SHORT-TERM PSYCHOTHERAPY IN THE TREATMENT OF ASTHMA

BY

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The symptom complex of asthma when found in Service personnel may often present difficulties in the problems of treatment and disposal. Protracted and frequent hospitalization, the threat of acute recurrences and the necessary restrictions in employment may do much to affect adversely the career of a Regular soldier, who, until the onset of his disability, has probably given long and efficient service. Where in these cases there are minimal pathological changes in the respiratory system and where the relationship to allergy is vague and indeterminate, the tendency of the modern physician is to emphasize more and more the significance of emotional factors in the etiology of the disease.

It has been known for nearly three hundred years that the manifestations of asthma were clearly related to the state of the "nerves" in the sufferer, but it is only in the last twenty years that the psychosomatic aspects of this condition have been scientifically established. British psychiatrists have made valuable contributions to the early studies of that group of diseases comprising asthma—migraine, hay-fever, colitis and prurigo. Wittkower [1] suggested that the large majority of asthmatic conditions had a twofold causation. There was, on one hand, the person with an allergic predisposition in whom emotional conflict acted as a trigger to activate the latent asthma, and, on the other, the constitutional neurotic who was subject to asthma of true allergic origin. In the same year Rogerson, Hardcastle and Duguid [2], when investigating asthma in children, wrote that the hallmarks of the asthma-prurigo personality in young patients were "High intelligence in verbal tests with poorer performance ability; marked over-anxiety with a lack of self-confidence; considerable latent aggressiveness and egocentricity." A year later in a classic paper Gillespie [3] stated: "An idea may become the affective stimulus which elicits the asthmatic response just as much as pollen or horsehair." He observed that asthmatics generally exhibited a neurotic type of personality long before the onset of the asthma, and that the asthma itself could be replaced by anxiety, could express a conflict between impulse and conscience, and was often a protection against or a mode of escape from an intolerable situation.

The psycho-analytic approach as exemplified by French [4] to the problem of asthma produced the observation that one of the common features in asthmatic patients was the fear of family disruption arising from a sexual urge towards the
parent, with the resulting emotional conflict and the threatened loss of parental love. The reaction to this threat was a repressed cry of fear and frustration, symbolized in the asthmatic attack. Utilizing the Rorschach projection test, Schatia [5] stated that his findings confirmed the impression that asthmatics tend to have compulsive personalities without evidence of phobias or compulsions. Weiss and English [6] assert that a large number of asthmatic children are over-anxious and insecure and that they are divided into two distinct groups. There are the over-protected only children, usually boys, who have been very much wanted by the parents, and there are the unwanted children, whose parents compensate for their repressed hostility towards them by excessive solicitude and attention. Dunbar [7], when discussing adult asthmatics, refers to them as being either smiling and unruffled or openly dependent and emotionally unstable.

Whilst most of the literature with its valuable contributions to the understanding of the psychopathology of asthma has been concerned with children and psychoneurotic adults, very little has been described of this condition in institutionalized mental patients. Prout [8] in a recent informative paper has made a brief survey of the relevant published material and has described a small number of cases of asthma occurring in psychotics under his care.

In the treatment of asthma the aid of the psychiatrist is enlisted in the majority of cases only after there has been a diminishing satisfactory response to routine drug therapy and when the patient has become discouraged and set in the habits of illness. In certain early selected cases psychotherapy can be of marked value. From the service man's point of view deep analysis is unpractical. It takes too long, may interfere seriously with the military life of the patient and restrict his normal activities, and in general is not justified by the results, occasionally complicated by the emergence of some florid psychotic manifestations. But a superficial psychotherapy of a more dynamic nature which attempts for the comprehension of the patient to equate the appearance of the asthmatic symptoms with the co-existing life situation may in a few brief sessions achieve considerable improvement.

The two following cases, seen and treated by the writer, are quoted because they have many points in common, exhibit characteristic features of the asthmatic personality and history, and because they have responded sufficiently well to psychotherapy to return to responsible military employment without further complaint.

**CASES**

**Case 1, A.B.—**Male. Age 36½ years. Major. Infantry, 12 years' service. Married. **Medical History.—**Twenty-five years' history of mild bronchial asthma without any great disability. First severe attack of asthma in November, 1945, followed by recurrences in February and March, 1947. Between May and September, 1949, his condition was such as to interfere seriously with his work and confine him to bed. The therapeutic response to ephedrine and allied drugs had become decreasingly effective. Each attack was preceded by a mild urticarial reaction and hot "flushes." Skin tests for allergens were variable and non-specific. There was no family history of asthma.
Personal History.—The only son and the second eldest in a family of four children, he was reared in a comfortable upper middle-class environment and had a conventional education as a day-boy at preparatory and public school. Of average ability he passed School Certificate at 15 years and left at the age of 19 years. Three years were spent in a large factory as a trainee-executive, but he always had the Army in mind as a career. Commissioned in the S.R. in 1936, he was appointed to a Regular commission in 1938, in which year his father died. As a junior officer he took part in the evacuation of Dunkirk. In 1942 he graduated from the Staff College, and it was at this period that he found it necessary to control his asthma by injections of adrenaline. He had been married in 1941. From 1943 to 1949 he served as a G.S.O.2 on active service overseas, and in Staff appointments in the U.K., where his work was exacting and specialized. During this period his wife and children were living with his mother, and there were many difficulties with unexpressed resentment on both sides. After attending a special and intensive course in 1949 he was appointed an inter-service liaison officer overseas. Almost immediately his asthma became worse and seriously interfered with his preparation of an important memorandum for his General, resulting in his evacuation to U.K. for treatment.

Psychiatric Examination.—He was an intelligent and ambitious individual with a high level of aspiration, but with no great confidence in his own ability to attain the high standards he had set for himself. He anticipated any failures by adopting a self-depreciatory attitude, was much too anxious to be in the good graces of his seniors, and had learnt to suppress completely any overt expression of resentment or disapproval. He exhibited obsessional and egocentric traits, and found it difficult to relax away from his work. For the greater part of his life he had been dominated by his mother, and treated her with great respect and admiration if not with any marked affection. It was elicited that of late his asthma had become worse when spending the week-ends with his wife, and this was associated with a loss of sexual potency. The other important fact was that he had assumed his new appointment with some trepidation, since the officer he was relieving was noted for his outstanding professional record, his numerous social graces and his good standing with the senior officers at the H.Q. Whilst in hospital this officer was a passive, amenable patient who did everything to co-operate with the medical staff, and who gave the impression that he was sorry for causing any inconvenience but felt he was putting up a good show in the face of many difficulties.


Medical History.—This warrant officer had suffered from a mild degree of bronchial asthma for 18 years, but only complained of severe and disabling asthmatic symptoms following a perforated appendix in December, 1949. For three months he had been totally unemployed owing to his dyspnoea on exertion. There was no family history of asthma, and all the skin tests were indecisive and unreliable for specificity. He had been referred to a psychiatrist for the first time early in 1951.

Personal History.—The oldest of five children, his early life was spent in the company of the others in a convent, in which they had been placed by a war-widow mother who was unable to support them. He felt himself responsible for his brothers and sisters. Leaving the convent at the age of 14 years to enter domestic service, he lost contact with the rest of his family. For various reasons he disliked his new life and enlisted in the Army although under age. His subsequent career was satisfactory, resulting in slightly accelerated promotion and a reputation for conscientiousness that
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earned him throughout the regiment the soubriquet of "Methodical T—___.” By 1939 he was a Sergeant, and later became a P.T.I. In 1942 he refused an immediate commission as a Q.M. because it might have meant leaving his wife, from whom he had already been separated a long time, and he also felt that as an officer he would have to adopt certain standards of living, which he did not think himself capable of maintaining. Since then he had been employed in U.K. in various capacities as an instructor. His last employment, which he disliked intensely, had been on a Travelling Team, where there had been constant movement, irregular hours and meals, indifferent lodgings and frequent long separations from his wife and child.

He had been married 13 years, had one son (5 years), and was happily married. There was no family history of asthma or allergy, but the wife suffered from “heart-trouble,” which was probably of psychogenic origin.

Psychiatric Examination.—A sparsely built, grey-haired man looking older than his years. The inspiration in breathing, which appeared to be forced and unnatural, was directly related to the degree of emotional stress and the extent of medical observation. Of average intelligence, he had initially very little insight into the nature of his symptoms, and was egocentric to a marked degree. A passive, co-operative hospital patient, his attacks of breathlessness were almost theatrical in quality. Over a series of interviews investigation revealed the following factors:

1. A life-long craving for security, affection, and popularity.
2. Extreme dependence upon his wife, with an associated resentment both at himself and at her for his great need of her moral support. At one stage he admitted that he had often felt “like throwing her out of the window.”
3. Resentment at his early rejection by his mother.
4. A degree of suppressed envy of his less capable contemporaries who had reached commissioned rank. He always suspected that they might attempt to be patronizing towards him.
5. An obsessional attitude in providing for the welfare of his wife and child by expending money on elaborate long-term financial insurances.
6. His vehement dislike of his most recent employment, and his resentment on that basis at his Commanding Officer.

Comments on the Case Notes

In the histories of these two patients of widely differing social environments and professional backgrounds there are striking similarities. In both there was at the outset strong scepticism at the suggestion of any psychological causation of the more severe symptoms. Both were the responsible male members of their respective families after the death of the father. They strongly denied, when first questioned, any difficulties in their married lives, but later volunteered the information of long-standing grievances against their wives. Frequent irritable outbursts were followed by immediate reconciliations with over-compensation for mild guilt-feelings. Although capable and conscientious in their respective spheres, they had both rigidly suppressed their critical faculties in regard to the actions of authority, and gave the impression of being over-disciplined and too conscious of their own possible shortcomings. When in hospital they were both
“good” patients who were content to sit around and wait for something to be done. There was in each case an identical need for liking and acceptance by contemporaries and commendation from superiors. Asthma, when it appeared in these patients, was undoubtedly and fundamentally a protective mechanism.

Treatment and Progress

The first interview in each case was devoted to neutralizing the passive psychological resistance, which always seems to be present in patients of this type on being referred to the psychiatrist, to establishing a good rapport, and to a brief but lucid and non-technical explanation of the effect of emotional stress on physiological function. A detailed life history was then taken, and particular attention was paid to those stress-points which seemed to be significant, but which invariably tended to be glossed over in the patient’s own story. The subsequent procedure was dictated by the rate of progress, the facilities for out-patient treatment, and the intellectual grasp and capacity for insight of the individual. The crucial point appears to be when the therapist has gained the confidence of the patient who perhaps for the first time in his life is able to relax the guards on his emotional expression and “get things off his chest.” He is generally surprised and almost shamefacedly self-conscious when confronted with the evidence of his antagonistic reactions towards people and principles, which all his life he has been indoctrinated to respect and hold in regard. The efficacy of this type of emotional revelation has already been recognized by French and Johnson [9], who postulated a dynamic relationship between confession and asthma.

Case 1.—In the opinion of the writer this officer was of an allergic predisposition, but his acute attacks were precipitated by emotional crises. It was decided to make use of his logical and staff-trained mind to assist in his own treatment. First the week-end asthma was related to his psycho-sexual impotence with its vicious circle of apprehension of further impotence. This disability itself was explained on the presence of definite intra-family tensions, with the recognition of the patient’s divided loyalties to his mother and wife. When he had really appreciated these factors he was asked to make a life chart paying special attention to the time relationships of his acute asthmatic attacks. This type of chart, as explained by Harrowes [10] and based on the dynamic psychiatry teachings of Adolf Meyer, correlates somatic illness with age, occupational stress, leisure activities, social adaptation and sexual maturation. It was immediately obvious when this chart was completed that the severity of each attack was directly proportional to the degree of newly assumed responsibilities in his professional and domestic lives. Recognition of this dependent reaction led to a physical improvement, sufficiently marked to allow him to return to duty. In view of the true allergic element in his condition he was instructed in breathing exercises by the physiotherapist, and advised to continue with the occasional use of his prescribed anti-spasmodic drugs.

He was seen on three successive occasions at fortnightly intervals and his progress was rapid and uninterrupted. Accommodation for his wife and children was found well away from his mother, and his marital adaptation was satisfactory. His recovery was considerably hastened when he learnt that the brilliant officer whom he had
relieved in the staff appointment was humanly frail and had been found responsible for some major administrative faults. Since his last interview many months ago he has been in full and efficient employment without any complaint of disabling symptoms.

Case 2.—This warrant officer was considered to be a constitutional psychoneurotic in whom the dyspneic symptoms were embodied as a hysterical mode of expression. At the end of the first interview the response in this patient, who previously could walk the length of the ward only with difficulty, was even more marked. He stated, "I haven't felt so well for a long time. I don't know what you've done, but you seem to have hit the nail on the head," and walked without distress along the whole length of a long hospital corridor to his ward. He accepted the psychological interpretation of his symptoms and was allowed to read a book on psychosomatic medicine for the layman by Dunbar [11]. This was followed by a slight relapse, probably due to the recognition that he was neither as self-sufficient, independent nor adult as he had imagined himself to be. After two further interviews at intervals of a few days he was sent on sick leave and returned to his Depot, where, through the good offices of the Commandant, he was retained on the permanent instructional staff and allowed to live out with his family. Although such rapid recoveries are often suspect, this patient has made no further complaints, is working well, and should continue to do so until the termination of his service.

SUMMARY AND CONCLUSIONS

A very brief summary is made of the more important contributions to the literature of asthma and psychiatry.

Two cases are described of long-standing asthmatic syndromes in military personnel, with comments on predisposing emotional stresses, treatment and progress.

It is concluded that in certain selected cases of asthma, where psychological factors are predominant, short-term psychotherapy initiated in hospital and continued in an out-patient clinic may achieve immediately satisfactory results, shorten the periods of hospitalization and absence from duty, and restore valuable personnel to full and efficient military employment.

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REFERENCES


