Is "loss" a precipitating factor in the onset of juvenile rheumatoid arthritis?

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IS "LOSS" A PRECIPITATING FACTOR IN THE ONSET OF JUVENILE RHEUMATOID ARTHRITIS?

AN ABSTRACT OF A THESIS
SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF SOCIAL WORK

BY

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Arthritis an inflammation of the joints of the body. The term refers to all conditions that causes stiffness, swelling, soreness, or pain in the joints. There are many types of arthritis. Some are caused by infection, some by injury, some by aging, and some by entirely unknown causes.

Juvenile rheumatoid arthritis is a connective disorder beginning before puberty. It rarely begins before six months of age, and is slightly more common in girls than in boys. This disease has also been classified as a psychosomatic disorder. The incidence of juvenile rheumatoid arthritis is not known. The etiology is unknown. The roles of infectious, traumatic, psychologic, immunologic, and heredity factors are uncertain.

Since so much is unknown or uncertain about this chronic disease, the researcher would like to explore one area of juvenile rheumatoid arthritis. The area would consist of how psyche and soma are related in the functioning or disfunctioning of children with this disease.

This study has two major purposes. They are as follows: (1) To ascertain if a termination of a relationship through (a) death of a parent, grandparent or sibling, (b) death of a parent wherein a parent remarries, (c) illness of a parent or sibling, (d) a disaster e.g. fire, (e) unemployment of a parent and insufficient income for the the family are factors in the onset of juvenile rheumatoid arthritis. (2) To seek out other common factors in the cases studied which are precipitating factors in the onset of the disease. Such as: (a) the family incidence or heredity, (b) an overly close mother-child relationship, and (c) severe deprivation early in the mother's life.
The Social Service Department at Children's Seashore House studies the medical and social aspects of each patient admitted to the hospital through the utilization of the Ross Interview. The Ross Interview is used because of the detailed social and developmental history obtained in reference to the client. Therefore, all of the information desired pertaining to this study was obtained chiefly from the case records. The study was based on reading 34 case records from the period 1965-66, and abstracting from them the required data. After reading the 34 case records, it was found that there were only 5 comprehensive social histories. However, the remaining 29 cases had several factors in common. Thus, making them also important in this study.

An analysis and interpretation of the data revealed that:

(A) The greatest percentage of the children experienced their clinical onset of the disease between the ages of 6 and 10.

(B) It was revealed that in a sample of 34 children (13 boys and 21 girls), there were six cases or 18 per cent in which the factor of loss was a precipitating factor in the onset of juvenile rheumatoid arthritis.

(C) There were five cases of childhood injuries in the sample which showed no apparent loss or emotional factor before the onset of the disease.

(D) The dominant personality characteristics of the mothers of the patients was also revealed in the study. The most dominant characteristic of the mothers in this sample was seen as extremely self-sacrificing.
(E) there is need in the area of future research to clarify the role that the father plays in the life of the arthritic child.

(F) there is a need to clarify the correlation of childhood injuries to the onset of juvenile rheumatoid arthritis.
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E. J. R.
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CHAPTER I

INTRODUCTION

Significance of the study.—Arthritis is an inflammation of the joints of the body. The term refers to all conditions that causes stiffness, swelling, soreness, or pain in the joints. There are many different types of arthritis. Some are caused by infection, some by injury, some by aging, and some by entirely unknown causes.\footnote{The World Book Encyclopedia, "Arthritis", Volume A, P. 717.}

Estimates of the number of cases of arthritis vary widely because of different methods of classification and the difficulties encountered in making simple, precise diagnoses. Considering the rheumatic diseases as a whole, for instance, modern classifications list almost 100 disease entities within the group.\footnote{Today's Facts About Arthritis, (The Arthritis Foundation, 1966), p. 2.}

In addition, since these are not contagious diseases whose occurrence must be reported, no exact incidence can be determined. But based on a projection of a household interview study conducted by the United States Government, the
rate of major forms of arthritis has been estimated at 70 cases per 1,000 people who are not in hospitals or other institutions. This gives a national total of over 13,000,000 victims.¹

Chronic arthritis is common. It has three main forms: (1) osteo-arthritis, (2) rheumatoid arthritis, and (3) goat.

Osteoarthritis results from wear and tear on the joints. Most persons over 50 years have osteoarthritis in some degree. This disease is the most common cause of painful knees, backs, and fingers. However, it seldom causes crippling.

Of all the major forms of arthritis, rheumatoid arthritis is undoubtedly the most painful and the most crippling. This form of arthritis can develop in persons of any age. The disease is progressive, involving many joints. It causes much swelling and pain. Eventually the joints stiffen in deformed positions, producing crippling.

Goat is more common than is generally believed. This disorder is usually inherited. It is caused by a chemical disturbance in the body.²

¹Ibid., p.3.

Juvenile rheumatoid arthritis is a connective tissue disorder beginning before puberty. It rarely begins before six months of age, and is slightly more common in girls than in boys. This disease has also been classified as a psychosomatic disorder. The incidence of juvenile rheumatoid arthritis is not known. The etiology is unknown. The roles of infectious, traumatic, psychologic, immunologic, and heredity factors are uncertain.\(^1\)

Since so much is unknown or uncertain about this chronic disease, as a medical social work student, the researcher would like to explore one area of juvenile rheumatoid arthritis. The area would consist of how psyche and soma are related in the functioning or disfunctioning of children with this disease.

This study will seek to find out can the interaction between the psychic and organic aspects of juvenile rheumatoid arthritis be exactly defined and described throughout the course of the disease. For instance, in a case of stomach ulcers, what occurs between the early period, when emotional tension first disturbs the digestive processes, and the later period, when the fully formed ulcer can be seen clearly in the

\(^{1}\)Ibid., p. 477.
X-ray plate. The researcher feels that if this question can be answered in the incidence of juvenile rheumatoid arthritis, the medical social worker's role will be greatly increased in value.

The researcher would be interested to know to what extent does the emotional factor of loss as defined in the latter part of the study, contribute to the many other factors that bring on the occurrence of juvenile rheumatoid arthritis and its recurrence. The data gathered would greatly aid the medical social worker in the following ways:

1. The patient would be treated as "a whole."

2. The worker would be attuned to the possibility that an emotional factor or stressful situation such as loss could play a major role in the onset of the disease.

3. The medical social worker through her involvement in the team relationship would be able to present the information gained through her awareness to the physician and other members of the medical staff.

The line of thought lying behind the psychosomatic concept stresses the relation—rather than the difference, which had previously been built up through artificial distinction—between the two major components in the term,"psyche" and "soma." It is an effort to make the idea of the "patient as a whole" real and workable, in so far as any such complex idea
can be made practical.\textsuperscript{1} Hopefully, this study will clarify the complex role which psychic and organic factors play in relation to juvenile rheumatoid arthritis.

\textbf{Evolution of the problem.--} Basically, this problem evolved from an earlier study done by Gaston Blom and Babette Whipple.\textsuperscript{2} These people were part of a research group which included a psychiatrist, a psychologist, and a social worker. Their report concerned a method of studying the emotional factors in psychosomatic diseases in children. Their study involved the Child Psychiatry Unit of the Massachusetts General Hospital.

The researcher's interest in the study was stimulated by many reasons: (1) my block field placement afforded me the opportunity to observe some of the children who had been diagnosed as juvenile rheumatoid arthritic patients, (2) the medical director of the agency was strongly concerned about the medical and social welfare of children with this disease, and (3) during the fiscal year 1964-65, there were 419 patients

\begin{itemize}
\end{itemize}
admitted to Children's Seashore House. Among these patients were 58 different diagnoses and juvenile rheumatoid arthritis was prevalent among them.

Statement of the problem.—The problem in this study is to ascertain if the emotional factor of loss is a precipitating factor in the onset of juvenile rheumatoid arthritis.

Purpose of the study.—This study has two major purposes. They are as follows: (1) To ascertain if a termination of a relationship through (a) death of a parent, grandparent or sibling (b) death of a parent wherein a parent remarries (c) a disaster e.g. fire (d) illness of a parent or sibling, and (e) unemployment of a parent and insufficient income for the family are factors in the onset of juvenile rheumatoid arthritis. (2) To seek out other common factors in the cases studied which were precipitating factors in the onset of the disease. Such as: (a) the family incidence or heredity, (b) an overly close mother-child relationship, and (c) severe deprivation early in the mother's life.

Definition of terms.—The important terms used throughout this study are defined as follows:

1. **Juvenile rheumatoid arthritis** refers to a chronic, generally progressive disease involving multiple joints. The disease in children may
also be referred to as Still's Disease.¹

2. **Loss** in relation to this study is defined as a termination of relationship through miscarriage, desertion, death and moving.

3. **Psychosomatic** denotes the constant and inseparable interaction of the psyche (mind) and the soma (body). It is most commonly used to refer to illnesses in which the manifestations are primarily physical with at least a partial emotional.²

4. **Enuresis** refers to bed-wetting of any age-range.

5. **Ross Interview.** The Ross Interview was designed by Dr. Donald C. Ross, psychiatrist at the Philadelphia Child Guidance Clinic. This interview is utilized by the Social Service Department at Children's Seashore House because of the comprehensive social and developmental history obtained in reference to the client.

**Method of research.**—The Social Service Department at Children's Seashore House studies the medical and social aspects of each patient and this information is filed for future utilization. Therefore, all of the information desired pertaining to the "whole child" and his family, was obtained

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¹Still's Disease is a disease of childhood first described by Sir Frederic George Still. It is characterized by inflammation of several joints (similar to the changes found in rheumatoid arthritis), enlarge spleen and lymph glands, and fever.

²The Ross Interview is utilized by the Social Service Department at Children's Seashore House because of its detailed social and developmental history obtained in reference to the client. See Appendix A.
chiefly from the case records. The study was based on reading 34 case records from the period 1965-66, and abstracting from them the required data. After reading the 34 case records, it was found that there were only 5 comprehensive social histories. However, the remaining 29 cases had several factors in common. Thus, making them also important in this study. From these records, there was secured a clearer picture of the juvenile rheumatoid arthritic patient.

Formal, personal interviews with the patients were not possible because most of the patients during the period of study had been discharged.

Locale and period of study.--This study was conducted in Atlantic City, New Jersey at the Children's Seashore House, during the Block Field Placement.

Survey of related literature.--In searching for literature pertinent to this study, the researcher discovered that investigations have been explored by psychosomaticists, psychologists, physicians, and social workers. A review of the literature will be presented in terms of these five schools of thought.

Psychosomaticists

The premise of the psychosomaticists concerning
the study states: "bodily changes may be brought about by mental stimuli, by emotions, just as effectively as by bacteria and toxins and that physiological changes accompanying emotion may disturb the function of any organ in the body."\textsuperscript{1}

Flanders Dunbar, a pioneer investigator of the emotional components of organic diseases states: "It is fallacious to assume that, because a physical ailment can arise from emotional events, therefore, it must be psychogenic." This author gave as an example - how it would be possible for peptic ulcers to have causes entirely independent of the emotions; however, it is now widely agreed that emotional factors are of great importance in the causation or perpetuation of peptic ulcer.\textsuperscript{2}

The incidence of grief reactions among the psychogenic factors in asthma and rheumatoid arthritis has been mentioned by Stanley Cobb and Erich Lindermann in relation to ulcerative colitis.\textsuperscript{3} Erich Lindermann, in a study of 87 cases, describes sorrow as the essential emotion and the disease as


the expression of a pathological grief reaction. Bereavement as the precipitating factor is used by Lindemann in a wide sense. It may be experienced by the loss of a meaningful person by death, separation, rejection or disillusionment, by loss of a part of one's body, or by changes in psychological status, e.g. graduation or failure and loss of self-esteem.¹

Psychologists

The psychological aspects of rheumatoid arthritis are getting increasing attention. The psychologists feel that in some respects it appears to be a stress disease, associated with environmental stress, especially poverty, grief and family worry.²

Psychiatrists

R. Z. Solomon and C. I. Solomon write that "there is increasing evidence of neuromuscular and psychiatric factors in the disease of rheumatoid arthritis." And like others they stress:

"Tension, repressed hostility and resentment have been recognized as factors in the etiology of arthritis. It has been suggested that emotional disturbances, producing

changes in neuroendocrine system, may cause derangements in the metabolism of the joint and may thus be instrumental in producing the clinical picture of arthritis.¹

Physicians

Leon Hellman gives a good review of the literature relative to stress and to adrenocorticotropic hormone (ACTH) in relation to arthritis. He writes:

"It is quite possible that a more subtle form of stress in the guise of emotional conflicts is implicated in changes of the pituitary-adrenal system so as to render it less responsive to alter the balance between various adrenal hormones secreted. A patient with rheumatoid arthritis would cure himself if his hypothalamus and pituitary would interlock to increase the secretion of ACTH."²

Louis a Gottschalk, H. M. Serola and Louis B. Shapiro in their study of muscular tension and psychological conflict, report an experiment in which they made use of electrographic records. They say, in effect, that the preliminary study shows rheumatoid arthritis to be reflected in psychological tensions and conflict which involve the somatic muscular system.³


³Louis A. Gottschalk, and Louis B. Shapiro, "Psychological Mental Disorders," Journal of Nerves and Mental Disorders, XXX (May 1950), pp. 735-743.
Thomas Holmes and Harold G. Wolff report that when the arthritic patients are blocked in their efforts to take action, or cannot decide what action to take, the relatively intense sustained muscle tension is provocative of "the pain of the backache syndrome."¹

Social Workers

Bessie G. Schless commented on the pathologies confronting arthritic patients. There were many problems reviewed, including economic and stress accompanying a chronic illness productive of physical change. The author also stated that the arthritic person was essentially a hostile person "so fearful of the intensity of resentment that he unconsciously encases his joints in concrete so that he cannot strike out against the world."²

H. Lehn, K. Menninger, and M. Mayman comment on the fact that arthritis causes more chronic disability than does any other one condition, and question why so little attention to the psychosomatic approach of this syndrome has been given.


They further state:

"A precarious balance of aggression and dependency is established in the arthritic patients and when this balance is upset, the joints assume the burden by compromise. An over-charge of aggression is controlled by an inadequate ego through self-destructive allocation to the mobile structures of the soma. The pathologically strong passive erotic needs of the individual are gratified by the attention of doctors, nurses, and masseurs."¹

In the evaluation of the data gathered, the researcher has found the following literature to be very helpful.

Emotional reactions to disturbing environmental events have been considered by a number of different people to bear some relationship to the onset of exacerbation of rheumatoid arthritis. Worry over financial matters has been suggested by R. L. Cecil and Bauer Cobb, as occurring frequently in association with the onset of the disease. Another factor is anxiety over sick relatives or family worry.² Grief has often been noted which is felt to be part of the general problem of loss or separation. Unrelieved anger is also suggested as an emotional reaction especially if there is an unconscious resentment

¹H. Lehn, K. Menninger and M. Mayman, "Personality Factors in Osteo-arthritis" American Nerves and Mental Diseases, XI (June 1960), 753.

against someone.

Up to this point, the researcher has not introduced any material as to the role that the parents or family play in the life of an arthritic child. There was ample information to cover this subject. The following quote is representative:

"There has been an observation by E. W. Boland that the mothers of rheumatoid arthritic patients seem to have provided an inadequate feeling of security in early life. This was manifested by a rejection of the child, either openly, or by an extreme degree of overprotectiveness and over-anxiety. The result was a hampering of the child's development toward a free, independent existence, and the fostering of attitudes of dependence and helplessness. It was also noted that there was a history of severe emotional or physical deprivation in the life of the mother and child."¹

It has been reported that arthritic patients frequently perceived one or both of their parents as rather strict and uncompromising in discipline. More specifically, this has been noted in other studies to the role that the mother exemplified. A report based primarily on female cases stated that in the family background there was usually a strong, domineering, demanding mother, and a gentle, compliant father.²

A different study, based on male patients said that the mother was perceived as a hard-working, efficient "Christian" woman, exemplifying self-sacrifice to the point of martyrdom.

²Ibid., p. 278.
but also acting as the main disciplinarian, and a strict one at that.\(^1\) Father was seen as inconsistent in his behavior, being both weak and strong, and somewhat unpredictable, as in outbursts of feeling to situations where he usually showed minimal feeling.\(^2\)

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\(^1\) This report can be found in E. W. Boland's, *Psychogenic Rheumatism*, (Philadelphia: Lea and Febiger, 1948), p. 273.

\(^2\) Ibid., p. 278.
CHAPTER II

FEATURES OF RHEUMATOID ARTHRITIS

Rheumatoid arthritis was first clinically described by V. Cornil in 1890. This disease causes an inflammation of the joint lining (the synovial membrane). This inflamed tissue may extend and destroy the joint and its supporting structures, resulting in a "stiff" and deformed joint. One joint may be stiff and painful for weeks or months before other joints are attacked. Typically, the joints of the fingers, hands, and knees become swollen. The fingers acquire a sausage shaped appearance as the joints closest to the palm of the hand become swollen. Nodules may appear immediately under the skin, around the elbows, wrists, fingers and ankles. In addition, to the joint symptoms, there is a marked wasting away of the muscles. The patient presents a generally emaciated appearance, fatigues easily, and frequently suffers from anemia.¹

In 1890, S. Diamentberger, on the bases of 35 published cases and 3 cases of his own, also suggested that the most arthritis is first observed in the large joints, that the onset is often acute and the course remittent, that disturbances of growth are frequent, and that the prognosis is better in children than in adults.¹

In 1897, George Frederick Still described additional features, including high fever, pericarditis, lymph-adenopathy, and splenomegaly. Still's Disease is also an eponym used for juvenile rheumatoid arthritis in general. Doctor Still also pointed out that in a child the articular phenomena of arthritis becomes a matter of merely secondary importance; because, judging from clinical evidence he felt that a child may suffer severely from rheumatoid arthritis and may not have had a pain in its joints in its life.²

The symptoms of rheumatoid arthritis in childhood, differ from these in adults chiefly in the much slighter character of the joint manifestations.

The joint symptoms in a child are often so slight

¹Ibid., p. 221
that the parents often take no notice of them, beyond dismiss- 
missing them from their memory with the confronting as-
surance that they are "only growing pains."¹ The practical 
importance of recognizing the significance of these slight 
"growing pains", in the limbs in children can hardly be 
overrated. They may be the earliest indication of arthritis, 
and as such should always serve as a danger signal.

**Disturbances of growth and development.**—A decrease 
in general growth and development occurs in about half of the 
children with rheumatoid arthritis.² This might be related 
to active disease, as well as to prolonged administration of 
corticosteroids. Growth is often resumed and the child may 
reach normal proportions rapidly when the disease becomes 
inactive. When the disease is actively Prolonged, premature 
closure of the epiphyses will prevent further growth, while 
the development of secondary sex characteristics may be re-
tarded as well.

As we have seen, there are some disturbances in growth; 
and the secondary sex characteristics may also be retarded 
in the arthritic child. This disturbance may prevent him

¹ Ibid., p. 441.
from being in scientific terminology a "normal" child. Therefore, at this point, the researcher would like to illustrate through the aid of a profile the everyday appearance of the "normal" and arthritic child. This profile will include these children in the five stages of development. The examples of children cited in reference to the arthritic child are taken from the cases studied.

The "Normal" and the Juvenile Rheumatoid Arthritic Child: A Comparison.--A child progresses through five stages of development. They are (1) infancy, (2) early childhood, (3) childhood, (4) preadolescence, and (5) adolescence. We are aware that a child would pass through these stages of development with a minimal of "childhood diseases" such as: measles, mumps, chicken pox, and small pox. Our society, for the protection of its youth, enforces a sanction which states that a child in the first three stages mentioned above must have certain immunization shots to protect the child and to protect society against the spread of contagious diseases. Unfortunately, there is no known immunity cure for the child with the chronic disease of rheumatoid arthritis.

Now, let's look closer at our "normal" child and the child with arthritis. There were no cases in the researcher's sample that would illustratively represent a child in the
infancy stage. Therefore, this discussion will begin with the early childhood or "toddler's" stage.

At two years of age, the "normal" child is a toddler and explorer. He can run. He is likely to fall frequently not only because of his light mass, small base and relatively light center of gravity but also because of his lacks in foresight and learned motor skills. The climbing of stairs and the walking of simple inclines fascinates him. Not only can he carry himself anywhere he wants to by walking and running, but before he is three he is frequently a master of one form of vehicle location; i.e., he can ride a tricycle, if given the opportunity to learn.¹

In his social relations the young two-year old is more adult centered than peer-centered. At nursery school for instance, he is more inclined to ignore or play alongside other children than to play cooperatively with them.

The rheumatoid arthritic child as a toddler may have a history similar to the following description. The clinical onset of the disease began with a limp in the left leg. The disease progressed to the right knee, then on to the left finger. Therefore, unlike the "normal" child wherein the

climbing of stairs and the walking of simple inclines may be fascinating, the pain of the disease prevents this child from practicing this early childhood pleasure. The social relations of this child might be considered to be similar to those of the "normal" child. However, his relations are more adult centered because of this greater dependency needs.

Moving on into the childhood stage, we find that formal education usually begins around six years of age. Also, it indicates the belief of society that the "normal" child of this age can take reasonably good care of himself and can work with a group. The six-year-old's control of his body is shown by his ability to climb almost anything in sight, skip, hop and gallop, as well as run fleetly. He grasps a knife, fork, spoon and pencil with a tight fingerhold. In the matter of dressing, he is quite independent, only an occasional snuggly fitting rubber boot or awkwardly placed button produces calls for help. Important in revealing his social progress is the fact that the "normal" six-year-old cries relatively infrequently, in contrast with the "normal" two-year-old. Emotional explosions, such as undirected tantrums occur seldomly.

It has been noted by Bessie Schless, a social worker,
that the arthritic person was essentially a fearful person encasing his joints in concrete so that he cannot strike out against the world. With this in mind, the researcher thinks of a little patient who was "normal" until she entered school at the age of six. Clinically, she developed pain in her left knee joint. This was followed by stiffness in the patient's neck. Later, the patient developed severe pain and swelling of the left foot. Now, the patient has multiple joint movement. The patient cries frequently and has very directed temper tantrums. Again, because of the illness, the patient is still very dependent upon her mother.

The preadolescent is often called the gang age, since "normal" children of this age seem to go in packs. Informal clubs, pass words and code language are their special joy and are signs of the increasing dependence. At 10 to 11 years of age, the "normal" child tends to league himself strongly with his peers and those of his own social group.

The preadolescent arthritic child, the characteristics of whom the researcher abstracted from the case histories of arthritic children, could not care less about a gang, pass words, or code languages. This child still bed wets. The

\[1\] Schless, op. cit., p. 352.
patient is described as being a passive child by his parents. At times, the patient is very shy and introverted having few peer relationships except those of his siblings.

The adolescence period usually ranges from 11 to 23. This is the period when the "normal" individual completes his growth and the development of the structures and functions which make procreation possible. The "normal" adolescent begins to think of himself as grown, asserting his independence and wanting to be responsible for his own destiny.

As the reader shall see through Chapters III and IV, most of the cases studied intensively were in the adolescent age group. The common characteristics of the arthritic adolescent will be given in the following chapters.

In comparing the "normal" and the rheumatoid arthritic child, the researcher feels that the two models are similar in the sense they represent children with similar needs and requirements for a happy and adjusted life. However, the major differences between these two models fall into two basic areas. They are: (1) physical growth, and (2) emotional growth. A child in any of the foregoing stages of development is expected by our society to accomplish with age certain physical, emotional, and social growths. Growth is the basic
of all change. If a child did not increase in stature and weight, if his muscles did not become strong, if his sex organs did not increase in size and efficiency to meet the requirements of an enlarged body, if his brain did not mature, the child would never become an adult.

Of all the major forms of arthritis, rheumatoid arthritis is the most crippling. Therefore, the child with this disease has to fight long-lasting, enervating, nerve-wracking pain, from which he may or may not have periods of relief. Not only does long-continued pain have disabling effect on the personality; pain also interferes with rehabilitation, because it limits the exercising of joints and self care adaptations which are part of physical and social restoration.¹

CHAPTER III

FIVE CASE STUDIES

Only through presenting the individual cases of the five comprehensive case studies can the reader fully appreciate the Ross Interview utilized by the Social Service Department of the Children's Seashore House. It is the purpose of this chapter to show pertinent data that might relate to the role which psychic and organic factors play in direct relation to juvenile rheumatoid arthritis.

Vicky, age 14. In mid-December of 1964, Vicky had a transient rash which might have been German measles. During the first week in June of 1965, Vicky had a virus that she recovered from in a few days. After the virus the mother noticed that her child bruised quite easily. A special kind of drug was prescribed for the virus by the maternal grandfather who has since died.

In December of 1965, Vicky had another virus which lasted about four or five days. There was no medication administered. A week later, she developed flu, and was quite ill. She had a fever, and was unable to raise her head from the bed. She was dizzy and developed headaches. The patient also developed a gastrointestinal upset and became nauseous. Vicky complained of vague aches and pain in her legs then her feet began to swell. Vicky's maternal grandfather died March 6, 1966 and the child was hospitalized March 7, 1966.
Mr. P. mentioned that Vicky developed a mild phobia in nursery school. When she entered junior high school, she had a few emotional conflicts and she was anxious. The parents feel that their child was unhappy because she was separated from her friends because of the geographical location of their house and she had to attend a school where few of her friends went. She was very unhappy in the seventh grade.

Mrs. P. explained that as a child she had a chronic ulcerative colitis. This condition existed in the mother's adolescence stage of development. Mrs. P. stated that she had a very lonely childhood. The mother describes Vicky as being active and defiant.

Mr. P. feels that his wife is guilty and full of self-blame. He thinks that maybe Vicky's illness is hereditary. He further feels that Mrs. P. is very rigid and strict in comparison with himself. There has always been considerable conflict between the child and mother. Mrs. P. related that her husband is a good support figure, but he does not understand their child as she does.

Stancy, age 9. Stancy was in good health until March 13, 1964, at which time he developed a sore throat and beta hemolytic streptococcus was cultured. He was placed on penicillin therapy and appeared to respond to this treatment. On March 20, 1964, he developed soreness of both ears. On March 24, 1964 high fever and myalgia were noted by his parents.

Mr. and Mrs. L. had no idea about the cause of juvenile rheumatoid arthritis and wondered if it were caused by the measles vaccine that Stancy had had one week before the onset of his illness in March. They were particularly anxious, too, as to whether he was bed wetting at the hospital as he had been at home for many years. They reported that he started to bed wet at age 5½.
Stancy started kindergarten when he was 5½ and was described by his teacher as being overly-polite, and overly-good. Two weeks after he started school he apparently developed enuresis, and there has been a persistence of this condition. Mr. L. agreed that his son is quite a passive, guarded child. His parents particularly mentioned how very modest he is about his genitals.

Mrs. L. had gained 70 pounds prior to the pregnancy with Stancy. She was so obese that it was difficult for her to walk around. She took diet pills throughout the first six months, but had not X-rays or other medication. Mrs. L. was quite high strung throughout the pregnancy because of her excessive weight. She was afraid of being alone at home for the first time in her life (husband worked nights). Also the family was under a lot financial pressure. Her oldest child had colic and cried constantly and the mother said that she caused this because she was anxious and disturbed. Mr. L. still works at night, and leaves most of the child-rearing to his wife. Mr. L. constantly compared the ill-health of Stancy to the good health of his other three siblings.

It was recorded that occasionally Mrs. L. had gastric colitis. There were no such factors in the life of Mr. L.

**Angla, age 12.** Mr. and Mrs. O. voiced concern about their separation from Angla due to her illness. The patient has become quite dependent and demanding of her mother. Angla’s present condition started in December of 1963 with her ankle and hand aching. The condition was not diagnosed, however, until February of 1964 at Cooper Hospital.

Mrs. O. said she had severe headaches and lost both her parents when Angla was about 2 years of age. At that same time, the family was in the process of building their home. Angla was neglected doing this period. Mrs. O. said that she was pregnant when Angla was about three and thus the child was forced all the more to be on her
Angla had many friends in the neighborhood to play with, however, she often preferred to play alone. She said she was easily frustrated with other children's mistakes and was constantly jumping around from one task to another, as she grew older from one friend to another.

Mrs. O. related that she has had several crises during the past. Her third child has had a series of illnesses over the past year and ended the year by needing a tonsillectomy. Both he and Angla had measles also for the second time. Mr. O. was not seen too much in the picture as he relates to the patient. However, Mrs. O. said that he is a good provider.

It might be of interest to note that although pregnancy was uncomplicated for Mrs. O., she also gained a lot of weight, at least 50 pounds, during her pregnancy.

Debbie, age 14. The first four years of Debbie's life, her maternal grandmother lived with the family until her death. The maternal grandmother felt the mother made too much over Debbie's constant complaining about pain in her legs. At any rate, Debbie was never hospitalized until last January 12, 1964.

When Debbie was 3½ years old, she suffered an attack of rheumatic fever. During this period of time, the mother said that Debbie also developed a cold, followed by low fevers. Debbie had measles when she was five years old and was very ill. This was when she started to have severe pain in her legs.

In May of 1964, Debbie developed a temperature of 104 degrees which later resulted in a long-lasting virus. The fever persisted. Penicillin was administered and Debbie broke out in hives.

During her pregnancy, Mrs. S. was afraid that she was going to die. She also was fearful that she and her baby would die during delivery. Mrs. S.
has expressed fears that Debbie's illness might be the death of her child. Mrs. S. related that she was so anxious over Debbie's health because she had a very deprived childhood and that she wanted everything to go right for her daughter.

Mrs. S. described Debbie as being a very meticulous child and that everything has to be in the same place. She is a very quiet child. Because she has been ill for a period of time, Debbie was not able to attend school until she was seven years old. Then, before she was fully adjusted in school, the family moved to a different city. Therefore, Mrs. S. Feels that Debbie is behind in school and this may effect the fact that she does not do very well in school.

The parents were divorced after the birth of Debbie.

**Janet, age 9.** Janet was diagnosed as having juvenile rheumatoid arthritis at the age of three. The parents said that since infancy they had noticed that Janet had particularly sensitive hands and feet but considered it no more than super-sensitive skin. They then noticed that when they changed her diapers her legs appeared stiff. However, they attributed this to her being sensitive to the diapers. When she began walking with her legs held rigid, the parents felt that their child had flat feet. When Janet was 2½, her parents tried corrective shoes, and the condition grew worse. When Janet was 3 years old, she was hospitalized for 12 days and diagnosed as having arthritis.

Because of Janet's illness, she is two grades behind her class. However, she strives very hard to do good work. She is often depressed about her grades. She completed the first semester of second grade last week and earned a "D" in reading, and "C" in arithmetic. Mr. B. feels that Janet craves attention far more than their other two children. He also feels that Janet and her older sister are always competing with each other.

Mr. B. admits that Janet is his favorite, but he feels that there is an overly-close mother-child
relationship. The parents describe Janet as being quiet and withdrawn, however, she expresses separation anxieties when her parents are not present for any length of time. The parents related repeatedly that if Janet felt that she was not getting sufficient attention, she becomes quite demanding. If attention is still denied, she will go into quite a temper tantrum of crying and screaming. It is also interesting to note that Janet still has the problem of enuresis.

The above five cases were representative of how the Ross Interview is utilized at Children's Seashore House. The five cases also show us how the history of illness, description of the child's current behavior, developmental history and the parent-child inter-action can be used in the full evaluation and treatment of the child.
CHAPTER IV

CLASSIFICATION AND ANALYSIS OF DATA

The collection of data was collected by reading the records of 34 case histories taken from the closed files of the Social Service Department of Children's Seashore House, Atlantic City, New Jersey. The cases studied had been diagnosed as juvenile rheumatoid arthritic patients. After reading the 34 case records, it was found that there were only 5 comprehensive social histories. These five cases were the only cases in which the Ross Interview had been utilized and were presented in Chapter III. This chapter will present the remaining 29 cases of the sample studied. The 29 remaining cases had several factors in common. Thus, making them also important in this study.

True to the model portrayed in the review of literature, there were more girls diagnosed as rheumatoid arthritics than boys. Table 1 shows the ages and sex of the 34 children studied.

Table 1 shows that 14 per cent of the girls experienced the clinical onset of the disease during the age range of
1-5. Eight per cent of the boys experienced the clinical onset of the disease during this age range. Between the ages of 6 and 10, 18 per cent of the girls experienced their clinical onset of the disease, while 26 per cent of the boys had their clinical onset of the disease at this age range. Between the ages of 11 and 15, 14 per cent of the girls had their clinical onset at this age, while 2 per cent of the boys had their clinical onset of the disease at this age. Fourteen per cent of the girls were between the ages of 16 and 20, while 4 per cent of the boys were similarly diagnosed as rheumatoid arthritics.

**TABLE I**

**STUDY SAMPLE BY AGE AND SEX**

<table>
<thead>
<tr>
<th>Ages in Years</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under one year</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1-5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>6-10</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>11-15</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>16-20</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>14</td>
</tr>
</tbody>
</table>

Table 2 shows that 22 per cent of the children were between the ages of 1 and 5. Forty-four per cent of the children clinically diagnosed with this disease were
### TABLE 2

**Sample of Children Studied by Age Range**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
</tr>
<tr>
<td>Under one year</td>
<td>0</td>
</tr>
<tr>
<td>1 - 5</td>
<td>14</td>
</tr>
<tr>
<td>6 - 10</td>
<td>18</td>
</tr>
<tr>
<td>11 - 15</td>
<td>14</td>
</tr>
<tr>
<td>16 - 20</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>60</td>
</tr>
</tbody>
</table>

Between the ages of 6 and 10. Sixteen per cent were between the ages of 11 and 15. And, 18 per cent were between the age range of 16 and 20.

The data representing the 29 remaining cases will now be presented. This data will be presented in six categories. They are: (1) childhood diseases, (2) childhood injuries, (3) family financial worries, (4) death or divorce, (5) heredity, and (6) miscellaneous.

**Childhood Diseases**

This category represents those children whose onset of the disease was preceded by a virus infection, fever, or other childhood diseases, such as; measles and chicken pox.

Jimmy was evaluated because his mother noticed that he did not seem anxious to be active. The boy had just recovered from an episode of the virus.
infection he had about two weeks.

In late December of 1965, Kenneth, age 6, started to run a high fever and complained of pain in his left side and chest. There was some swelling in the left ankle and all of this was accompanied by a fever.

Annie, age 7, was well until November 1964, when she first developed pain in her left knee joint. March 1965, following mild chicken pox, the child developed severe pain and swelling of the left foot. Now she has multiple joint involvement.

**Childhood Injuries**

This category represents those cases wherein there were no apparent loss or emotional factors in the onset of the disease.

The onset of Lizzie's disease was seemingly precipitated by her being pushed over a hill wherein she sprained her ankle. Thereafter, she complained of severe pain in her knee and fingers. Her case was later diagnosed as rheumatoid arthritis.

Bruce complained that his right ankle bothered him. Then the right wrist became involved. The condition later involved his left toe. His case was diagnosed as rheumatoid arthritis.

Paul was never a physically co-ordinated boy; he always rode a bicycle poorly, he never skated very well, he lacked skill in swimming and other active sports. In January 1965, Paul started complaining about pain in his knee and ankle joints. This later involved the wrists and hands. His case was also diagnosed as rheumatoid arthritis.

Judy's condition was noticed by the swelling of her knuckles. Later, this was diagnosed as arthritis.
Wayne's parents stated that their child had fallen and within 24 hours of the fall, with no apparent immediate injury, he began to feel severe pain in his right foot and knee which immobilized the boy. Later, after he was hospitalized, the case was diagnosed as rheumatoid arthritis.

**Family Financial Worries**

This category represents those children whose disease was preceded by the family's worry over financial matters or the unemployment of the main support figure.

Mr. King lost his job two months ago and had not been able to secure employment insurance although he filed a claim. Brenda's condition started with a limp in her left foot six weeks later. Then she developed severe pain and stiffness in her neck, followed by involvement of the left foot and right hand.

Mrs. Martin explained that the family moved to Philadelphia last October from Roscommon, Michigan because of the financial problems they had faced there. Mrs. Martin said that Anthony, age 10, started to complain of pain in his right hand after they had been in Philadelphia for two months. She feels that her child had trouble adjusting to his new environment.

In addition to a high fever which accompanied Mark's condition, the Adamson's were also faced with a financial crisis. One of the goals in this family is to move back to England. They moved to the United States in the summer of 1964 because they had difficulty finding adequate housing. The oldest children were born in England and Mark and his twin sister were born in Canada nine months after they left England. When Mark was four years old, the family left Canada. From Canada they went to Seattle where Mrs. Adamson's father
worked at Boeing Aircraft. The family stayed there four years and then were transferred to New Orleans, Louisiana for two years. Now they reside in Philadelphia and the parents noted the swelling of Mark's fingers and right foot.

Death or Divorce

This category represents those children who suffered the loss of a sibling or parent through death or divorce.

In October of 1963, Carolyn, age 5, was hospitalized and was sick for 8 months before she died of Neuroblastoma. Since Marolyn was 5 years old when her twin died, she remembers the incident very well. The mother pointed out that about the time of the twin's death, or shortly after, the family moved to a new neighborhood and this seemed to aggravate the situation for Marolyn. So much so, that she had to be hospitalized. Her greatest fear is that of dying.

Mrs. M. feels life is kind of a series of losses. She and her husband were separated at the onset of Karen's disease. Now they are divorced and Mrs. M. immediately started to work, leaving Karen in the care of her maternal grandmother. In April 1964, Karen was hospitalized with her disease being diagnosed as chronic involvement of all joints.

Amy, age 7 months, died three years ago. The onset of Verna's illness dates back to the time of her sister's death. Mrs. R. stated that Verna was very protective of her baby sister and is still very depressed over the loss.

Calvin's mother is and always has been over protective of her children, mainly because she feels very guilty over her divorce. She gives in to her children, especially Calvin. Approximately one year ago, she was engaged to be married. Later, Calvin began to complain of pain in his knee and ankle.
Heredity

This category will be represented by those children whose families have a history of the disease.

Betty, age 14, was hospitalized in September 1965. Mrs. C. has an enormous amount of anxiety in trying to allow Betty to be away from her. Mr. C. thinks his wife is more upset about the separation than Betty. Mrs. C. also had arthritis and feels because of this she understands how Betty feels.

Tommy, age 4½, and Martha, age 6, are siblings. They both have arthritis. Mrs. J. is very tense and nervous. Martha was the first child to be clinically diagnosed as having juvenile rheumatoid arthritis. It began with the stiffness of the neck. Later, the ankles were involved. Tommy's symptoms began the same way as his sister's.

Miscellaneous

This category gives representation to those miscellaneous factors which were found in some of the remaining cases.

Toilet training was started between 8 and 9 months, and completed at two years of age, but Marsha continued to have a marked degree of enuresis until 6 years ago, when she stopped. However, it coincided again with her starting to school and later the onset of the disease. Marsha is in the adolescence stage and she still wets the bed. Her mother states that she seems to have lost interest in her general appearance.

Alfred, age 13, is shy, especially to new situations and strangers. He seems to be very anxious to please. This young man also still wets the bed.

Mary contacted the disease in October 1965. She had
just entered kindergarten when she became ill with arthritis. The disease was noted in her fingers and right ankle.

Timmy's parents revealed that their son has a number of phobias - he is afraid to be alone. He is afraid of falling. Before the onset of the disease, this child had experienced several nightmares in which he saw himself in a wheelchair. The parents seem to feel that this experience alone was the factor in the onset of the disease for their child.

Table 3 shows the precipitating factors most commonly found in the onset of juvenile rheumatoid arthritis from the sample studied. The precipitating factors seen in the five comprehensive social histories will be included in the table.

**TABLE 3**

LOSS OR EMOTIONAL FACTORS ASSOCIATED WITH THE ONSET OF JUVENILE RHEUMATOID ARTHRITIS

<table>
<thead>
<tr>
<th>Factors Involved</th>
<th>Number of Children</th>
<th>Per Cent of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood Diseases</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Childhood Injuries</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Family Financial Worries</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Death or Divorce</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Heredity</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>No Data Available</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 3 shows that 18 per cent of the cases diagnosed as juvenile rheumatoid arthritis was precipitated by the factor of loss, e.g. death or divorce. Fifteen per cent...
of the cases had an incidence of childhood disease and 15 per cent to childhood injuries. Eight per cent of the precipitating factors were seen in family financial worries. Six per cent were seen in heredity factors, while 12 per cent were seen in miscellaneous factors.

It is one of the truisms of American life that the parents or family play an important role in the life of the child.\(^1\) Kessler portrays the mothers of the arthritic as having severe deprivations in childhood and a feeling of insecurity.\(^2\) She tends to be extremely over-protective and over-anxious. These factors alone would seem to hamper a child's development toward a free, independent existence; therefore, leading the child to be more dependent upon its mother. The parents of arthritic children are also felt to be strict and uncompromising in discipline.\(^3\)

Table 4 shows those cases where there was a recording of the personality or character make-up of the mothers. This data was available for 12 of the 34 cases in the sample of present study. The characteristics of the mothers could be classified into the following five categories:

\(^1\)Kessler, op. cit., p. 352.
\(^2\)Ibid., p. 354
\(^3\)Ibid., p. 355.
(1) severe deprivation in childhood, (2) extremely tense and nervous, (3) overly-close mother-child relationship, (4) overly strict, very demanding and expect far too much from the behavior of the child, and (5) extremely self-sacrificing person, extremely over-protective and easily influenced by her child.

**TABLE 4**

**DOMINANT PERSONALITY CHARACTERISTICS OF THE MOTHERS OF TWELVE RHEUMATOID ARTHRITIC CHILDREN**

<table>
<thead>
<tr>
<th>Characteristics of Mothers</th>
<th>Number of Mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe deprivation in childhood</td>
<td>3</td>
</tr>
<tr>
<td>Extremely tense and nervous</td>
<td>1</td>
</tr>
<tr>
<td>Overly-close mother-child relationship</td>
<td>2</td>
</tr>
<tr>
<td>Very rigid and demanding</td>
<td>2</td>
</tr>
<tr>
<td>Extremely self-sacrificing</td>
<td>4</td>
</tr>
<tr>
<td>No data available</td>
<td>22</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

Table 4 shows that three of the mothers had severe deprivations in their childhood. It is the feeling of Gaston Blom and Babette Whipple that the mothers in this category seem to give a type of smothering love to their children. Thus, giving them the material things that were denied them in their childhood.\(^1\)

\(^1\) Cole, *op. cit.*, p. 453.
Only one mother was categorized as extremely tense and nervous. The case records reveal that this condition became worse after her child's illness was diagnosed as rheumatoid arthritis. The family physician indicated that Mrs. X. was a psychologically disturbed person, being full of guilt and self-blame because of her child's illness.

Table 4 also reveals that there were two cases where there was an overly-close mother-child relationship. The case record states that one of the mothers has a tendency to feel sorry for her son, much more so than her husband does. Table 4 also shows that there were two cases in which the parents were reportedly very rigid, overly-strict, very demanding and expected far too much from the behavior of their children. Lastly, four mothers were classified as extremely self-sacrificing people, extremely over-protective and easily influenced by their children. The following two excerpts from agency case records are illustrative of this type of mother.

Mrs. Y. is an extremely self-sacrificing person, extremely over-protective, and easily influenced by Sammie. She finds it almost impossible to accept the separation from her child and yet complains bitterly when the two are together. She is a very nervous, high strung person. The area of family relationship seems to be very disorganized. In the hospital, Sammie was able to participate very nicely in rehabilitation
programs and was trained to use his potential resources. However, when he returns home he regresses into a helplessly dependent child within 10 days.

Andrew has a tendency to repress any feelings of pain and discomfort in the presence of nurses and medical personnel. However, as much as he represses these feelings, as soon as his mother visits, he seems to fall apart and express many psychosomatic complaints, and it makes it very difficult to determine whether he is in real pain and discomfort or whether he is playing on his mother's sympathy for her attention.

In twenty-two of the cases studied, there were no records of the personality or emotional stability of the mothers.

The father in the life of the arthritic child is portrayed in the literature as being inconsistent and exhibiting unpredictable behavior. In the sample of arthritic children studied, the father seemed to be content to let his spouse carry the load of rearing and disciplining the children. Unfortunately data confirming the presence of the father was only available for six of the cases studied.
CHAPTER V

SUMMARY AND CONCLUSIONS

The purpose of this study was to ascertain if "loss" was a precipitating factor in the onset of juvenile rheumatoid arthritis. The study was based on reading 34 cases from the period 1965-66, and abstracting from them the required data. After reading the 34 case records, it was found that there were only 5 comprehensive social histories. However, the remaining 29 cases were also utilized in this study.

Table 1 showed that for the sample studied, the greatest percentage of the children experienced their clinical onset of the disease between the ages of 6 and 10. Forty per cent of the children were in this age range.

Table 3 revealed that in a sample of 34 children (13 boys and 21 girls) there were six cases or 18 per cent in which the factor of loss was a precipitating factor in the onset of juvenile rheumatoid arthritis. However, there were five cases of childhood injuries in the sample which showed no apparent loss or emotional factor before
the onset of the disease. This data was shown in Table 3. Analysis of the other variables in Table 4 showed that there were those cases in which the family's worry over financial matters or the unemployment of the main support figure was involved. The family heredity involved two cases. These factors were seen in Table 3.

Another objective of this study was to find out if the interaction between the psychic and organic aspects of juvenile rheumatoid arthritis could be defined and described throughout the course of the disease. Therefore, with the help of the features of this disease described by Dr. George Still, we were able to see an outline of these features in the cases studied, especially in the five comprehensive studies. We were able to see for instance, in the case of Vicky how the emotional conflict of the death of her maternal grandfather of whom she was very close; the virus, the flu and other clinical factors were apparent in the onset of her disease.

It was also observed in this study, how the parent of the child plays a very important role in the health of the child. Special attention was given to the mothers of the patient. One could see how the over-protectiveness of
a mother only made her son regress and complain more bitterly of his condition. Table 4 showed the dominant personality characteristics of the mothers of the patients studied. The most dominant characteristic of the mothers in this sample was seen as extremely self-sacrificing.

**Implications of Findings to Medical Social Work.**-- Up to this point, a pretty grave picture has been painted for the arthritic child. However, as in any other chronic disease, there is hope for a cure and a more medically based etiology of the disease. The medical social worker can provide hope for the family of an arthritic child. The social worker could relate to the over-protective mother the fact that her child needs to feel a degree of independence. It should be impressed upon the patient that rheumatoid arthritis by no means always progresses to extreme disability.

In relation to treatment, it is important to note that the arthritic is in a precarious state of balance and needs a certain amount of protection. However, not extreme over-protectiveness that might be exhibited by the parent. Further, little things may undo all gains made and start the patient downhill again. We have seen that emotional upsets, virus infection, or any other form of stress is
hazardous to the state of balance.

The distressed and anxious parent could also be informed by the medical social worker about the possibility of surgery to correct some of the deformities of their child. Surgery is sometimes employed to correct deformities, especially in the hips, knees, and elbows, but this is not usually performed until the active disease process has disappeared.¹

Other forms of treatment include the application of casts and splints, and manipulation (forceful straightening) under anesthesia. In most cases, however, the arthritic is helped by long-time conservative treatment—by medical supervision, drugs, and careful attention by the client and by his social worker, physical therapist, and public health nurse to the practical aspects of the daily regimen and environment.

Implications of Findings for Future Research.--In order to develop a more accurate profile of the arthritic child, future research should be done around the following areas:

(1) The role that the father plays in the life of the arthritic child.

(2) A profile of the personality characteristics of the mothers of arthritic children.

¹ Travis, op. cit., p. 43.
(3) The correlation of childhood injuries to the onset of juvenile rheumatoid arthritis.

These areas for future research were selected because:

(1) the fathers of the patients were only seen in six of the 34 cases, (2) there were only twelve cases wherein the personality characteristics of the mothers were revealed, and (3) the factor of loss was noted in six of the cases studied, however, the incidence of childhood injuries was noted in five cases in the sample. It would be profitable to know to what extent childhood injuries play in the onset of juvenile rheumatoid arthritis.
APPENDIX A

PRE-ADMISSION OUTLINES OF THE
ROSS INTERVIEW

1. INTERVIEW WITH BOTH PARENTS

   A. Family Data
   1. Patient's full name, birthdate
   2. Parent's full names, occupations, birthdates
   3. Address, telephone
   4. Diagnosis
   5. Referrant
   6. School and grade
   7. Religion
   8. Siblings and birthdates

   B. History of Illness
   1. Date of first symptoms and parents' handling of them.
   2. Chronological development of illness to the present.
   3. Circumstances leading to current hospitalization.
   4. Parental understanding of illness and reaction to it.

   C. Description of Current Behavior
   1. Adjustment to illness.
   2. Reaction to impending hospitalization.
   3. Degree of activity restriction and child's reaction to it.
   4. Peer relationships and effect of illness on them, if any.
   5. Family relationships (individually) and manner in which family members have reacted to child and his illness.
   6. Discipline and child's reaction to it.
   7. Present school progress and child's school relationships.
D. **Home Environment**

1. Physical description of the home.
2. Child's accommodations within the home.
3. Daily family activities as they affect child (e.g., working mother, father not in home, etc.)
4. Arrangements for caretaking of child.

11. **INTERVIEW WITH MOTHER**

A. **Developmental History**

1. Birth
   a. Circumstances surrounding conception (child planned, unplanned, mother's attitude toward pregnancy, living conditions of parents, etc.)
   b. Life crises or medical complications in pregnancy.
   c. Experience with labor and delivery.
   d. Mother's reaction to first seeing child.
   e. Vigor of sucking.
   f. Complications, if any, for mother or child in hospital.

2. Infancy
   b. Infant's wake-sleep patterns.
   c. Feeding: breast or bottle and reason.
   d. Vomiting, diarrhea, illnesses, if any.
   e. Acceptance of strained foods and cereals.
   f. Age and management of sitting unsupported, walking, speaking words and sentences.

3. Primary Reaction Patterns (covering only the period between birth and age two)
   a. Activity - how active a child was he in the first two years?
   b. Rhythmicity - was he biologically regular in the first two years?
   c. Approach-Withdrawal - did he easily accept new toys, food and people or did he first withdraw from them?
d. Adaptability - would he make himself at home in a strange and new situation or would he cling to mother?
e. Mood - was he a happy, positive baby or a cranky, irritable baby?
f. Threshold of Responsiveness - how sensitive was he to sound, strong sunlight and the texture of clothing?
g. Persistence - would he stick at a frustrating task or would he give up if found difficult?
h. Distractibility - could you draw his attention away from something he was doing or would he immediately return to it?
i. Intensity of Reaction (positive and negative) if you gave him something he wanted or took him some place he wanted to go, would he show some pleasure and excitement? If you took something away from him that he particularly wanted, would he show anger?

4. Pre-School Years

a. Activity level of child.
b. Degree of independence.
c. Tolerance for frustration.
d. Inquisitiveness
e. Persistence with a task.
f. Typical play activities engaged in.
g. Peer, sibling and parental relationships.
h. Management and disciplining of child.
i. Nursery school progress (if attended) and reaction to separation from mother.
j. Kindergarten progress and comments of teacher.

5. School Years

a. Detailed progress of each succeeding school year to the present, including academic achievement, teacher and peer relationships and attitude toward school work.
b. Management of child in the home as he develops, noting behavior changes, if any.
B. **Mother's Background**

1. Place of birth, number and ages of siblings.
2. Description of her father as she remembers him from childhood, his occupation and the quality of her relationship with him.
3. Description and evaluation of her childhood, including peer relationships.
4. Description of her mother as she remembers her from childhood, and the quality of her relationship with her.
5. Menarche
6. School progress, educational level attained and attitude toward school achievement.
7. Dating.
8. Employment history, if any.
9. Courtship history and evaluation of marriage.
10. Description of husband and her view of him as a support figure.
11. Description of other children.
12. Activities apart from child rearing.

111. **INTERVIEW WITH FATHER**

A. **Parent-Child Interaction**

1. Father-child interaction as the father has observed it.
2. Daily management of the child in the home and the father's views on discipline.
3. Mother-child interaction as the father has observed it.
4. Description of other children.

B. **Father's Background**

1. Place of birth, number and ages of siblings.
2. Description of his father as he remembers him from childhood, his occupation and the quality of his relationship with him.
3. Description of his mother as he remembers her from childhood, and the quality of his relationship with her.
4. Description and evaluation of his childhood, including peer relationships.
5. School progress, educational level attained
7. Armed services and employment history to the present.
8. Courtship history and evaluation of marriage.
9. Description of wife and his wife of her as a support figure.
10. Activities apart from child rearing.
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**PAMPHLETS**