THE "CHRONIC RHEUMATIC" AND HIS PAINS

PSYCHOSOMATIC ASPECTS OF CHRONIC NON-ARTICULAR RHEUMATISM

BY

PHILIP ELLMAN and DAVID SHAW

From the Rheumatism Unit, St. Stephen's Hospital, London

Non-articular rheumatism embraces some 75 per cent. of cases of chronic rheumatic disorders, including fibrositis, muscular rheumatism, neuritis, panniculitis, capsulitis, pleurodynia, lumbago, and so on. The term "fibrositis" is applied to many maladies sharing a common symptomatology of pain, stiffness, and limitation of movement. The status of fibrositis with particular reference to the problem of differential diagnosis was reviewed by Ellman (1947). The multiple causes of backache, including psychological, have been dealt with by Cohen (1948). Valentine (1947) made a comprehensive review of the aetiological factors.

Hurst (1943) declared that patients with "genuine" sciatica or lumbago usually recover in two or three weeks if given rest, and that pain persisting after this is almost always a result of hysterical perpetuation. In discussing the normal duration of lumbago or sciatica, presumably associated with internal muscle strains or exposure to cold or damp, Halliday (1944) states that, although the duration of pain of this type depends on the nature, degree, and locality of the trauma, it seems unlikely that it should continue over months or years; workers subjected to cold or wet surroundings or to draughts may continue symptomless for years, and if they report sick it is often at a time of some emotional disturbance usually associated with inward feelings of resentment.

It has long been recognized that emotional factors play an important role; Halliday (1944) found that 30 per cent. of 145 consecutive patients labelled as having "rheumatism" were incapacitated because of psychoneurosis, and that "psychoneurotic rheumatism" accounted for 40 to 60 per cent. of those who remained on the sick list for two months or more. Ellman and others (1942), in a study of fifty "fibrositis" patients with a history of 3 months or more, made psychiatric diagnoses in 38 (76 per cent.). Flind and Barber (1945) found that in about 42 per cent. of patients admitted to R.A.F. special rheumatic centres the disability was essentially psychogenic. Such "psychogenic rheumatism" was the most frequent cause of disability (34 per cent.) in 450 soldiers with rheumatic complaints admitted to U.S. military hospitals (Boland and Corr, 1945). Hench and Boland (1946), in a review of rheumatic disorders affecting American soldiers in the second world war, claim that 15 to 20 per cent. of men admitted to special rheumatism centres were in fact suffering from "psychogenic rheumatism". They stress the

importance of recognizing this psychoneurosis affecting the locomotor system—"a musculo-skeletal expression of functional disorders". They assert that this is one of the commonest causes of localized aches and pains in muscles and joints in both civilian and military life, and attempt a differentiation on clinical grounds between what they term "primary fibrösitis" and "psychogenic rheumatism".

Boland (1947), elaborating this conception, refers to Weiss (1947), who remarked on the significance of "smouldering discontent" in such cases. Hench (1948), and Tegner and others (1949), draw attention to the same problem. Investigating the subject from a different angle, Edmonds (1947) reported that muscular pains were prominent in 47 per cent. of a series of 183 psychoneurotics.

Present Investigation

Material.—We have studied 109 cases (78 women and 31 men) of chronic non-articular rheumatism over a period of four years, 1943 to 1947. Their ages ranged from 19 to 68 years, 44 being the average. They were mainly drawn from the artisan class. Seven of the men—a foreman, a labourer, a bricklayer, a stonemason, an asphalter, and two painters—were connected with the building trade. All had a history of attendance at a Rheumatism Unit for 6 months or more, and all were given a full clinical, radiological, and pathological examination by one of us (P.E.). The diagnosis of "non-articular rheumatism" was made largely by exclusion, investigation having failed to reveal abnormal physical signs of rheumatic disease. In the few cases where some abnormality was found—e.g. mild or very early evidence of degenerative joint disease on x-ray examination—it was considered insufficient to account for the symptomatology. Every case was also examined psychiatrically by one of us (D.S.).

A series of 58 controls (34 women and 24 men) of comparable age and social class was subjected to similar physical and psychiatric examinations. The main particulars regarding both patients and controls are set out in Table I.

TABLE I
PARTICULARS OF CASES UNDER REVIEW

Group ..		Patients					Controls					
Total No. ..		109					58					
Average Age		44					46.5					
Marital Status ..		Single	Married	Separated Divorced			Single		Married		Widowed	
Male ..		3	26	2			2		22		0	
Female ..		20	57	0			2		30		2	
Medical Category ..		Duration of Disease (yrs)					Diagnosis					
		—2	3-5	6-10	11-20	20—	Hernia		Varicose		Hallux Valgus	Internal derangement of knee
							Inguinal	Femoral	Veins	Ulcers		
Male ..		7	12	8	3	1	18	0	2	2	0	2
Female ..		25	16	24	10	3	2	12	8	4	8	0

Symptomatology.—The cardinal symptoms were pain and stiffness, the pain being variously described as "burning", "searing", "like cold water poured down the

neck", "aching", or "dragging". Painful paraesthesiae, "pins and needles", pricking sensations, and unpleasant numb feelings, were associated with limb and back pains in thirteen cases. In the majority the pain and stiffness were comparatively localized. In 34 cases the site was the lower part of the back. The pain was predominantly right-sided in 21 cases and left-sided in eighteen. Both Halliday (1944) and Edmonds (1947) have remarked on the special frequency of left-sided pain and its psychological significance in these cases, but this localization was not evident in our series.

Sixteen patients complained of more or less generalized pain, sometimes described as a general soreness of the bones; they included five with chronic anxiety states, three with endogenous depression, and two hysterics (e.g. Case 1).

Sixteen patients complained that the pains were made worse by changes in the weather, and by cold and damp. Fourteen found the pain worse at rest, or at night. These patients complained typically of getting "fixed" or "set" and would tend to keep on the move to prevent it.

Response to Physiotherapy.—This was variable. Where relief was obtained, as it was in 35 cases, it was often only temporary, and twenty patients maintained that they were either not affected or were actually made worse by physiotherapy.

Associated Symptoms.—A spontaneous complaint of depression, varying from mild to suicidal, was noted in 49 cases. Sleeplessness was a feature in 32 cases and in most of these pain was not the cause. Fatigue and a general lack of energy and zest were stressed by 26 patients. Headache, usually frontal, was a symptom in thirteen cases, and in most of these was associated with a moderate or severe degree of depression. Irritability, intolerance of noise, stammering, and "jumpiness" were noted in others. Seven female patients displaying marked anxiety were menopausal, and complained of headaches, dizziness, and attacks of flushing.

Initial Diagnosis.—The patients had been variously diagnosed initially, as suffering from chronic fibrositis, lumbosacral strain, postural deformity, low backache, functional backache, capsulitis or bursitis, peri-arthritis, sciatic pain, degenerative arthritis, and so on. In a few, the diagnosis of rheumatoid arthritis had been made, and four female patients, none of whom now had signs of active rheumatic disease, had been given courses of gold treatment.

Men.—Twenty out of 31 showed a complete absence of abnormal findings. Minimal or moderate osteo-arthritic changes were found on x-ray examination in a few, but these were not considered adequate to explain the symptoms.

Women.—Out of 78, 59 showed complete absence of physical signs in the locomotor system, with negative x-ray and pathological findings. In eleven cases an erythrocyte sedimentation rate of 20 mm. or over was found; in four of them this was an isolated pathological finding. In the remaining seven, x-ray evidence of a mild or moderate degree of degenerative arthritis or spondylitis osteo-arthritica was found, in spite of the raised erythrocyte sedimentation rate. These mild, and often strictly localized, arthritic changes could not have accounted for the widespread symptomatology. The disparity between the gross nature of the symptoms and the poverty of the physical findings was often striking (Case 2).

Neurotic Symptoms

Attention was now directed to an investigation of neurotic features. Positive evidence of neurosis was sought as indicated below, and was checked where possible by a parallel enquiry in the control series:

- (1) Family history of mental or nervous disorder or instability.
- (2) Evidence of instability in childhood or of a previous nervous breakdown.

- (3) Precipitation of symptoms by emotional conflict, or serious aggravation by a significant environmental situation.
- (4) Confirmatory evidence on examination of a neurosis of or a significant personality structure.

The results of these enquiries regarding (1), (2), and (3) are set out in Table II.

TABLE II
RESULTS OF INVESTIGATION OF NEUROTIC FEATURES
AND PRECIPITATING EMOTIONAL STRESS

Lines of Enquiry		Patients						Controls	
		Male		Female		Total			
		No.	%	No.	%	No.	%	No.	%
(1) Family history	Neurotic breakdown or instability ..	18	58	36	46	54	49	8	14
	“ Rheumatism ” ..	12	38	41	57	53	48	5	11
	Combined nervous disorder and “ rheumatism ”	9	29	20	26	29	27	0	—
(2) Previous personal history of nervous instability .. (including major psychoses) ..		10 (3)	31 (10)	43 (13)	55 (17)	53 (16)	48 (14)	12	21
(3) Precipitating emotional stress ..		3	10	27	35	30	27	6	12

(1) **Family History of Neuropathy and Psychopathy (with or without "Rheumatism").**—36 women and 18 men had a positive family history of 49 per cent., compared with 14 per cent. of the controls. (A typical patient was Case 3.)

(2) **Earlier Neurotic Traits and Previous Mental Breakdown.**—There was a history of nervous instability in 43 women, thirteen of whom had a previous major neurotic or psychotic illness, mostly depressive in nature (Case 4). Ten men had similar histories, and of these, three had suffered from a serious psychotic illness (neurasthenic in one, and depressive in the other two). Neurotic trends in early life had mainly taken the form of strong fears and phobias clearly remembered from childhood. Fears of the dark, of thunderstorms, of cats or dogs, or of noise generally, were frequently described and in some these early phobias persisted. In other cases a sense of inferiority had been present from childhood, often associated with emotional over-reaction to stress or excitement. Nail-biting, stammering, tics, sleep-walking, and enuresis were other neurotic traits. To what extent these indicated constitutional inadequacy was not always easy to assess, but in a few cases the environmental stress had been considerable (Cases 5 and 6). In all, 48 per cent. of the patients fell into this category; the comparable figure in the control series was only 21 per cent.

(3) **Emotional Stress as a Precipitating Cause.**—In this enquiry it was important to avoid leading questions; some patients appear to over-emphasize such factors,

but to others the relationship between some source of stress and the onset or exacerbation of symptoms may first become clear in the course of taking the history and is received as a minor revelation. In 27 women and three men (27 per cent.), evidence was obtained of some event of great emotional significance immediately prior to the onset of symptoms (Cases 7, 8, 9). In the control series emotional stress preceded the onset of symptoms in only two men and four women (11 per cent.). The incidence of various forms of stress is set out in Table III.

TABLE III
INCIDENCE OF EMOTIONAL STRESS

Form of Stress	Male		Female		Total	
	No.	%	No.	%	No.	%
Sexual and marital worries	—		11	15	11	10
Accident or illness in the family ..	—		8	10	8	7
Serious personal ill-health	1	3.5	3	4	4	3.5
Change of job	2	6.5	1	1	3	2.5
Financial set-back	—		2	2.5	2	2
Loss of home in air-raid	—		2	2.5	2	2
Total Patients	3	10	27	35	30	27
Total Controls	2	8	4	12	6	11

In some there was an overwhelming combination of stress in connexion with a bereavement and the patient's own breakdown in health (Case 8). In others there appeared at first to have been no antecedent emotional stress. Nevertheless, the chronicity, the psychiatric state, the complete absence of signs of rheumatic disease, and often the lack of response to physiotherapy, were felt to warrant further enquiry into the environmental situation prior to the onset of symptoms. A potent source of tension was then revealed; a distressing situational conflict had been suppressed, or attention diverted to some trivial accident as an aggravating factor (Case 9).

(4) **Personality Disorders.**—These fell in the main into four categories, the relative proportions of which are set out in Table IV.

(a) *Obsessional Personalities.*—The largest single group in this section was made up of the fussy, fidgety type. Among the women, one frequently came across the meticulously houseproud individual who worried excessively over her routine of work, was easily flustered, and constantly anticipated things going wrong. Often high-principled, independent, and self-reliant, these patients were tortured by visions of being crippled, and a burden to their families (Case 10). Associated with the obsessionalism was a general rigidity of outlook, a tendency to repress emotion, and often sexual inhibition (Case 11). One woman said she never read a book because she thought she should be doing something more useful. They never allowed themselves adequate relaxation, and had an almost missionary zeal to put things right (Case 12).

A second group of obsessives, mainly women, could be described as the hard-working, self-sacrificing, often unimaginative, type who make few demands on life. A few in this group, sub-normal in intelligence, had taken on considerable family responsibilities without much protest or evident desire for change. Self-effacing and uncomplaining,

TABLE IV
RESULTS OF INVESTIGATION OF PATIENTS' PERSONALITY TYPES

Types of Personality Disturbance	Male		Female		Total	
	No.	%	No.	%	No.	%
(a) Obsessional	8	27	43	54	51	47
(b) Energetic, sporting, narcissistic	6	19	10	13·5	16	15
(c) Self-assertive, driving	1	3	8	10	9	8
(d) Hysterical	3	10	7	9	10	9
Total Significant Personalities ..	18	59	68	86	86	79
Approximate Normal Personalities..	13	41	10	13·5	23	21
Total Patients	31	100	78	100	109	100

such women cope with great difficulties, often in spite of the serious handicap of chronic ill-health. Not uncommonly the extra physiological burden of the menopause precipitates a frank depressive breakdown (Case 13).

A third group of obsessionals comprised the pessimistic, apologetic, over-anxious worriers. Quiet, lonely, sensitive personalities, they are often phobic and ill-adapted socially. They anticipate the worst and are haunted with fears that their pains are one stage on the path to helpless invalidism (Case 14).

(b) *Energetic Personalities, "Keep-Fit Fans" and "Body-Lovers"*.—The second category, comprising the active, energetic, high-spirited type, is in complete contrast. These are the "outdoor" sports-lovers, and "keep-fit" enthusiasts. The women tend to be tomboyish and sociable, with a wide circle of friends and varied interests, being often as handy about house or garden as most men. The men are often keen on athletics and take an almost narcissistic pride in their bodies. They are bright, jovial, and friendly, but their pre-occupation with physical fitness sometimes amounts to a mild hypochondriasis. Not infrequently their sporting activity is taken up as a diversion from a dissatisfying employment. Popular medical books are studied and special courses of physical training religiously followed, with the help, not infrequently, of the home "health ray" or infra-red lamp (Case 15).

(c) *Self-assertive, Driving Personalities*.—The third category is the self-assertive, ambitious, driving type, corresponding more closely with the commonly described "ulcer" personality (Case 16).

(d) *Hysterical Personalities*.—Fourth come the hysterical personalities, demonstrative, emotional, and often histrionic. In a few, conversion symptoms have appeared; they include the typical voluble, smiling hysteric, the happy martyr, as exemplified by Case 17.

Psychiatric Features

It is difficult to say where a nervous temperament ends, and a frank neurosis begins. Culpin and Smith (1930) evolved a method of evaluating nervous symptoms by personal interviews,* which has been adapted to our series. The

* Mild nervous characteristics (shyness, etc.) which did not deter the subject from action or interfere with his happiness were not regarded as symptoms. The zero on the scale indicated that no particular nervous symptoms were discoverable. A patient with one or few nervous symptoms, slight in degree, and affecting him occasionally, was regarded as displaying only a mild personality disorder. When a patient had very definite nervous symptoms, usually presenting emotionally as fear or anxiety, and of such a degree as to interfere in some way with his behaviour, the disorder was graded according to severity as mild, moderate, or severe neurotic disorder.

patients were first graded on the Culpin-Smith scale according to the absence or severity of nervous symptoms and the findings are set out in Table V.

TABLE V
PATIENTS WITH SIGNIFICANT PERSONALITY DISTURBANCE
OR NEUROTIC ILLNESS

Abnormality	Male		Female		Total	
	No.	%	No.	%	No.	%
(1) Anxiety State	14	42	42	55	56	50
(2) Depressive State	2	5	12	15	14	13
(3) Hysteria	6	19	7	9	13	12
(4) Psychopathy	1	4	2	3	3	4
(5) Hypomania	0	—	1	—	1	—
Total with neurotic illness or disturbed personality ..	23	70	64	82	87	79
Total with nil or only slight abnormality	8	30	14	18	22	21
Total patients	31	100	78	100	109	100

(1) **Anxiety States.**—These predominated, the patients being tired, worried people, who, in addition to their pains, complained of headaches, sleeplessness, irritability, and depression. In the majority, tension of some degree was present, and was frequently closely related to an involved environmental situation (Case 18), and linked with a sense of bitterness, frustration, and even acute resentment. A few were inadequate, rather pathetic people of subnormal intelligence unable to cope adequately with housekeeping problems. It was the rule rather than the exception to find several inter-related spheres of acute conflict and tension in the same patient (Case 19). In thirteen female cases the menopause was an additional aetiological factor. The men more often showed tension linked with maladjustment in the industrial or occupational sphere, some having been forced by circumstances to take up work for which they were temperamentally unsuited. Others, though unfit for much responsibility, were yet bitterly aggrieved at the lack of promotion (Case 20).

(2) **Depressive States.**—The degree of depression varied widely. In two it was severe, and suicidal promptings were present. Most of the cases could be regarded as moderately severe reactive depressions. Emotional stress immediately prior to the onset of symptoms was noted in no less than eight of the women. Disillusionment and frustration in marriage, desertion by the husband, prolonged illness or death of husband or fiancé, were examples of the severe stress operating in this small group. The outstanding impression was the strength and persistence of the quiet struggle of the personality against immense environmental odds until the breaking point came with the development of an overt depressive illness. The complaint of pains in the back and limbs was practically always accompanied by a spontaneous complaint of depression, weariness, and often sleeplessness. Tension was absent or slight. The patient grieved over bereavement, financial losses, or the prolonged invalidism of a spouse. Several seemed to be, as it were, in mourning for their past. They were keenly aware that they were altered persons—tired, dejected, with practically nothing left of their former zest and initiative. They wanted to cry but frequently had no idea why. Two patients spontaneously remarked on the close connexion in time between their moods of depression and the exacerbation of their pains (Case 21).

(3) **Hysterical States.**—In these cases the duration of the symptoms tended to be long and indefinite. There was a multitude of complaints, often elaborated with much emphasis

and display. The situation was dramatized and the pains, usually generalized, were described in extreme and sometimes lurid terms. "Terrible backaches", "horrible feelings", "as if I were being split in two", and intense burning pains bringing on a collapse, were all described. Eight cases gave a family history of neurotic or psychotic disorder, and in seven there was a combined incidence in the family history of "rheumatism" and psychiatric illness. Two women had had a previous nervous breakdown, in both cases almost certainly hysterical in nature. It is evident that there was a particularly strong constitutional loading in this group of hysterics. There were significant environmental situations, and sexual maladjustment or serious marital disharmony was common, particularly amongst the women. In three women the menopause was an additional aetiological factor. In the men the onset of symptoms not infrequently followed an accident or alleged fibrositis which occurred on active service when the pensions issue was an important one (Case 23). In two men dullness or mental deficiency was associated with hysterical symptoms (Case 24).

As far as the clinical aspects were concerned, there were four examples—one man and three women—of typical conversion hysteria (Case 25).

(4) **Psychopathic States.**—Three cases fell into this category—one man (Case 26) and two women.

(5) **Hypomania.**—There was only one case (Case 27).

Nature and Cause of the Disability

Tables II, IV, and V demonstrate that though the symptomatology could not be explained in terms of active organic disorder, neurotic disorders were numerous.

We found a family history of neurotic or psychotic breakdown in 54 cases (49 to 50 per cent. as compared with only 14 per cent. in the controls), and previous nervous instability in 53 (48 per cent. as compared with 21 per cent. in the controls). Precipitating emotional stress played a dominant role in thirty patients (27 per cent. as compared with 11 per cent. in the controls). In addition, there was evidence of personality disorder or actual neurosis in 86 (79 per cent.). In all these the actual physical disability resulted from functional symptoms, and could presumably be regarded, therefore, as "psychogenic rheumatism" (in Boland's sense). The psychiatric diagnosis in 50 per cent. was anxiety state, tension of some degree being present in the majority. Frustration and resentment over a personal or domestic problem of emotional significance to the patient was commonly linked with the anxiety. It has been remarked that the fundamental feature in many cases of non-articular rheumatism was aggressiveness (Ellman and others, 1942).

Muscles serve as means of attack and defence. Internal tension is released by muscle action. If the external expression of aggression in the form of muscular action is inherited by repressive forces, muscle tension may result, and may be felt as pain and stiffness, and wrongly diagnosed as fibrositis, etc. Such repressive forces may lie in the nature of the particular environmental situation, which admits of no solution but poses a tremendous dilemma for the patient. Thus the conflict continues for years and the manner in which the resulting tensions are dealt with depends very largely on the personality structure of the subject exposed to them. The characteristically inhibited, rigid, obsessional person (the commonest personality-type in our series) is, by temperament, less capable of dealing with such

tensions. With his hypertrophied sense of duty and his tendency to brood over the pros and cons, he is at a serious disadvantage. Because expression of his conflict is restricted, a psychiatric and psychosomatic illness may result.

In this connexion Sherrington's comment may be worth quoting. The best outlet for tension, he says, is muscular action, the next best is speech, and the least effective is thought. The clinical picture of "chronic non-articular rheumatism" is more common in women, and women predominated in our series; one reason may be that by convention, as much as by temperament, women are less able to provide an effective outlet for tension in the form of action.

Choice of Symptom.—These two features (aggression, and a predominant personality pattern tending towards the rigid, obsessional, over-scrupulous, "driving" type) recur in the literature of the psychosomatic disorders (Stalker, 1949; and Halliday, 1943). Repressed hostility and aggressive impulses making the patient "boil with rage" have been incriminated in hypertensive cardiovascular disease, the asthma-eczema-prurigo syndrome (Rogerson, 1943), ulcerative colitis (Wittkower, 1938), migraine (Wolff, 1947), dermatitis (Robertson, 1947), enuresis (Stalker, 1947), and primary dysmenorrhoea (Wittkower and Wilson, 1940). There is anger, it is said, even behind laryngitis and the common cold, and epilepsy, according to some writers, is merely a mass discharge of hostility. Yet there appears to be no explanation for the choice of symptom. Why is one system affected rather than another in any individual case? Why does X develop ulcerative colitis, Y hypersensitive heart disease, and Z recurrent disabling aches and pains?

Saul (1944) claims that psychosomatic medicine is entering an epoch of "specificity", and that psycho-analytical investigation of the specific emotional constellations producing specific physiological disturbances will answer this question of localization. He almost appears to claim sole rights for analysts in this sphere of psychosomatic disorders, inferring that non-analysts have not the necessary training to appreciate the problems encountered. Perhaps because of a realization of the inherent weakness of this assumption that a particular psychosomatic syndrome results from a specific emotional setting, various other explanations have been advanced to explain the choice of symptom. A subtle variation in the personality pattern has been held by some to account for the localization. Dunbar (1943) delineated fine shades of personality type, claiming that they are specific for certain disease entities. She described the rheumatic, traumatic, and hypertensive personalities, but these variants are by no means clear-cut, for different investigators would, no doubt, stress different factors in each subject.

In our series, the composite group of the obsessional, over-anxious personality type comprised nearly half the total number, and the fear of becoming crippled and useless was often linked with this obsessiveness and perfectionism. But this is far from distinguishing a specific "rheumatic personality" type. The wide range of patterns included the inadequate person, the self-assertive and ambitious person, the "keep-fit" enthusiast, and the hysterical personality.

Others claim that the psychological situation can focus the pathology upon one or other organ, and describe the result as an "organ-neurosis". Fenichel (1945) explains peptic ulcers as due to a chronic hypersecretion of the stomach in response to a hunger for narcissistic love in persons with "frustrated oral-receptive demanding attitudes". Halliday (1937) explains some of his "rheumatic" cases in terms of symbolism, although on a cruder level, saying that the man with a stiff and painful back is expressing inability to bear his burden, and that the man with a stiff leg is expressing a frustrated desire to kick somebody. In the vexed question of "organ-neurosis" many will undoubtedly agree with Crookshank (1930):

"Premature and often fantastic attempts at interpretation in the light of this, that, or other metaphysical or psychological theory have set up much mistrust of psychological work in the minds of the medical Philistines."

Halliday (1943) noticed the significantly high proportion of the same or associated disorders in parents or relatives of patients suffering from psychosomatic affections, and Stalker (1949) has remarked on the frequency with which psychosomatic symptoms are superimposed upon existing organic defects. In our series, there was a family history of rheumatism in 53 cases (48 per cent. as compared with 11 per cent. of controls). An associated incidence of rheumatism with neurotic or psychotic disorder in the family history was found in 29 cases (27 per cent.), but in none of the controls. This implies that heredity and constitutional factors are important in determining localization. This is not merely a question of inherited predisposition; a role is played by "psychological infection" from an affected parent or sibling to whom the patient had strong attachments. Several of our patients could recall painful childhood memories of the complete helplessness or twisted, deformed limbs of a close relative.*

Another factor helping to focus attention on the locomotor system was pre-existing rheumatic disorder, doubtful or actual, in seventeen patients (16 per cent. as compared with 8.5 per cent. of controls). There was a history of a previous attack of acute fibrositis, lumbago, or sciatica in three men and six women. Three women had been given a course of gold therapy (in one case repeated courses) without lasting benefit. Another had had vaccine treatment for years for a non-existent "chronic arthritis". Four women had suffered from rheumatic fever, and one had mitral stenosis as a result. In two men a tentative diagnosis of a disk lesion had been made, with only slight supporting evidence. Whether musculo-skeletal disorder is actually present, or is only believed to be present by the patient or his doctor, a ready field for exploitation by the emotions is provided. The numerous patent-medicine advertisements reinforce the suggestion in the already emotionally disturbed individual that his joints will become gnarled, deformed, and eaten away by uric acid.

Thus there appears to be strong evidence that in the majority of cases of non-articular rheumatism there are present not only general factors (such as a

* One used to pray that she might endure if called upon to do so in the same saintly manner as her revered crippled mother.

psychoneurotic predisposition and a personality-structure tending towards the obsessional and the over-anxious), but also factors calculated to influence localization (such as a family history and a previous personal history of rheumatism). Whether precipitated by severe emotional crisis, or occurring as the cumulative result of many inter-related worries and conflicts, a final turn of the environmental screw, or perhaps the additional load of the menopause, determines the onset of an incapacity, usually persistent, often phasic, and unrelieved by the ordinary methods of treatment.

Diagnostic Label.—It seems clear that the nature of this often very prolonged incapacity is psychiatric in the majority of cases. The "rheumatism", with its chronic aches and pains, is merely part of the neurotic disorder. The patient aches in his limbs because, in fact, he aches in his mind. In still more cases there is a significant character or personality disturbance which, while not amounting to a neurotic disorder, strongly suggests that the incapacity is psychiatrically determined. Are we to follow Boland in calling these cases "psychogenic rheumatism"? In our opinion that term is unsatisfactory. In the first place, we merely substitute two vague words for one, and secondly, such a name perpetuates the idea that "rheumatism" is actually present. If the patient is psychiatrically ill we should say so. If, for example, we are in a position to diagnose an anxiety state we should do so—firstly, because this avoids stressing the non-existent and so minimizes the danger of "fixing" the symptoms, and secondly, because thereby the road to a more positive therapy is opened, so that we may explain the role played by tension and the need for adjustment in the particular environmental situation.

Conclusion

If, therefore, as we believe, "chronic non-articular rheumatism" frequently arises from a psychosomatic disorder, adequate facilities for the investigation of the psychiatric factors involved must be included in the national schemes devised for the prevention and treatment of rheumatism, and the necessity for looking beyond the muscles and ligaments to the home, family, and place of work, should be recognized by practitioners. In general we have no difficulty in persuading patients to accept the role played by emotion in the causation and development of their illness. Many are quite suitable for out-patient psychiatric treatment by psychotherapy, supported where necessary by sedation; others will require in-patient treatment, in the psychiatric ward of a general hospital, where such facilities exist, or in neurosis centres.

Summary

- (1) In 109 cases of "chronic non-articular rheumatism" no evidence of active rheumatic disease was found, in spite of the very long duration of symptoms.
- (2) There was a family history of neuropathy and psychopathy in 49 per cent. of cases as compared with 14 per cent. of controls, and an incidence of early neurotic traits and previous nervous breakdown in 48 per cent. of cases as compared with 21 per cent. of controls.

(3) Evidence of significant emotional stress just prior to the onset of symptoms was found in 27 per cent. of cases as compared with 11 per cent. of controls.

(4) The predominant type of personality among the patients was the over-anxious, inhibited, obsessional.

(5) In 79 per cent. of cases there was evidence of a significant personality disturbance, or of a frank neurosis.

(6) Half the cases showed anxiety state, usually linked with considerable tension. Frustration and resentment in a disturbing environmental situation were common.

(7) Evidence has been adduced to show the importance of neurosis or predisposition, and of the "focusing" effect of previous injury or disease of the muscles and joints in the patient and his family.

(8) Implications regarding diagnosis and treatment are reviewed.

We should like to acknowledge the facilities afforded in this investigation by Sir Allen Daley, Medical Officer of Health, L.C.C., Dr. J. C. Cuthbert, Medical Superintendent of Dorking County Hospital, and Dr. E. B. Brooke, Physician Superintendent, St. Helier Hospital, Carshalton. We should also like to thank our colleagues of the Rheumatism Unit of St. Stephen's Hospital, Fulham, London, for their help and co-operation. Finally, we are greatly indebted to Professor Sir Henry Cohen and Dr. Hugh Dunlop for reading the manuscript and making many valuable suggestions.

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APPENDIX

Case Histories

Case 1.—A man, aged 34, complained of "pains spreading all over my body from my left shoulder region. Sore parts come up at unexpected places, when these pains get worse I can feel something like whipcord. If anybody holds me I feel generally tender". This patient, whose "shell-shocked" father still received a pension from the first world war, was a coal miner until he had a neurasthenic breakdown in 1937. Declared unfit for work in the mines, he did casual jobs until 1939, when he became a Civil Defence First-Aider. After being rejected for military service, he was later—on pressure it seems from the Civil Defence Medical Officer—re-examined, and graded A1. After two years' service not involving any particular stress, he was invalidated out on the grounds of psychoneurosis. He had since done very little sustained work because of his constant generalized aches and pains, which he was told were due to fibrositis, and was appealing for a pension. Psychiatrically he was a querulous, resentful, chronic hysteric.

Case 2.—A married woman, aged 58, complained, "I ache all over, every joint aches and cracks . . . it's all round the hips, my stomach is never still . . . my doctor says I have gastric nerves and depression . . . I'm driving my husband insane". The only positive finding was a mild degree of spondylitis osteo-arthritis on x-ray examination. This patient, whose family history was alleged to be negative, was brought up in a poor home, and was regarded as "delicate". Widowed at 28, she was left with a 10-year-old daughter. Her second marriage was not very successful, and about three years ago she learned of her husband's infidelity. About the same time her only son was killed in action. She still grieves over him and continues to complain of generalized aches and pains. Six months ago she received manipulative treatment at the hands of an osteopath, who said her neck was in a "terrible state". The effects of this treatment she described in lurid detail, complaining that her nerves were "shot to pieces". She became so agitated and restless in the last two months that she was removed to an observation ward and advised to enter a mental hospital as a voluntary patient.

A voluble woman of subnormal intelligence, she had broken down psychiatrically with a mixed depressive and hysterical illness as a result of severe domestic worry. Such "rheumatic" features as she presented were merely incidental.

Case 3.—A woman, aged 59, with no evidence of organic disorder, had complained for nearly two years of pains in the neck and right arm. Several courses of physiotherapy had given only partial and temporary relief. More recently sleeplessness and "horrible depression" have become the main features of her illness. Her mother, who died six years ago, was a forceful personality who dominated the household. She was fiery and quick-tempered, and very emotional and highly-strung; for years she was crippled with chronic arthritis and was confined to a chair, demanding and receiving every sympathy from her placid, unambitious husband and the entire family. A sister of the patient, a few years her senior, has also complained of pains in the right arm and is still under treatment. "Her illness began a few months before mine. We have frequently talked about our symptoms. She is very much like me in every way."

Case 4.—A woman, aged 35, had a severe reactive depression and was suicidal. She was engaged to an R.A.F. pilot whom she had known for many years and a week before they were to be married he was shot down in the Battle of Britain. She had insisted and had been allowed, she stated, to see his burnt-up body.

Case 5.—At the age of 9 this patient had witnessed a suicidal attempt by her mother, distracted by a drunken husband.

Case 6.—This patient had been shut in a chicken house when she was six years of age, and a persistent phobia of being stifled had prevented her travelling in any closed vehicle.

Case 7.—A woman, aged 56, complained of pains in the back and knees for over 18 years, ever since her husband, whom she married at 24, deserted her. The husband gambled and drank:

they were perpetually in debt, and more than once her 90-year-old father, a forthright and high-principled man, whom she "worshipped", had come to the rescue. Her husband left her with four children, ranging from 4 to 12 years, and an accumulation of debts. Her mother (who suffered from "rheumatism of the back"), a strict disciplinarian, had opposed the marriage and she was frightened to approach her; her mother-in-law advised her to seek Public Assistance. She worked hard to bring up her family, doing daily morning work as a cleaner and dressmaking at nights. She is an obsessively anxious personality. Brought up in a comfortable home, she found the financial and marital insecurity a terrible strain. Worried by the thought that she would be crippled by her "rheumatism", she had become sleepless, anxious, and depressed. Positive physical signs, apart from minimal spondylitis osteo-arthritis on radiological examination, were absent.

Case 8.—A woman, aged 35, broke down in health four years ago, within a month of the news that her husband had been killed in action. She was admitted to hospital with pneumonia and pleurisy and was later told she had pulmonary tuberculosis. She spent over 16 months in a sanatorium and while there began to complain of dull aches in the right shoulder. These pains persisted, although her chest condition was responding to treatment, and she now complains of severe headaches and increasing depression and sleeplessness. She grieves over her dead husband and contrasts her previous carefree disposition with her present depressed and emotional state. She lives with her elderly bronchitic mother, who, being separated from her husband, has taken a post as housekeeper and portress in a block of flats. They are both tied to this poorly-paid job, and the patient feels bound to help her mother in the heavy routine work. Since contracting tuberculosis she feels herself a target for all kinds of disorders and is convinced she is developing arthritis. There is no evidence of any rheumatic disorder on complete physical and radiological examination.

Case 9.—A married woman, aged 36, complained of headaches and pains in the shoulders of some four or five years' duration. Her symptoms became more severe, after a minor accident on a tube escalator four months ago, when she became dizzy and stumbled, but sustained no apparent injury. Her husband, who was away on active service for over three years, had returned four years ago to his job in a local bank. A clever needlewoman, she has carried on with this work for most of her married life to give herself independence, and to pay for expensive boarding-schools for her two children. She at first denied any serious domestic or marital source of worry. Nevertheless, she was anxious and somewhat tense, and complained of severe frontal headache and pain in her left shoulder. She was seen at intervals and prescribed sedative treatment with little response. Six weeks after her first attendance, however, after some preliminary hesitation, she spontaneously poured forth her trouble. She had had relations with an unstable psychopathic man while her husband was away, and her headaches and shoulder pains dated from about the time of her husband's return, when she had tried to break the liaison, but the man threatened suicide. After a period when she did not hear from him, he contacted her a few months ago, accused her of giving him venereal disease, and threatened to tell her husband.

Case 10.—A married woman, aged 39, stated she had had pains all over her body since childhood. She was a delicate child and forbidden exercises and exertion. For over 20 years she had been treated for vague "rheumatic" pains, but in the last few years they had become much more severe. Her father was crippled with rheumatism, so that she did not recall ever seeing him walking. She was extremely attached to him, but did not look upon his death four years ago as a blow, "It was a happy release—he was drawn into such shapes by his rheumatism." She had been a nervous child, and many childish phobias as well as a nervous precipitancy and frequency of micturition still persist. She is a sensitive person, who had always taken great pains to do everything correctly. "I feel almost physically hurt to see things go wrong—I keep worrying until I put them right." She fears she will be crippled like her father, and consequently unable to work.

Case 11.—A prim and precise spinster, aged 59, with a 7-months' history of pains in shoulders and legs, with completely negative physical findings, admits she is a slave to routine. "I don't like showing any emotion to anybody and I despise anybody who does."

Case 12.—A man, aged 46, with a 2-year history of pains around the left shoulder, had treated himself with his own infra-red lamp and continued at his job as progress-chaser in a busy factory. Obsessional in marked degree, he finds his work a great strain. "I have to devote myself to method and routine, and I am forced to check everything many times over." A man of great

energy and extremely painstaking and thorough by temperament, he hates to see slacking and laziness. "When anybody asks me to do a job, it's done—it irritates me to see younger men sliding out of their duties."

Case 13.—A spinster, aged 52, now entering her menopause, has complained of joint pains for over 20 years. She dates the onset to a sudden crippling attack of lumbago. Subsequently, in the course of her work as gym. mistress in an elementary school, she fell and injured her left knee. Recurring pains in the knee and back have been afforded only temporary relief by physiotherapy. Her mother had suffered from rheumatism, and the patient herself, though a nervous, shy, and ailing child, trained as a teacher, specializing in physical training. She is a quiet, conscientious person who, in addition to her long history of invalidism, now suffers from increasing deafness. She has carried on her job, although advised 20 years ago to give it up. Always energetic and active, she has had a constant dread of becoming crippled like her mother. "I have always had a horror of being crippled and helpless—the thought of being dependent on others haunts me—I hope the doctor would put me to sleep first."

Case 14.—An ex-policeman, aged 47, complained of pains in the back and shoulders for over 15 years. He had failed to get promotion and had become frustrated and unsettled. He continued to complain of widespread pains and received numerous courses of physiotherapy without benefit. Local novocaine injections were equally useless. Finally, two years ago, he was discharged and awarded a small pension. He is a gloomy, worrying individual. He would panic and sweat at some disturbing thought, and he visualized himself in a bath-chair, crippled with neuritis and fibrositis.

Case 15.—A married man, aged 41, complained of numbness and pains in the legs and difficulty in walking for over 5 years. He had taken a great personal pride in physical fitness and he reads popular articles and magazines on health and physical culture. He was outstandingly good at games at school, and has kept up his interests in sport as a diversion from an occupation which he finds distasteful. After a number of blind-alley jobs he was taught bricklaying by his bricklayer father. He has a sense of frustration and irritation in this work, and a haunting fear that he will be crippled and deformed by the exposure and usual traumata of his occupation.

Case 16.—A woman, aged 39, dominated by her mother, a sufferer from chronic arthritis, has little regard or affection for her easy-going, unambitious father. She is married to a man of similar temperament—charming and sympathetic, but lacking in drive. She herself had a promising school career, was ambitious and energetic, and became a staff supervisor at 23. Her husband's wage is small, and she is forced to do part-time clerical work. She retains her self-confidence, but this only makes her more dissatisfied and irritated with a "boring, humdrum existence". "I wish I were a man so that I could do the pushing."

Case 17.—A woman, aged 56, complained of numbness in the right leg and pains in the region of the right knee. A delicate child, she ran away from a comfortable home at the age of 20 to marry a university student. Her husband, "terribly clever—almost a genius—but quite unstable" appears to have been an irresponsible, chronic alcoholic. Her son is a schizophrenic under treatment in a mental hospital. When her husband lost his position through drink, at 25 I took minor parts in pantomime. She now lives alone in a small attic flat dependent on her earnings as assistant in a beauty parlour. A well-preserved woman, she gives a chatty account of her unhappy marriage and present problems without any display of concern. "I have a strong will-power and I keep all my symptoms in check", she says, referring particularly to the right leg where a typical hysterical anaesthesia can be demonstrated.

Case 18.—A woman, aged 36, whose husband is an irascible, chronic invalid, incapable of sustained work, has had to do daily domestic work to supplement the small family income. She was haunted by the fear of becoming crippled and unable to provide for her two young children.

Case 19.—A young woman, aged 30, who complained of low back pain, is one of twins, and has always been nervous and morbidly self-conscious. She has bitter memories of a residential school to which she went on the death of her parents, and recollections of being beaten on the back. In the last year she has become infatuated with a married man living apart from his wife. There is lasting resentment of the injustice meted out to her as a child, and further irritation and tension because she is now estranged from her foster-parents as the result of her liaison.

Case 20.—A man, aged 43, gave an 8-year history of pains in the limbs. For a few years before this he had been acting as warden of a Church Army hostel, and had found the strain of this work increasingly difficult. An ex-miner, he had felt an urge to take up social work after a mine accident to his back, and had become an officer in the Church Army. He was a keen and obsessively thorough organizer. As resident warden of a hostel for the destitute he had never allowed himself adequate relaxation and had become more and more irritable and tense with his charges, many of whom he felt were imposing on his generosity. "I felt I could hit them", he said. There are also serious sexual difficulties; his wife is frigid and they have never had successful intercourse; he displays considerable guilt because he has masturbated freely for years.

Case 21.—A married woman, aged 43, a district nurse, complained of pains in her limbs for nearly 4 years. She had been nursing her husband, ill with bronchiectasis, for over a year, and also carrying on her work in a difficult and scattered country district. She sometimes had to lock her restless and confused husband in his room, while she went to an urgent case. Conscientious, reserved, self-effacing, she had been dominated by her elderly mother, who had opposed her marriage very strongly, and was not prepared to ease her daughter's burden. There was a family history on the maternal side of both rheumatism and psychosis—an uncle had committed suicide in a mental hospital. As a child the patient had "growing pains", and was told she was "rheumatically". Always keen to become a nurse, she had begun her training at 19, after five unhappy years as a milliner's apprentice. Six years ago she married a man whose first wife, a consumptive, she had nursed in her last illness. He had been ill ever since and, though now improved in health, is irritable and impatient. She is now depressed and weary, and feels unable to carry on.

Case 22.—A man, aged 58, complained of generalized pains of some 3 years' duration. He had been treated on and off for osteo-arthritis of the spine, had taken much patent medicine, and had had considerable time off from work. Nothing had given him relief and he had become steadily more anorexic, sleepless, and depressed. He had been deaf since childhood and yet had worked as a lorry-driver until the onset of his illness. Previously, a lively, active, and friendly individual, he had now become miserable and dejected, and avoided company. He was severely depressed—sighing and moaning at the interview—and he complained of a dry tongue, sore mouth, and obstinate constipation. There were no physical signs of active rheumatic disorder. The picture was one of typical endogenous depression.

Case 23.—A man, aged 49, complained of difficulty in walking, as well as generalized pains and stiffness. He came into the examination room with the aid of a stick, limping in a peculiar manner, both his shoes had external wedges. A former chief steward in the Polish Merchant Navy, he had assisted in the evacuation from Dunkirk in 1940. He complained soon afterwards of generalized pains and stiffness, was treated for fibrositis with only very temporary improvement, and was invalided out in 1941 with "osteo-arthritis". He had recurring pains and stiffness in the limbs and paid for courses of treatment in private clinics with little relief. He still received a small pension on the grounds of osteo-arthritis, but expected this to end in a few months' time. He protested that all he wanted was his health and "justice", and he had more than once appealed against an earlier decision of the authorities to reduce his pension. His first marriage in Poland had been a failure and was legally dissolved. In England he had married an Austrian woman who herself complained of rheumatism. There was no evidence on examination of any active rheumatic disorder, or of any gross organic disease. The only abnormality was a functional paresis of the right leg.

Case 24.—A man, aged 32, had been treated in a plaster jacket for a prolapsed disk after a car accident two years ago. After temporary relief he had begun to complain again of pains in the back and "gripping" feelings in the neck—the same feeling, he stated, that he used to get when he was in the air-raid shelter during the "blitz". Physically no abnormality was discoverable. Mentally he was a somewhat fatuous defective. He left a special school when he was 16, barely able to do the simplest sums, but had managed, albeit with difficulty, to retain a routine job under supervision. A sister suffers with rheumatism.

Case 25.—A woman, aged 52, complained of pains in the right arm. Her symptoms began in 1939 when her marital difficulties were at their worst. Her husband was habitually drunk and violent; during the early part of the war he would chase her out of the shelter while air-raids were in progress. Finally, she divorced him and later remarried. She kept relatively well and happy,

but in the last year had begun to have menopausal floodings. The pains in her arm became worse and some six months ago she woke up one morning to find her right arm numb and practically useless. Her reaction to her present symptoms and past unhappiness is one almost of indifference—even when recalling the morbid details of her first marriage she is remarkably little affected. There is a family history of rheumatism. On examination a functional paresis of the right arm and hypoaesthesia of glove distribution was present.

Case 26.—A man, aged 48, a typical aggressive psychopath, complained of pains in the right arm and shoulder, poor appetite and sleep, bad temper, and general dissatisfaction. He was an illegitimate child, who had never had a settled home atmosphere. He played truant from school, plagued his foster-parents, and at 15 joined the army, giving a false age. His health in the army was reasonably good, but he was treated for bouts of fibrositis and myalgia. His marriage in 1930 lasted only three years, and a second liaison came to an end a few years ago because of his own aggressive behaviour, as he freely admits. Dogmatic and self-opinionated, he came in for the interview in a furious temper because he had been kept waiting. Discontented with his conditions of work as a tool-maker, he harbours bitter resentment against his family, his employers, and society in general.

Case 27.—An unmarried woman, aged 35, began to suffer from muscular pains while she was a petty officer in the W.R.N.S. Difficulties experienced on returning to her former job as a children's nurse, antagonism at home, and misunderstandings with her own local doctor, had culminated in a manic episode which had recently necessitated admission to a mental hospital.

Aspect Psychosomatique du "Rhumatisme Chronique Non-Articulaire"

RÉSUMÉ

(1) Dans 109 cas de "rhumatisme chronique non-articulaire" les auteurs n'ont pas pu prouver la présence d'une maladie rhumatismale active, bien que les symptômes aient existé depuis très longtemps.

(2) Des antécédents familiaux neuropathiques et psychopathiques furent relevés chez 49% des malades et chez 14% des témoins. Des traits ou des accidents pithiatiques furent trouvés dans le passé de 48% des malades et de 21% des témoins.

(3) Chez 27% des malades et chez 11% des témoins un état de tension émotionnelle significative avait précédé l'apparition des symptômes.

(4) Comme type de personnalité, l'anxieux, l'inhibé, et l'obsédé prédominait parmi les patients.

(5) Dans 79% des cas on observa des troubles de personnalité ou bien une névrose franche.

(6) La moitié des cas présentaient un état d'anxiété, généralement accompagnée d'une tension émotionnelle considérable. La frustration et le ressentiment en milieu extérieur perturbant étaient communs.

(7) On met en relief l'importance de la névrose ou de la prédisposition ainsi que de l'effet "braquant" d'un traumatisme antérieur, d'une maladie des muscles ou des articulations survenant chez le patient ou dans sa famille.

(8) Les auteurs discutent le diagnostic et le traitement à la lumière de ces données.

Aspecto Psicossomático del "Reumatismo Crónico sin Lesión Articular"

RESUMEN

(1) En 109 casos de reumatismo crónico sin lesión articular no se pudo demostrar la presencia de una enfermedad reumática activa a pesar de que los síntomas existieran desde mucho tiempo.

(2) Antecedentes familiares neuropáticos y psicopáticos fueron hallados en el 49 por cien de los enfermos y en el 14 por cien de los testigos. Rasgos neuróticos precoces o un quebrantamiento nervioso previo fueron encontrados en el pasado de 48 por cien de los casos y de 21 por cien de los testigos.

(3) En el 27 por cien de los casos y en el 11 por cien de los testigos se comprobó que una tensión emocional significativa había precedido la aparición de los síntomas.

(4) Entre los enfermos predominaba el tipo de personalidad angustiosa, inhibida, y obsesiva.

(5) En el 79 por cien de los casos se ha observado trastornos de la personalidad o una neurosis franca.

(6) La mitad de los casos presentaba un estado de angustia, generalmente vinculada con una tensión considerable. Frustración y resentimiento en un medio ambiente perturbador eran comunes.

(7) Se destaca la importancia de la neurosis y de la predisposición, así como del efecto "enfocador" de un traumatismo previo o de una afección muscular o articular previa del paciente o de un miembro de su familia.

(8) Se discuten las implicaciones diagnósticas y terapéuticas.