Annales Academiae Paedagogicae Cracoviensis
Folia 55 Studia Psychologica III (2008)

Agnieszka Czuszkiewicz, Dorota Wilanowska-Parda

Psychotherapy in bronchial asthma

The impact that mental factors have on the origin and course of many ailments has been perceived already since the ancient times. The term *psychosomatic illness* was introduced by German and English authors in the early 19th century.

It was Franz Alexander who made a significant contribution to the development of research on disorders in which mental factors play important role. In 1950 he published the traditional list of psychosomatic diseases. Alongside bronchial asthma, the list included essential hypertension, ulcerative ileocolitis, hyperthyroidism, atopic dermatitis and chronic rheumatism. Alexander is also the author of the theory of specific conflicts which are deemed responsible for respective disorders.

Today the view dominates that the mental component affects both the origin and the progress of most diseases, while in the case of psychosomatic illnesses it is considered crucial. The focus is also on somatopsychic phenomena as being a mental reaction to somatic disorder, in which category a patient's perception, his/her way of handling the illness, emotions, personality changes, and cognitive dysfunction are all contained.

Even though the widely-accepted, current definition of bronchial asthma considers exclusively its biological aspect, a growing number of specialist publications emphasize the importance of mental and social agents in the development of the illness.

In consequence of such an approach to bronchial asthma, complex, interdisciplinary rehabilitation models with psychotherapeutic assistance on the agenda are being created.

In accordance with the saying that 'an ounce of prevention is worth a pound of cure' and in order to cure the very cause in the case of illness, psychotherapy was put on the large list of the forms of help in asthma.

Interrelation between mental factors, the disease onset and its further course can be interpreted in the light of different theoretical premises, with psychoanalytic,

systems, behavioral-cognitive and integrative approach all being worth noting here. As a result of choosing a particular paradigm, an appropriate method of conducting the therapy and the mode of therapeutic interventions are taken.

The authors of the present article aim at gathering the diversity of theories together and presenting the array of useful therapeutic techniques.

The psychoanalytic concept

Historically speaking, psychoanalysts as well as psychoanalytic psychotherapists have had the greatest experience regarding psychotherapy in asthma. According to the theory they advocate, we assume that the very mechanism of bronchial asthma emergence is similar for both children and adults, whereas direct factors leading to the appearance of disease symptoms are decidedly different. Children are often subject to asthma co-occurring with allergy, and the classical as well as modern research, conducted in accordance with psychoanalytic theory, have suggested a close relationship between the mental mechanisms involved in the emergence of allergy and bronchial asthma. Numerous works prove that, in the case of children, the asthma symptoms may recede during puberty. It does not automatically indicate, however, that there has been a change in the ways of solving mental conflicts. Patients may experience persisting generalized somatization of mental states or a change from certain bodily symptoms to other. In virtually all cases bronchial hypersensitivity linked with mental hypersensitivity is observable.

The interest in bronchial asthma was originated, both in psychoanalytic theory and practice, by the aforementioned pioneering, and classical today, 1952 work by Franz Alexander, in which he included bronchial asthma into the traditional 'psychosomatic seven'. In the author's view, the primary conflict of a child suffering from asthma consists in unresolved dependence on his/her mother. Anything that threatens to separate a child from the protecting mother or her substitute may lead to an asthma attack, understood here as a symbolic expression of a suppressed cry or wail for mother. In his opinion, however, the essential problem lies in the relation between two etiological agents: emotional and allergy-triggering. In turn, Sperling (1978) believes that in the mother – asthmatic child relation there dominates a conflict around the separation – autonomy issue. Sperling concluded that the mothers of the children she conducted research on maintained with them a relationship which she described as a 'psychosomatic relation'. When the child is healthy in such a relationship, he/she is rejected by the mother and displays drive for autonomy, while when the child is ill and helpless, the mother 'emotionally strengthens' her offspring by lavishing attention and care on the child. Still, Overbeck's research states a thesis that a symbiotic nature of relations between children and their parents stems from the fact that the latter have not made the most of mental mourning after the loss of

important objects in the past. Children ailing from bronchial asthma have a vital task to perform – to preserve their parents' mental homeostasis and protect them from depression.

Among the researchers of the subject there have been disputes over the concept of 'psychosomatic personality', and whether a particular type of somatic disorders can be accompanied by specific personality or character traits. The so-called 'French School' scholars spread the idea that people suffering from psychosomatic disorders are characterized by a special way of thinking and experiencing relations with another person. Furthermore, studies conducted in the United States resulted in coining the term 'alexithymia'. The name denotes some people's inability to find appropriate words describing their emotions. They are either unaware of their feelings, or incapable of distinguishing between them. Trying to explain this question, some of the researchers claim that people suffering from psychosomatic diseases experienced so tough emotions in the past that a mental confrontation with them would pose a threat to the patients' sense of identity as well as their mental continuity. The interpretation of an asthma attack proposed by Groen remains in the spirit of the above analysis and the like. In her opinion, it occurs in a specific emotional situation, with prevailing sense of being cornered, either physically or through the conflict with an important person, and of having no possibility to express one's dissatisfaction or irritation, either verbally or through action. Such an approach springs from perceiving asthma onset as a display of early developmental deficit, the child – carer relation being also a factor here. It seems that psychotherapy aiming to reorganize a patient's mental structure is, from this viewpoint, the most adequate method of treatment. Thus, within analytical concept, an individual psychoanalytic psychotherapy would be the desired procedure. To a certain extent, the above theses are complemented by the fact that in the course of treating people that ail from psychosomatic disorders the mentalization process or reflective functioning plays a crucial part. According to the scholars dealing with this process, the carer's ability to observe the child's fluctuating mental states is absolutely indispensable to the development of the child's reflective functioning. The quality of early relations with the carer influences shaping the child's self image and image of others later on. Children whose parents find it difficult to activate reflective skills involving their own mental experience, fall thereby victim to the trauma of particular sort. They possess a specific type of affect regulation, which very often results in somatization of mental states.

The psychotherapist's task may amount to enabling the asthmatic to create such a mental representation of self as to supplant physical self with mental self. Patient's somatosensory memories must be formulated in thought.

Currently, the belief that psychoanalytic therapy is the appropriate manner of treating the asthmatics is becoming increasingly popular. It is not recommended, though, in the case of patients suffering from acute respiratory malfunction.

The systems concept

The principal premise of the systems model is the statement that a psychosomatic illness is an element of interaction within the entire family system and that it plays a significant part there. Therefore, the goal of psychotherapy in this approach would boil down to introducing such a change in the system as to eliminate the need to use the symptoms to, for instance, communicate with others.

The field of interest encompasses here anything that happens between family members; the entirety of behavior that defines a given patient's relations and family identity. The focus is not on a specific patient, but on the system, in which one person is a 'disease carrier'.

It is recommendable to refer here to the 1978 work by Minuchin and collaborators, who, on the basis of research of families with children suffering from psychosomatic disorders, i.e. anorexia nervosa, juvenile diabetes and bronchial asthma, described the model of the so-called 'psychosomatic family'. Such a system would be characterized by: 1) overentanglement, 2) overprotectiveness, 3) low tolerance for conflicts and inadequate techniques of solving them, 4) small potential for change, that is family's difficulty taking decisions about change, 5) child's entanglement in conflicts between parents.

The description of 'psychosomatic family' was later completed and modified several times by other researchers of the subject, namely Stierlin and collaborators (1999) and Wood (1993). The reports by Meijer and Oppenheimer (1995), who conducted studies on families with asthmatic children, also seem worthy of notice. They challenged some characteristics of Minuchin's model. Among other things, they treated overentanglement and overprotectiveness as a consequence of illness in the family and saw them as a defense mechanism rather than initial features of the system. Moreover, they noticed that both have a beneficial influence on the course of treatment. They did not prove in their work that the child's illness in 'psychosomatic families' was supposed to divert attention from matrimonial conflict. They divided the whole of phenomena taking place within such families into two interplaying groups of factors. The first one consisted of variables applying to the course of illness and to child's and parents' ways of coping with it. The following are included here: intensification of the pathological process, its controllability, and the method of treatment (pharmacology and medical advice). The second group includes variables that concern parents, i.e. their social status, possible social pathology, relationships, as well as variables having to do with the functioning of the family system, i.e. cohesion, adaptation, acceptance or rejection, educational attitudes and child's characteristics, i.e. age, sex, anxiousness and neuroticism level.

Nowadays, it is increasingly assumed that it is hard to speak of a certain model of 'psychosomatic families'. Rather, there dominates a conviction that an accurate diagnosis of the family system is impossible and that communication processes within the system are unpredictable. Greater importance is attached to the question of

what kind of subjective definition of the problem is adopted by the particular family member – the one looking for help.

The research by Bovensiepen and Wilhelm (1981), even though outside the systems concept, but still within the 'family' trend, is also worth mentioning here. The scholars perceive the positive part that fathers play in families with children ailing from asthma. They are described as caring individuals who reveal a sort of maternal instinct, but at the same time are unsure of their manly role. On one hand, these features make it possible for a child to experience closeness to an empathic object. On the other hand, they may hinder orientation in the family structure and a child's identification with the role associated with his/her sex.

In the literature of the subject there appears a thesis that, in considering the origin and progress of the disease, a much wider perspective should be taken, so that both the aspect of the family system and the asthmatic's intrapersonal elements are taken into consideration.

The cognitive-behavioral concept

In the cognitive approach, great emphasis is placed on the importance of thinking processes for the development of particular behavior involving particular emotions, the symptoms being generated in the outcome. The therapy based on this concept would essentially mean applying interventions leading to the transformation of thought content. In this context, it is mainly about the way of interpreting one's own behavior, other people's behavior and disorders affecting a given patient. The proponents of the cognitive approach adopt a view that a person's belief system regarding his/her symptoms, significance attached to them and their etiology as well as a person's self-knowledge, all play a crucial role in the origin and course of psychosomatic illnesses.

On the basis of the cognitive approach Creer designed one of the models of psychoeducational assistance. He assumed that teaching the patients the ways of handling the escalating symptoms of disease is nothing but the acquisition of skills. He divided the process into two stages. The first one included gathering information about oneself and about the ailment to make right decisions concerning one's behavior on the grounds of this data. The following stage was based on a group discussion and consisted in working out specific instructions that were to help realize the decisions taken, explain obscure elements as well as help understand some patients' reaction. One of many forms of teaching through cognitive training is **assertiveness training**. Its purpose is to acquire and practice the skills of adopting certain interpersonal attitudes, which allow free acceptance and expression of feelings, needs, requests and opinions. Patients have an opportunity to repeatedly practice, e.g. in

the form of psychodrama, specific, real-life situations they otherwise find difficult to solve.

An individual's behavior, understood as an effect of stimulus, is, in turn, the point of interest in the behavioral approach. Particular behavior involves: the learning process, a current state of motivation, individual differences determined genetically or extragenetically. Pathology is seen here as a set of undesirable actions or lack of actions desired in particular situations. With reference to the asthmatic patients, it is assumed that an attack of dyspnea is an acquired form of expressing a patient's inner conflicts. In certain situations, asthmatic children are capable of "triggering" an attack of dyspnea themselves. They do it by means of crying, laughing, shouting or experiencing intensive emotions. The goal of therapy in that case is to make use of selected, precisely determined techniques of experimentally proven effectiveness so as to remove or minimize the symptoms on the basis of elemental laws of learning.

Some of the methods, like: relaxation training, biofeedback, systematic desensitization and others, have been recognized and incorporated by doctors into the process of treatment and rehabilitation of bronchial asthma.

Relaxation training consists in acquiring concentration skills in order to relax and overcome stress. Some of the authors underline the fact that the training is necessary for patients to perform breathing exercises effectively. The author of autogenic training is a Berlin doctor, J.H. Schultz, PhD. The name originates from the Greek word *autos* meaning 'oneself' and *genos* – a birth, origin, kind. 'Autogenic' signifies then 'training one's EGO'. In autogenic training a primary significance is attached to yielding to suggestions for calmness, a pleasant inertia and warmth – feelings linked to the ability to relax muscle tone. Verbal suggestions accompanying the relaxation (e.g. 'you relax completely, do not think about anything, your muscles are relaxed, you are breathing rhythmically and peacefully, feeling pleasant warmth, you are calm and relaxed', etc.) and intentional submission to their content facilitate proper course of passive rest. Owing to the concurrent conscious control over stimulating and inhibiting processes, the autogenic training brings the sense of causativity and satisfaction with the achieved outcome. Mastering the skills of deep, calm breathing, of stopping the activity of thinking processes, isolating oneself from external stimuli as well as conscious control over relaxing muscle tone, are all of great importance here.

Jacobson's relaxation technique has similar purposes. It is about making particular intentional moves with arms, legs, a trunk and a face in order to flex and relax particular portions of body muscles. Initially, flexing and relaxing the muscles serves to teach patients realize the difference between sensations coming from tense and relaxed muscles. With time, systematic exercise helps to develop the habit of relaxing one's own muscles.

In turn, **biofeedback**, that is, precisely speaking, temperature biofeedback is applicable in the cases when controlling the activity of sympathetic system is desired. Biofeedback is a good indicator of this type of stimulation. It is used to train general relaxation by asking a patient to try to raise skin temperature. Obviously, respiratory

failure in asthma triggers anxiety, which by itself increases oxygen demand, intensifying thus the stress reaction caused by the primary stimulus.

The cognitive-behavioral therapy also makes use of **PEF measurement** (peak respiratory flow) to monitor escalation of symptoms. A special device informs a patient about the contraction level of the bronchial tree. A patient gradually learns in what situations breathlessness intensifies and what may alleviate the symptoms. Sometimes self-observation diaries are used for that purpose. Simultaneously, a patient develops skills facilitating the respiration. In this case the therapy aims at training a patient to assess the level of symptomatic risk, obtain an intellectual insight into the illness and overcome the illness-related difficulties.

Systematic desensitization is another fairly common behavioral technique. It comprises of relaxation and another stage, during which a patient together with a therapist determine the hierarchy of asthma symptoms, from the lightest to the most serious. Next, during the following sessions, a patient visualizes the discussed situations, starting with the most tolerable ones. As soon as fear arises, he/she indicates it to the therapist. When the situation does not generate anxiety anymore, they proceed to the next one. By this means patients learn to control fear during the attacks of dyspnea, which is beneficial to the further course of the disease.

As a technique originating in humanistic psychology and transactional analysis, **visualization**, similarly to some degree to desensitization, includes relaxation, suggestion and anticipation. The authors of this technique assume that before any action, a human being creates a mental image of it and that the quality of this image as well as positive or negative anticipatory attitude considerably determine the final result of the action. Each experienced emotion has its biological resonance, e.g. in respiratory function. One of controllable manifestations of this psychosomatic interaction is a person's attitude towards life. The most important thing is *how*, not *what*, we experience. Visualization allows creating the way of experiencing the past, present and future.

Relieving the discomfort of asthmatic children through **hypnotherapy** seems to be one of the most rewarding applications of this universal method. In her study, Olga Ferreiro presented the efficacy of such techniques. The results were so evident that on the basis of reactions to hypnosis she managed to differentiate between infectious, allergic and emotional cases of children's asthma. What is more, after the hypnosis the tests revealed a significant improvement in the condition of lungs. When implemented with children, the technique is extremely simple: the young patients are asked to show what their asthma attack looks like. It appears that nearly all children can learn to control asthma by means of hypnosis. In contrast to adults, children are more intrigued than frightened by the idea. Nevertheless, hypnosis is sporadically applied to asthma treatment in Poland. Many reports, mostly poorly documented and often contradictory, imply the effectiveness of hypnosis in regulating immune responses, both innate and adaptive. Relatively many studies of asthmatics reveal essential methodological deficiencies. Therefore, hypnotherapy is mostly used as a complementary technique.

Finally, to make the present analysis more reliable, it is necessary to mention **meditation**, which should be classified as a clinically applied method that requires additional verification. The gist of this technique is to pursue the so-called superconsciousness state, which is characterized by calmness and peace of mind. Concentrating consciousness on a particular object or stimulus is here an instrument of achieving the desired effect.

Other therapeutic techniques

Work with the body

In therapeutic work with patients suffering from asthma or other psychosomatic disorders, the issue of body and physicality as well as relations between body and psyche is quite crucial. It is well-known that in the process of development of child's sense of self, it is very important for a child to experience sensory contact with mother, especially to feel her touch, smell and movement. The data from the literature of the subject suggests that during this period asthmatics suffer considerable deficiencies in this respect. Then, many clinical observations prove that various forms of work with the body, conducted individually or collectively, bring to psychosomatic patients a great deal of fascination and happiness. To name some of them, we could mention different massage techniques, calisthenics, team games or the Eastern methods, like yoga or tai-chi. Apparently, the decisive element affecting the choice and continuation of a given form of interaction is a subjective sensation of pleasure that stems from experiencing one's own body. Direct tactile sensations may, for example, help a patient define his/her body limits, whereas work with the body performed in groups may act as a collective object, being vitally important in the separation – individualization process.

Considering the issues brought up in the present article, the theory of functioning of the hypothalamus – hypophysis – adrenal gland axis seems quite interesting. According to this theory, the axis in question is activated both during physical effort and stressful situations. Great physical effort brings about substantial stimulation of the aforesaid gland set, while a long-term training reduces its reactivity in such a way that a person active physically on a regular basis reacts with a lesser system activation in response to danger. In the light of this, systematic exercise makes one of self-regulation methods.

Continuing in the field of work with the body, one must not omit **Lowen's bioenergetic therapy.** In its author's viewpoint, disorders have their source in chronic emotional tensions, which are caused by unrelieved intrapsychic conflicts. Such a condition sparks off respiratory disorders and increase in muscle tone. Asthmatics never take full breaths – their breathing is shallow and muscles are flexed. They create thus a physiological blockage against experiencing the emotions they are afraid of.

In order to 'liberate' a patient from the chronic tensions, this approach offers specific physical exercises, such as massage and stretching as well as training a patient to breathe fully and deeply. The exercises lead to relieve the emotions that were denied and suppressed by the individual. Along with change in muscular, physiological structure of a patient's body, also its characterological structure changes.

Bearing in mind that calm and deep breathing has a broncho-dilating effect – as opposed to hyperventilation, which is broncho-constricting and triggers dyspnea attacks – it is necessary to mention here the **deepened breathing technique (rebirthing)**. During the breathing session the suppressed memories and the awareness of the split-off aspects of self are restored. This technique assumes that the blocked energy remains in the body and causes chronic muscular tensions – the so-called 'muscular grip'. The aim of RB is to remove the tensive 'blocks', to make a patient realize their source and to integrate the denied content. Implementation of this technique requires, however, taking necessary precautions.

When working on the physical self, a useful contribution can be brought by psychodrawing, especially the life-sized drawing of a patient him/herself. The works that follow may reveal the changes taking place within a patient's representation of his/her own body. Hence, a patient's drawings constitute a fundamental platform in attempting to understand his/her intrapsychic mechanisms. From a patient's perspective, on the other hand, the drawings may become a substantial support in defining the borders between inner and outer world. Drawings created as a part of therapeutic process always express an individual's past experience, his/her present emotional state and refer to the relation between a patient and a therapist.

All in all, one may venture to air two reflections. Psychotherapy in asthma has not moved beyond the stage of 'brainstorming', i.e. generating and verifying many different hypotheses and techniques. So far, no psychotherapeutic method that would be specific for asthma has been found. Bronchial asthma acts rather as one of many psychosomatic diseases. The fact that the range of possibilities is wide enables therapists to adjust the technique to a patient's individual abilities and goals.

The authors of the present article hold the view that the model proposed by Groen (1982) seems to be the most effective of all. This model allows for the asthma treatment supervised by the interdisciplinary team of specialists, including an allergist, pulmunologist, physical rehabilitator, psychiatrist and psychologist-psychotherapist. It offers an opportunity of a full-context treatment, facilitates synchronizing various therapeutic interactions and meeting individualized needs and expectations of patients suffering from bronchial asthma.

References

Brzoza Z., Badura-Brzoza K., Matysiakiewicz J., Rogala B., Hese R.T. (2006). *Objawy lęku i depresji w chorobach alergicznych.* Psychiatria po Dyplomie, 3 (3), 65–66.

Budzyna-Dawidowski P., B. de Barbaro, Furgał M. (2000). *Podejście systemowe w diagnozie i leczeniu chorób psychosomatycznych. I: Systemowe rozumienie chorób psychosomatycznych.* Psychoterapia, 3 (114), 41–50.

Budzyna-Dawidowski P., B. de Barbaro, Furgał M. (2000). *Podejście systemowe w diagnozie i leczeniu chorób psychosomatycznych. II: Systemowa terapia rodzin w leczeniu chorób psychosomatycznych.* Psychoterapia, 3 (114), 51–58.

Dyga-Konarska M. (1996). *Psychologiczne zagadnienia związane z astmą oskrzelową u dzieci i młodzieży.* Nowa Klinika, (1), 35–38.

Everly G.S. Jr, Rosenfeld R. (1992). *Stres. Przyczyny, terapia i autoterapia.* Warszawa: PWN.

Grabowska P., Targowski T., Jahnz-Różyk K. (2004). *Aleksytymia a astma oskrzelowa.* Lekarz Wojskowy, 80(1), 57–58.

Grzesiuk L. (2002). *Psychoterapia.* Warszawa: PWN.

Hunter M.E. (2000*). Hipnoterapia.* Gdańsk: GWP.

Kruszewski J., (1997). *Metody niesprawdzone w diagnostyce i leczeniu chorób alergicznych.* Alergia Astma, 7, 16–21.

Lis-Turlejska M., (1991). *Nowe Zjawiska w Psychoterapii.* Warszawa: Agencja Wydawnicza Jacek Santorski & Co.

Meijer A.M., Oppenheimer L., (1995). *The excitation-adaptation model of pediatric chronic illness.* Family Process. Dec, 34(4), 441–454.

Namysłowska I., (2000). *Terapia rodzin.* Warszawa: Wydawnictwo IPN.

Nowobilski R. (2002). *Kompleksowy i interdyscyplinarny model rehabilitacji chorych na astmę oskrzelową.* Postępy Rehabilitacji, 16(1), 43–55.

Pietras T. Wituski A., (2000). *Psychosomatyczne czynniki w patogenezie i przebiegu astmy oskrzelowej.* Terapia, 8 (4), z. 1, 18–21.

Pilecka W., (1992). *Psychoterapia w leczeniu dzieci chorych na astmę.* Pediatria Polska, 67(1/2), 14–20.

Płusa T., (2004). *Epidemiologia astmy oskrzelowej.* Polski Merkuriusz Lekarski: 16 supl. 1: *XIV Konferencja Naukowo-Szkoleniowa Pneumonologów i Alergologów Wojskowej Służby Zdrowia,* 9–12.

Rogiewicz M., Talar J., (1994). *Psychoterapia u chorych na astmę oskrzelową.* Postępy Rehabilitacji, 8(1), 73–76.

Schier K., (2005). *Bez tchu i bez słowa.* Gdańsk: GWP.

Schier K. (2000). *Geneza i formy leczenia astmy oskrzelowej: perspektywa psychoanalityczna.* Psychoterapia, 1(112), 61–71.

Szewczyk L., Skowrońska M., (2003). *Zaburzenia psychosomatyczne u dzieci i młodzieży.* Warszawa: Wydawnictwo EMU.

Zubrzycka R., Emeryk A., (2002). *Wpływ astmy oskrzelowej u dziecka na funkcjonowanie jego rodziny.* Alergia Astma Immunologia, 7(1), 21–26.

Psychoterapia w astmie oskrzelowej

Streszczenie

Artykuł przedstawia przegląd teoretycznych koncepcji i technik pyschoterapeutycznych stosowanych wobec pacjentów cierpiących na astmę oskrzelową. Autorki skupiają się na trzech podejściach teoretycznych: koncepcjach psychoanalitycznych, systemowych, poznawczo-behawioralnych i analizują bazujące na nich metody terapii. Kliniczne doświadczenia autorek uprawniają do sformułowania następującego wniosku: niezależnie od przyjętego paradygmatu teoretycznego należy wybierać takie metody terapeutyczne, które na najbardziej skuteczny sposób pozwolą zaspokoić indywidualne potrzeby pacjentów.