operating in the behavior of the majority of the 80 patients. Examination of their experiences and environment has revealed something of the influences developing and maintaining these characteristics and something of their relation to the onset and course of arthritis.

It is the writer's belief, also, that something of the psychological intensity of these characteristic behavior patterns has been revealed in this study; and it is his hope that this presentation will carry that revelation of the intense needs and anxiety which underlie the unmeasurable stresses found in relation to this illness. This hope is related to indications from the experience of this study and from conclusions by several writers which agree with that of Booth [1] that in addition to medical treatment it is important that "the necessary equilibrium be restored in dynamic relations between the individual and his environment". This is the field where the social worker may put his talents to excellent use.

Principal Characteristics

The difficulty rheumatoid arthritis patients have in trying to form satisfying relationships with other people has been seen in their work

---

1. Gotthard C.Booth, "Personality and Chronic Arthritis", Journal of Nervous and Mental Diseases., Vol.85, No.6 (June 1937),pp.637-61.

relations where they attempt to avoid responsibility and any conflict with authority. This difficulty is also reflected in the anxious tenacity and hard work which tends to reduce criticism, and reduces anxiety about the lack of success in relationship and, consequently, in work. The difficulty is seen intensified in family and marital relations where relationship is a must and interdependence inescapable.

The patients' inability to accept dependency and to control their tempers has been shown in their assertion of independence in and their attempted withdrawal from all possible relationships. Their need of support and of being dependent is shown in their defense of strict parents, the high incidence of early marriage and their tenacious clinging to abusive spouses and unresponsive children, as well as in their stated concern and demonstrated self-sacrifice in these relationships.

That these people have difficulty in thinking through their problems and resort instead to precipitate action not related to the desired goal, has been seen in their withdrawal from situations of conflict and in their refusal to give in or to change attitudes and plans in the face of hardships until forced by illness or other circumstances. This difficulty appears to result in part from inhibiting hostility and in part from anxiety restricting the ability to think objectively.

That tension is reduced and pleasure obtained through muscular activity is seen in the statements of "love" of sports, especially those involving maximum of bodily movement such as swimming and skating, and is evident in the high incidence of such activity among these patients. Enjoyment of strenuous physical work is also evident.

It appears that these persons do have characteristic ways of handling personal relationships and of reducing tension through physical effort. It also appears that at a time of stress, when the physical means of reducing tension is overloaded, inefficient, or psychologically inadequate, arthritis frequently appears.

Development of Personality

The evidence indicates also that the parental influence is a large factor in the development of these behavior characteristics, an influence which remains with the patient and involves identification with the parent's personality even to the extent of arthritis, as noted also by Halliday. [1]

There has been evidence also that the stresses of adult life and relationships, especially the marital relationship, have tended to develop and intensify the characteristic behavior pattern and acceptance of the parental influence.

Illness too has generally had the effect of causing the patient to hold more doggedly to this pattern of behavior. However, several exceptions have been noted, and these appear to be directly related to improvement in the patients' health.

The Social Worker's Role in Treatment

The most important conclusion the writer has reached concerns the social worker's participation in the treatment of arthritis patients.

It has been indicated that these patients have much repressed hostility and general difficulty in establishing relationships. Their concern for others, self-sacrifice, and withdrawal, as well as the statements

---

1. J.L. Halliday, "The Psychological Approach to Rheumatism", Proceedings of the Royal Society of Medicine, Vol.31 (Nov.19,1937) p.171.

of many who criticised the lack of help by those whose help they rejected by their independence, indicate the depth of their need for and anxiety concerning relationships. It has been noted that in several cases illness which enabled dependency without criticism or relieved anxiety about sexual adjustment, caused some changes in the personality of the patient, especially when an authority more understanding and tolerant than the parents had counselled the change.

The writer's experience was that without exception these patients, having told their life story and the difficulties of their relationships to him, were impressed by the absence of disapproval, the understanding, and the rapport developed between them and the interviewer. When these patients were seen again, for a second interview or by chance at clinic, they showed unusual interest in renewing contact with the interviewer. Several had invited the interviewer to visit again and offered cooperation should he wish any further information. One patient,[1] having fought for two years against going to a nursing home, was able to tell the writer she really wanted to go after he had shown understanding of her attitudes. Another,[2] after a brief discussion of her marital difficulties, indicated insight into her husband's attitude and her own dominance, and expressed appreciation for the help received.

While the writer would not attempt to forecast the degree of success likely to attend such efforts, it is indicated by the personality changes and improvement in arthritis shown by three of his 20 patients and by the need for and interest in relationship shown by the others, that a

---

1. Case No. 3

2. Case No. 13

more intensive effort on the part of the social worker to reduce anxiety and tension in these patients would be well rewarded. However, we cannot emphasize too strongly that the worker must be able to accept hostility as a symptom of the patient's difficulty and respond with understanding and warmth. In the case of the patient who had been refusing to go to a nursing home,[1] it is significant to note that a social worker who had been using a manipulative approach had aroused all the patient's conflict with authority so that the patient had eventually to be forced to go. It might also be noted that this patient's conflict had been with her mother and the worker was female.

The role of anxiety in such physical illnesses as heart diseases, and gastrointestinal ulcers is generally accepted.[2] It is the writer's conclusion that the anxiety which, is heavily weighted with self-condemnation and fear and which attends the arthritis patient's early and unsuccessful attempts to gain the approval of parents and which increases through all his subsequent difficulties with dependency and relationships is the most serious factor adversely affecting his personality and developing the tension which appears to be directly related to his illness. The doctor and the social worker may do much to reduce this anxiety through an understanding relationship. They and all workers for human health and happiness may help prevent it by counselling and educating parents and future parents towards more tolerant and understanding handling of their children, by equipping them to provide adequate sex education, and by developing in them a sense of appreciation for the satisfaction of less restrictive parenthood.

---

1. Case No. 3

2. Weiss and English, Op.Cit. p. 229 and p. 437.

Implicit in the picture of personality and the developmental factors observed in these patients is a further conclusion concerning the equilibrium of the individual and society.

It would appear that the behavior pattern of moral strictness, industry and devotion to duty, tendencies to mind one's own business and repress aggressive impulses, which is generally approved and inculcated by our society in the socialization of new members has undesirable results in the personalities of arthritis. It is also indicated that others [1] who do not have arthritis have been subject to the same influences and have similar personality difficulties.

Dr.Hans Syz [2] indicates that human nature and the social order are aspects of a totality and that one cannot be ill or cured apart from the other. Also, that the illness of the individual personality is concomitant to an illness in society. Our findings indicate that the emphasis on the manifestations of morality and ethics mentioned may require modification. The evidence that the siblings of the patient did not always respond to the parental influence as the patient did, indicates the need for greater attention to the individual as such and not as another unit to be moulded by certain socialization pressures into a certain behavior pattern despite the differences of constitution, personality, needs and impulses.

---

1. Supra, p.5

2. Dr.Hans Syz, "The 'Social Neurosis' ", Reprinted from the American Journal of Sociology, Vol. XLII, No.6, (May 1937), p.895.

CHAPTER VII

CRITIQUE OF METHODOLOGY

The experience of this pilot study has enabled those participating to see the advantages of group and interdisciplinary research projects. This experience has also afforded a taste of the disadvantages and problems which may be reduced in future projects of this type.

The broad scope enabled by the interdisciplinary approach and design has provided the multiple focus which is essential to comprehensive study of illness and which is especially valuable to social workers. Orientation to the study of illness in terms of the design and concepts of this research, the planning, management and results of the study have all been interesting, stimulating and, to a very considerable degree, gratifying.

The success of group planning and operation of the study and the uniformity of material obtained has left much to be desired but has also given ground for enthusiastic planning of future projects in the light of this experience.

The time factor, the fact that this project was a venture into a new area, and the way in which the project developed were perhaps responsible for the major problems encountered or the lack of success in meeting them.

Inherent in the project from the beginning was the inability to plan it precisely, and the necessity for the researchers to adjust as the research developed. These adjustments were to constitute part of the learning value of it. Nevertheless, this constituted an acute handicap;

and the most important suggestion that may be offered for guidance in undertaking such ventures in the future is that the most complete possible understanding be achieved at the top supervisory level by all representatives of disciplines involved before the study is begun, and that the research be projected with the maximum possible definitiveness.

Trial interviews, suggested as the first step in orientation to the project, were not made owing to a delay caused by a difference of opinion as to whether orientation to the literature would not be a better primary approach. Both steps have value and in retrospect could and should have been integrated.

Important in this connection was the misconception that there would be a single report integrating the separate sections of the study, which was erroneously held almost to the end of the study. This resulted in a relatively late arbitrary assignment of sections for separate reports and the addition of the section on the personality of the rheumatoid arthritis patient. It also resulted in the loss of the unity implicit in the plan of the study.

Much duplication of effort resulted from this required method of reporting and the necessity of the four persons involved going their separate ways, just at the point that findings were emerging, and conclusions being drawn, meant that cross-stimulation of group thinking was lost and that the vitally important integration of findings could not take place.

It is the strong recommendation of the writer that such projects, designed and carried out through joint effort, should not be dismembered for presentation with the consequent loss of the fruits of cooperative research.

It is perhaps no less important that all participants at all levels and at all stages in the study should strive for basic understanding and integration of plans and procedures through systematically arranging for interviews and conferences throughout the period in which the research is conducted. It is the opinion of the writer that the difficulty of arranging such conferences at times suitable to those involved, and the amount of time consumed by frequent conferences would be found to be reasonable premiums on the assurance of greater success and satisfaction in the research. Failure to consider details of management and study in conferences resulted in differences of interpretation, in material sought, and in recording of interviews. One difference of this nature resulted in the writer's being the only student social worker who specifically questioned the sexual adjustment, which was found important in other studies of arthritis, as a basic aspect of information required concerning the emotional pattern in the patient's family.

Time lags, delays due to confusion and differential paces at which individuals work, and delays due to the need to solve problems by conference are inevitable in group projects. These delays may be minimized by fuller planning and consultation, and by effective leadership of the research group.

More intradisciplinary responsibility could also make for greater efficiency. A suggestion made in the early stages of this study, that each student social worker be responsible for the uniformity of information obtained by all four interviewers in one of the four aspects of the study, was not sufficiently considered at the time. Later it was recognized that this plan would have made for better integration and uniformity. This

would also have assured that individual interviewers were not neglecting one section, in which information was difficult to obtain, and were not overemphasizing another section in which their particular interest might lie.

Another factor in addition to the need for frequent conferences, discussion in detail, and mutual responsibility is the necessity of recognizing the research group as a group and utilizing these dynamics through skilled group leadership. A number of workers representing various disciplines brought together perhaps for the first time to carry out such a group project may have the potentialities of integration, mutual understanding and cooperation; but these qualities must be developed with a common focus. This would seem to be an important objective of the early conferences which are also concerned with planning the research and orienting the workers to its design and subject matter. Perhaps closer organization of the group with regard to schedule, form and agenda for meetings would assist this development as it would the efficiency of the study. In these comments concerning the group is the clear implication that one of the supervisory personnel should assume active responsibility for the group as such.

This specific section of the study was somewhat handicapped by not being represented by a separate section of questions in the information schedule. It was further handicapped by the segmental nature of the report which did not permit the use of findings from the other three studies specifically concerned with the areas discussed in Chapter V. This integration had been intended as a mutual verification of findings but

was impossible because the findings of the various studies were not simultaneously available.

Comparison of findings has also shown that both qualitative and quantitative analysis of the cases reported by other workers is quite inferior to analysis by the interviewer himself and it is suggested that for facility and accuracy it would be better for the interviewer to analyse all sections of his own cases than to analyse all cases in respect to one section. It is not possible to record all impressions of an interview which may later have value if known.

While the experience of this project has shown the need for earlier and more complete planning and has pointed up many shortcomings of method and management, the results of the study have coincided sufficiently with those of other studies of similar aspects of arthritis and indicate sufficient significance generally to bring satisfaction to those who participated and credit to those who designed it.

APPENDIX "A"

Schedule of Information Sought in Interviews.

NAME: AGE: SEX:
APPEARANCE:

ATTITUDE TO QUESTIONING:

EXTENT OF DISABILITY AT TIME OF STUDY:

PATIENT's ILLNESS.

1. Circumstances of onset (sudden or general - description in words of patient)

2. Course of illness (Worse or improved - by stages, fluctuating - patient's statement of degree of disability at at various stages, especially as affecting motility or eye-hand-mouth coordination.)

3. Treatment received from viewpoint of patient.

4. Attitudes towards illness.
   1. How did he accept illness (Accept full implications, regard as less serious than it was, indifferent, hostile.)

   2. Reaction (Greater effort, give in easily, no noticeable reaction)

   3. Any evidence of using illness to get own way?

   4. How does he feel his friends, associates, neighbours and representatives of social agencies are reacting to his illness? Is he satisfied with reactions?

ACTIVITIES OF PATIENT

	Before Illness	After Illness
Mental		
Body activity		
Business		
Social		
Recreational		
Cultural		
Religious		

PATTERNS OF THE FAMILY AT TIME OF STUDY

Dwelling
Type
Condition
Number of rooms
Sleeping arrangement
Heating - any dampness?

Lighting
Water supply
Washing facilities
Proximity to shopping centres
Social level of neighbourhood
Comments:

Was patient living in this residence at time illness began?
If not, was the house cold, damp?

Human Structure:

1. List of individuals living together as family; legal relationships.

2. Division of labor within household.

3. Occupations and work history of each member gainfully employed.

4. Income of family from all sources.

5. Social level.

6. Financial dominance in family.

Emotional Patterns of Present Family

1. Groupings in obtaining emotional satisfaction - emotional relationships.

2. Emotional and intellectual dominance.

3. Description of personality of each adult member in family (with special reference to person as being active/passive, self-reliant/dependent, self-interest/concern for others, domineering/anxious to avoid trouble, active competition/bottle up and/or explode)

4. More detailed description of personality of patient - Family, Occupational, Recreational, Cultural, Political, Religious fields.

5. Effects of illness on the family as a whole, individual members.

Family Dynamics (Parent Family)
(Distribution in time and space)

1. When and where did individuals marry?

2. How often and through what localities have they moved since marriage to present time?

Disruptive and Cohesive Tendencies

1. Was it the first time either partner had been married?

2. Have they ever separated?
3. If so, on how many occasions?
4. For what cause?
5. Peak size of family (include additional members as aunts, etc., if living with family at any time)

6. Was the family considered free from emotional tension? If not, what was the cause, how was it shown?

7. At what age did each sibling leave family? Include cause, emotional relationships at time of leaving.

8. Have any siblings ever returned to family after leaving - number of times, cause - emotional relationship on return?

9. List siblings and outstanding personality traits. Personality traits of parents.

APPENDIX "B"

Characteristics of Patients Studied

TABLE III

Sex and Marital Status

Marital Status	Total	Male	Female
Total	80	27	53
Married	43	17	26
Single	12	5	7
Divorced	2	1	1
Separated	12	3	9
Widowed	10	1	9
Common-law	1	0	1

TABLE IV

AGE

Age Group	Total number of patients	Patients	
		Male	Female
Total Number of Patients	80	27	53
16 - 25	3	3	0
26 - 35	9	4	5
36 - 45	20	7	13
46 - 55	23	10	13
56 - 65	18	3	15
Over 65	7	0	7

TABLE V.

Degree of Disability at Time of Study

Degree of Disability [a]	Patients		
	Total	Male	Female
Total Number of Patients	80	27	53
Bed-ridden [b]	5	1	4
Confined to house and require care [c]	11	7	4
Confined to house but do light work	17	3	14
Able to Work Part Time [d]	17	4	13
Able To Work Full Time [e]	30	12	18

(a) Degree of disability is considered here in terms of social function.

(b) Patients are considered as bed-ridden, when most of their time is spent in bed.

(c) Patients are considered as being confined to house when they are only able to go out with help.

(d) In the case of women patients, this applies to their ability to perform household tasks.

(e) In the case of women patients, they are considered as able to work full time when they perform household tasks with minimal assistance or require no assistance.

APPENDIX "C"

KEY CARD

Work Relations

1. Employed - Total _____ No. Male _____ No. Female _____

No. Housewives _____

2. Type of Employment - Individual _____ Cooperative _____

Work with people _____ With things _____

Predomintly physical _____ Mental _____

3. Employment Record - (a) regular employment _____ Changes _____

(b) Attitude to employment record - Accepting _____

Critical _____ Unconcerned _____

4. Responsibility -

Feeling of - strong _____ Moderate _____ Mild _____

5. Authority -

(a) Attitude to - Submissive _____ Rebellious _____ Independent but cooperative _____ Defiant and repressed _____

(b) Exercise of - With ease _____ With difficulty _____

Dominates _____ Seeks cooperation _____ Withdraws _____

6. Attitude to other workers - Equalitarian _____ Critical _____

7. Sharing of problems- Yes _____ No _____

8. Assessment of Responsibility for lack of more success - Self _____

Others _____

Social Relations

1. Recreation - Much _____ Little _____ None _____

Individual _____ Group _____ Muscular _____

Mental _____

2. Social Activities - (Clubs, etc) Many _____ Few _____ None _____

3. Friends - Many _____ Few _____

4. Personality characteristics in social relations -

Active _____ Passive _____ Self-reliant _____ Assert independence _____

Concern for others _____ Avoid trouble _____ Bottle up

aggression _____ Explosive temper _____ Worry _____ Physically

active _____

Parent Family Relations

1. Relationship with mother -

dependent _____ free _____ overindependent _____

2. Relationship with father -

dependent _____ free _____ overindependent _____

3. Relationship with siblings -

dependent _____ free _____ overindependent _____

4. Responsibility for relationship difficulties -

Self _____ others _____

5. Evidence of identification -

With strict parent _____ with dominant parent _____

6. Age on leaving home _____

Marital Relations

1. Sex _____

2. Age at marriage - patient _____ Partner _____

3. Relationship with partner - submissive _____ dominant _____

deep _____ superficial _____

4. Accept dependency - Yes _____ No _____

5. Sexual adjustment - satisfactory _____ unsatisfactory _____

6. Relationship with children - dominant _____ free _____

superficial _____ deep _____

BIBLIOGRAPHY

Alexander, F., Psychosomatic Medicine. New York: Norton Co. Inc., 1950

Booth, G.C. "Personality and Chronic Arthritis". Journal of Nervous and Mental Diseases, Vol.85, No.6, pp.637-661,(June '37)

Bush,P.D. "Arthritis." Journal of Rehabilitation, Vol.13, No2, p.24.

Cobb, S., Bauer, W., Whiting, I. "Environmental Factors in Rheumatoid Arthritis." Journal of the American Medical Association, Vol.113, No. 8, (1939), p.668.

Comroe, B.I. Arthritis and Allied Conditions. Chicago: 1944.

Deutsch, F. "The Use of the Psychosomatic Concept in Medicine". Bulletin of the Johns Hopkins Hospital,Vol. 80, No. 1 (Jan. 1947).

Dunbar, F. Emotions and Bodily Changes. New York: 1946.

Dunbar, F. Mind and Body: Psychosomatic Medicine. New York: 1947.

Giles, T.W. "Psychic Factors in Rheumatoid Arthritis." American Journal of Psychiatry, Vol. 93, No.1. (Nov. 1936).

Gordon, R.G. "Psychological Factors in Chronic Arthritis". British Medical Journal, Vol. 1 (June 10, 1939), pp.1165-69.

Halliday, J.M. "The concept of Psychosomatic Rheumatism". Reprinted from Annals of Internal Medicine, Vol. 15, No.4,(Oct.1941). Printed in U.S.A.

Halliday, J.M. "Psychological Aspects of Rheumatoid Arthritis". Proceedings of the Royal Society of Medicine, Vol. 35,(Feb.1942), pp.455-57.

Halliday, J.M. "Psychological Factors in Rheumatism". Reprinted from the British Medical Journal, (Jan.30 and Feb.6, 1937),pp.213 and 264.

Holbrook, W.P. and Hill, D.F. Manual of Rheumatic Diseases, Chicago: The Year Book Publishers, 1950.

Johnson, A., Shapiro, L.B., and Alexander, F. "Preliminary Report on a Psychosomatic Study of Rheumatoid Arthritis". Psychosomatic Medicine, Vol. IX, No.5 (Sept. Oct. 1947) p. 295.

Kluckhohn, C. and Murray, H.A. Personality in Nature, Society and Culture. New York: Alfred A. Knopf, 1949.

Krech, D. and Crutchfield, R.S. Theory and Problems of Social Psychology. New York: McGraw-Hill, 1948.

Law, S.G. "Interview Therapy of Psychosomatic Arthritis". Rheumatism, Vol. V, No.2 (April 1949), p.38.

Margolis,H.M. "Care of the Patient with Rheumatoid Arthritis". The Family, Vol. 25, No.9, (Jan.1945), p. 323.

Nissen, A. and Spencer,K.A. "The Psychogenic Problem in Chronic Rheumatoid Arthritis". New England Journal of Medicine, Vol. 214, No.12 (Mar.19, 1936), p.576.

Richardson,H.B. Patients Have Families. New York: The Commonwealth Fund, 1945.

Ruesch,Jurgen and Prestwood, A.R. "Communication and Bodily Disease". "Reprinted from Life, Stress and Bodily Disease", 1950. Proceedings of the Association for Research in Nervous and Mental Disease, 1949, Vol. 29.

Schless, Bessie. "Social Casework Services to the Arthritis Patient". The Family, Vol. 15, No.9 (1945), p. 331.

Selye, Hans, The Physiology and Pathology of Stress. Montreal: 1950.

Sullivan, Harry Stack. Conceptions of Modern Psychiatry. Washington: 1947.

Weiss, E. and English, O.S. Psychosomatic Medicine. Second Edition, Philadelphia and London: W.B. Saunders, 1949, pp.731-40.

Wittkower, Eric, A Psychiatrist Looks at Tuberculosis. London: The National Association for the Prevention of Tuberculosis, 1949.