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Hostility to Kith and Kin

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Summary

Ten male patients who shared a similar behaviour disorder have been seen. Their behaviour was characterized by extreme hostility towards close members of the family without aggressiveness towards others. The first manifestations of an increase in hostility may be acts aimed to injure or denigrate the spouse or close members of the family. The dynamics of Capgras's syndrome may be similar. This behaviour disorder must be recognized as one of many causes of conjugal conflict.

Introduction

It is a trite dictum that phenomena occurring in disease are but exaggerations of events which may be manifest in health. The cantankerousness displayed in the intimacy of the family circle is too common to attract attention. Habitual discord which is more than an occasional verbal sparring, and which may threaten the stability of the family, is also an everyday occurrence. "A little more than kin," and the odds are that the fellow creature will be "less than kind" (*Hamlet* 1, ii, 65).

My aim here is to draw attention to aggressiveness against the wife and other close relations which appears without valid reason after many years of happy conjugal relations. The begetter of this family discord is the husband who, however, seems to be totally free from irascibility in social intercourse outside his home. Because his malevolence is strictly circumscribed those who do not receive his abuses and taunts find it difficult,

if not impossible, to give credence to charges of cruelty made against a man who outside his home affects a personality entirely free from such traits. All the wives in this series found the incredulity of friends and social agencies embarrassing and distressing. When some wives, goaded by their husband's scorn—alternating with ostracism—eventually abandoned their husbands the latter were invariably taken completely by surprise. They lacked all insight into their past callous behaviour and were full of contrition. They clearly felt a deep affection for the spouses who had deserted them and were prepared to make amends.

Patients

Each of the 10 patients, ranging in age from 26 to 54 years, included in this series was submitted to a long interview during which all of them comported themselves with courtesy and politeness. It was only through meeting the spouse that the behaviour disorder within the bosom of the family came to light. Each wife described her husband's behaviour at home in practically the same terms. She claimed that the husband's behaviour had changed profoundly from the premorbid pattern. The prominent feature was a newly developed aggressiveness directed against herself and close members of the family. This aggressiveness was characterized by quick temper, rudeness, anger, and suspiciousness, and sometimes physical assault. A reduction of interpersonal relations with refusal to communicate were features in some cases. In each case the marital history given by the spouse failed to show any significant premorbid disturbance of conjugal relations.

In six cases kith and kin hostility appeared after head injuries of varying degrees of severity. Cardiac arrest during open-heart surgery was followed in one case by signs of focal brain damage, which were associated with the first appearance of hostility to members of the family. In two epileptic patients aggressiveness showed marked fluctuations which paralleled the epileptic state; scant temporal lobe seizures were associated with persistent interictal hostility of a similar circumscribed pattern. The following case illustrates the clinical features presented by this post-traumatic group of cases.

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CASE REPORT

Five months after sustaining a head injury associated with fracture of the left side of the vault of the skull the patient was able to resume work as engineer supervisor of maintenance of aircraft. His only residual complaint when he was seen two years after the accident was a persistent tinnitus. He discharged satisfactorily his exacting duties, which entailed personal contact with his superiors, peers, and subordinates. The accident resulted in litigation, in the course of which the patient met the defendant's solicitor, who described him as being "an extraordinarily pleasant plaintiff." Concurrently, the patient showed personality changes at home, which his wife described as follows: "... little things provoke a temper; he shows a lack of consideration for his family. He used to have good relations with his son, but since the accident, no matter what they discussed, they used to finish in a slanging match. If my son or his wife put the towel in the wrong place he would go for them. I believe [the patient's] temper was the reason why they emigrated. When, last Christmas, I told them, 'I can't like Dad anymore,' my son said, 'I can't blame you.' These have been the unhappiest years in my whole life. Even if he improves these two years have done something which cannot be repaired; it hurts when he says nasty things. There was a phase when everything I said was wrong—I still can't do anything right—he always finds fault with everything. First thing in the morning is the worst time. If you burn the toast that's a terrible thing and he flares up... he has almost gone berserk on occasions—mad—almost frighteningly so, as if he has lost his senses—shouts and carries on—just goes mad with temper. Though you try to make allowances for his accident it still affects you if you get it day in and day out. When the children were staying with us he would say: 'I heard what you said,' thinking we were talking about him when we weren't. He smokes and drinks more than he used to... he is spending money foolishly; he goes into the bar and, irrespective of who is there, buys them drinks. I have learnt to think before I say anything. When he is upset his favourite expression is 'You bloody idiot.' Many a time I would have run away from him if I had somewhere to go—I even thought of taking a bed-sitting room."

Discussion

These cases are presented as a phenomenological study of a group sharing a similar behaviour disorder, the essential element of which is an abrupt onset of hostility towards a few people with whom the male patient has close emotional ties, especially his wife. This enmity may also extend towards parents, siblings, and children. The sustained increase in hostility may first

show itself in acts aimed at injuring or denigrating the spouse or some close member of the family. These acts may occur under the influence of alcohol—so often one of the preconditions of wife-battering—or under chlorthalidazine medication. One patient on chlorthalidazine physically assaulted his wife for the first time in 20 years of marriage.¹

In Capgras's syndrome hostility is similarly projected on to close members of the family, ostensibly on the grounds that they are impostors disguised as exact doubles. As in the group of patients presented here head injuries and other cerebral conditions precede the onset of Capgras's symptoms in some cases.^{2,3} This pattern of antisocial behaviour within the family milieu may be due to release from inhibition, as a result of which there is a regression—in hierarchical terms—to a less adult mode of behaviour. Previous conditioning and past experience may facilitate the development of the behavioural disorder. Flugel's observation may provide an explanation for these phenomena, "It is man's unique and inevitable tragedy—due to his long period of helpless infancy—that he is compelled to hate those whom he also most loves."⁴ The poet, John Clare (1793-1864), who spent many years in the General Lunatic Asylum at Northampton, described this mental state in similar terms:

And even the dearest that I love the best
Are strange—nay, rather stranger than the rest.

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SHORT REPORTS

Oculocutaneous Reaction to Oxprenolol

A patient developed a psoriasiform eruption and dryness of the eyes after six months' treatment with oxprenolol. Forty-eight hours after oral challenge, the skin eruption recurred in the same places. Further challenge with practolol failed to reproduce the lesions.

Case Report

In November 1973 a 65-year-old woman was treated for hypertensive heart disease with methyl dopa 250 mg twice daily, digoxin 0.25 mg daily, and oxprenolol 20 mg twice daily. There was no past or family history of skin disease. In April 1974 she developed symmetrical psoriasiform plaques on the extensor aspects of both forearms (see fig.) and on both cheeks. The plaques had prominent marginate scaling with some clearing at the centre. The palmar and plantar skin was not affected. She complained of eye dryness, and tear secretion measured by Schirmer's test was reduced bilaterally. Oxprenolol was stopped. The skin eruption improved after seven days, beginning as a reduction in the peripheral scaling, and disappeared after two months. Treatment with methyl dopa and digoxin continued. Skin biopsy showed epidermal oedema and the epidermis was invaded in places by lymphocytes and histiocytes. There were scattered foci of swollen eosinophilic cells, some of which had pyknotic nuclei. There was oedema and a cellular infiltrate composed of lymphocytes and histiocytes in the papillary and reticular dermis. Direct immunofluorescence of the diseased skin showed a fine granular deposit of IgM and complement at the dermo-epidermal junction. The antinuclear factor test was negative.

In January 1975 after two days of oxprenolol (20 mg twice daily) she developed erythema in the same places as before and, after five days, scaling appeared at the margins of the erythema. Oxprenolol was discontinued, and the eruption subsided within two weeks. She was later given practolol 100 mg twice daily for seven days. The skin lesions did not recur and the drug was discontinued.

Psoriasiform plaques on extensor aspect of left forearm.

Discussion

Many cases of cutaneous and ocular reactions to practolol have been reported¹⁻³ but there have been no confirmed reports of such reactions in patients receiving oxprenolol. This patient had a psoriasiform eruption which recurred in the same places after oral challenge. The eruption was not preceded by scaling and thickening of the palmar and plantar skin, a feature which was invariably present in patients developing a psoriasiform eruption on practolol.³ Direct immunofluorescence showed a pattern similar to that described by these authors. Oxprenolol has been prescribed as an alternative β -blocking agent in patients who have developed cutaneous and ocular reactions to practolol. This report emphasizes the importance of