

## PROBLEMS PRESENTED BY ASTHMA AS A PSYCHOSOMATIC ILLNESS

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ASTHMA, as a psychosomatic disease, exemplifies, perhaps more clearly than any other illness, the difficulties encountered in dealing with psychosomatic problems. The main question is to determine a dominant personality type in this illness. The evidence in the literature does not help us to clarify the matter, and the statements we can find are less explicit than those about any other psychosomatic disease. Perhaps the reason for this is simply the absence of any definite personality type amongst asthmatics. Although this point has not been adequately proved, any psychotherapist with some clinical experience is aware of the variety of personality types in which asthma can occur. In my own experience I have not found any definite personality type in asthmatics, in spite of the fact that among the selected population seen by a psychiatrist, one would expect a certain type to emerge more clearly, and yet this is not so. The physician in general practice is bound to find a greater variety of personality types.

Another objection against establishing an asthmatic personality is the frequent finding of other psychosomatic disorders in different phases in the life of these patients. Not unusually they suffered previously from colitis, episodes of precordial anxiety, obsessional symptoms, or, what is more, depressive phases. There are many other workers who find a description of psychosomatic profiles often vague and inadequate.

There are other solutions to the problem of asthma which we find difficult to accept. ALEXANDER (1941) gives the interpretation of asthma as being related to an excessive dependence on the mother which has not been properly resolved. SAUL (1946) goes further in his views, asserting a strong wish in these patients to return to intrauterine life, a point which FREUD has already made. If we accept these views, we come up against the objection that the need for protection and the obscure tendency to regress to former phases of life is common to all neurotics, but is only expressed in different ways. In general, any interpretation trying to establish a psychogenic origin of asthma is insufficient. One often sees asthmatics in whom a psychic trauma produces an attack and, what is more significant, stops it. In one of my cases the attack was interrupted when the patient was told she was producing it by autosuggestion. But the same happens when the "status asthmaticus" is cut short by the administration of a placebo. Thus it seems as if there is a mysterious mechanism which is not always at our disposal. In some cases a relationship can be established, but not in others. It may be argued that such experiences are only meaningful in relation to previous ones, and that, as long as these are not uncovered, it is impossible to stop the attacks. However, psychoanalysts often fail to establish a relationship between asthmatic attacks and infantile conflicts. If we want to relate the conflicts to a desire to return to intrauterine life, we can say that in this case the individual cannot retain the memory as amnesic experience; this is shifting the

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ground considerably. Allergy is also in this case a form of biological experience, but then one has to explain why such a biological experience has to be relived, in an existential form, by means of other biological phenomena, one of which may be an attack of asthma.

To my way of thinking, the problem of asthma as a psychosomatic disease must take particular account of the frequently phasic occurrence of the disease, with at times the substitution of other psychosomatic disorders (neurocirculatory asthenia, migraine, etc.). In order to find a general explanation for this, some workers have resorted to an allergic interpretation of many psychosomatic conditions. Such an interpretation may be acceptable in some cases, such as when migraine replaces an asthmatic attack, but it is not so simple to understand when the change occurs between asthma and obsessional symptoms. This is one of the reasons why I have included in one large group a number of patients who are usually classed separately in general medicine, psychosomatics, and psychiatry, under the heading of vital or timopathic circle. In these patients the main disturbance is due to an alteration of the structure that gives rise to the instincts and vital feelings (fatigue, anxiety, malaise, sadness, etc.).

In some asthmatics I have observed the onset of agoraphobic giddiness at times when they were free from asthma. Other patients relate dreams of a vertiginous character. Both symptoms seem to point clearly to the fact that in the asthmatic there is a change in his experience of space. Asthma is a form of introjected anxiety. Asthma means narrowness, and, in an attack of asthma, not only the bronchial tubes are narrowed, but also the breathable world. The experience can be compared with that of a claustrophobic patient for whom the world also becomes small. They are both similar modes of existence.

In other papers I have tried to clarify this point (LOPEZ IBOR, 1950). In a great number of cases the so-called neurotic anxiety is in fact physiogenic; in other words, not reactive but somatically produced. The origin of this anxiety is probably determined by the diencephalon. Many authors have accepted a similar view regarding the mechanism of an asthmatic attack. STURM (1948) maintains that asthma has a central origin. The finding in the patient's life history of anxiety crisis, vertigo, circulatory disorders, phobias or obsessions, amongst others, shows a possible common origin for all these disturbances.

I have seen periods of anxiety and vertigo, following periods of asthmatic attacks, which I think are also referable to the diencephalon. They represent, as it were, an alteration of claustrophobia and agoraphobia. A sufferer from vertigo does not experience the anxiety of boundless space, but that of emptiness, of falling, or feeling faint. Similarly the asthmatic is not consciously aware of the space being narrowed, but this "narrowing" has been introjected. TROUSSEAU (1878) has described mental symptoms in asthmatics, which today we would class under claustrophobia.

Neurotic anxiety would then be a physiogenic anxiety elaborated at a personal level and consequently experienced in various ways, depending on the historical circumstances of the subject. This physiogenic anxiety I consider included in the timopathic circle, together with other disturbances which are characterized by oscillations of what SCHELER (1926) calls "vital feelings," such as happiness or sadness. We are dealing here with a clinical group similar to cyclothymia. Just

as it is possible to differentiate a phasic sadness of vital character, there is also phasic anxiety of vital character. The relationship between asthma and the timopathic circle is demonstrated by the numerous cases in which an asthmatic phase appears replacing or following a vital depression, or an obsessional or phobic phase. BROWN and GOITEN (1943), in a study of the personality of asthmatics, found these patients had a cyclothymic disposition associated with paranoid features, repressed hostility, and ideas of self-punishment. Repressed aggression and a self-punishing attitude are, in my view, some of the numerous components of a developed anxiety crisis. McDERMOTT and COBB (1939), in their work on asthma, emphasize a number of character traits such as cleanliness, punctuality, meticulousness, which are merely features of an anxious personality. In BOSS's (1954) anthropological interpretation of asthma, anxiety plays a very important role. Bronchial spasm, asphyxiation, and arrest of breathing are interpreted as a way of existence in a world overcharged with unbearable stimuli which reach a point of marked anxiety. The same applies to normal people in a heavy or noxious atmosphere: the response of the bronchial tubes is the same. Hence the return to the phase when the mother acted as a filter. These anthropological associations are based too much on the analysis of the situation, and they tend to disregard endogenous factors. A healthy person cannot breathe comfortably in an unhealthy atmosphere, but the asthmatic cannot breathe comfortably in a healthy atmosphere. The important thing to understand is why such a psychic or physical atmosphere becomes unhealthy for him. Is the source of intolerance in the atmosphere or in himself? The anthropological interpretation of the asthmatic crisis, establishing an analogy between the somatic and psychic levels, runs the risk of leading us into error, since it admits implicitly the same form of causality in both spheres. Physical causality is not the same as psychic determinism; the asthmatic crisis is like all crises, human and psychophysical: occurring simultaneously on both levels.

One of our patients, years after she had had asthmatic attacks, remarried and had a daughter. The birth produced a very severe anxiety crisis, and during it she developed a marked and persistent spasm of the neck of the uterus, to such a degree that a Caesarian section had to be performed. This suggests that the general phenomenon of "shutting off" and isolation would be also a general biological formula for certain patients, and that it would be projected on to different areas of neurological regulation.

What the asthmatic does in a crisis is to breathe in air which is not properly breathed out. Part of it is retained, and what he attempts to do is to expel it. The boundary which is established on the surface of the respiratory apparatus, between the subject and the world, is thus changed. The analogy with what happens in the obsessional patient is obvious. A patient suffering from an obsessional idea or impression finds that he cannot expel it from his mind. From the point of view of the symbolism of functions we must remember that breathing belongs, on the one hand, to the most rigid and unconscious automatism and, on the other, is clearly dependent on our volition, which is not the case with our circulation or digestion. This interaction of the will supposes the insertion of freedom, and probably in this way in ancient times breathing was related to the spirit.

Regarding the question of precipitation of asthmatic attacks, it is well known that attacks may be due to diverse and very curious mechanisms. One of my patients

had phasic attacks of asthma since childhood, always at 3 o'clock in the morning. On one occasion her husband decided to put the clock forward, but the patient woke up at the usual time, saying that she would soon have an attack. When told it was already 4 o'clock, the patient suffered no attack. Many similar examples can be found in the literature. It would be an error to pretend to solve the problem by calling it suggestion, and this is not because the term is faulty, but because it does not throw any light on the process involved. Such quick-acting suggestion is seldom seen in other illnesses; also, suggestion does not always work. In the case we mentioned, the trick of advancing the clock subsequently failed. Thus it appears that sometimes the patient is in a peculiar state of mind in which certain experiences are effective in response to that particular state.

The variety of personality types and circumstances in which an asthmatic attack can occur, show that this can be *overdetermined*, in the same way as the content of dreams, that is to say, they can play different roles of an unspecific kind in the individual life. If this is true, it would be, on the contrary, wrong to always attribute a fixed symbolism to the crises. The means of expression, either normal or abnormal, for a human being are inadequate compared with its enormous possibilities for action. Mental life absorbs the instinctual drives and transforms them into vital themes. The number of these is much richer than the basic instinctive structure. Every gesture is significant in a variety of ways. If this is the case with normal expressions, it must be all the more so with pathological mechanisms of an expressive character. The attack of asthma can be produced somatically—as in cardiac asthma—or mentally. If there is a multivalent somatic determinism, there is even greater multivalence in the psychic sphere. Hence the variety of personality types in asthma. We have then a variety of personalities which at a given moment use the more immediate mechanism of morbid expression.

One of my asthmatic patients had an enormous capacity for struggle, was ambitious, and anxious for power. On account of external circumstances, incidentally unjust, he had to abandon public life. He then developed asthmatic attacks, culminating in a "status asthmaticus." After the crisis he was able to reorganize his life, centring rather on values which were dependent on his own personality and less on external circumstances, all of which allowed him to become more adjusted.

This fact forces us to consider the problem of whether the "occasional apparatus," as BLEULER liked to call it, is predetermined in the patient. It seems very probable that this is in fact the case, and that in its production a number of factors intervene dependent on certain dispositions developed during early infancy. It seems to me that the asthmatic's first five years of life are worth careful analysis, such as that carried out by SPITZ (1950) in another group of patients.

The time of onset of asthmatic attacks, in relation to the development of the personality, deserves more attention than it has been given up to the moment. When one studies the development of personality in asthmatics throughout the years, marked differences are noticeable between them, not only in more or less permanent character traits, but in the way more variable ones unfold throughout their lives. I believe that such a study would throw a considerable amount of light on the prognosis of asthmatic patients. Something similar occurs in many other psychosomatic illnesses. Many asthmatics develop isolated crises appearing throughout their lives, others become chronic. Finally, in another group, to which I particularly

wish to draw attention, the crises cease or lessen, but the personality gradually changes. Some of my patients have been cured of their asthma, but they have then shown themselves as psychopathic or abnormal personalities, to such a degree that they required in-patient treatment.

I am inclined to think that the psychosomatic study of asthma—and of other illnesses—will advance much further if the limits of the so-called psychogenesis were taken into account. By psychogenesis one must understand an alteration produced by an experience, and it implies that the elimination of that experience would be enough to suppress the disturbance. (In psychoanalytic doctrine the interpretation is complicated by the addition of repressed experiences.) In fact, psychotherapeutic experience shows this is not always the case, and that the suppression of a conflict which is a determinant in the illness, or the recognition of a past experience, is not enough to produce a cure. In fact, very often psychic conflicts only act as *catalysts*. Their presence unleashes the disorder, but their absence does not cure it, and once the disorder is produced it takes its course unaffected by psychotherapy. In such cases one must admit that the corresponding nervous regulation takes its course autonomously, because it is not intrinsically linked with the precipitating experience. In many anxiety states and depressives we find a similar situation. An emotional shock produces the appearance of an anxiety crisis, but once produced it follows its own autonomous course. In fact, what the shock has done is to crystallize an abnormal mental state of a vital origin; or, to put it in another way, a physiogenic state which was already on the move. But this is not only noticeable in the case of vital illnesses. It is also noticeable in others which are clearly neurological. We have all seen the symptoms of Parkinsonism or spasmodic torticollis which appear to follow an emotional shock. However, no one would dare to speak today in such cases of psychogenic Parkinsonism. The shock has played a part, but one not strictly causal. I propose to call this action *catagenesis* (from the greek "cata," downwards). We are dealing here with a disturbance which takes place at the somatic level, "descending" or coming down from the psychic. In asthma we frequently find catagenic actions which set in motion a deep morbid state of affairs which already existed. In some asthmatic patients a careful anamnesis uncovers infancy episodes of bronchitis of an asthmatic type. Afterwards a highly charged experience can set in motion or reveal what already existed; the experience has not produced it. To speak in such cases of psychogenesis is inadequate.

#### REFERENCES

- BOSS M. (1954) *Einführung in die Psychosomatische Medizin*. Vg. Huber. Bern.
- BROWN E. A. and GOITEN L. (1943) Some aspects of mind in asthma and allergy. *J. Nerv. Ment. Dis.* XCVIII, 638.
- FRENCH T. M. and ALEXANDER F. (1941) Psychogenic factors in bronchial asthma. *Psychosomatic Medicine—Monographs II and IV* National Research Council, Washington, D. C.
- LOPEZ IBOR J. J. (1950) *La Angustia Vital*. Paz Montalvo, Madrid.
- MCDERMOTT N. T. and COBB S. (1939) Psychiatric Survey of 50 cases of Bronchial Asthma. *Psychosom. Med.* I, 203.
- SAUL L. J. (1946) The relations to the mother as seen in cases of allergy. *The Nervous Child* 5, 332.
- SCHELER M. (1926) *Der Formalismus in der Ethik*. Marholtz, Halle.
- SPITZ R. A. (1950) Relevancy of direct infant observation. *The Psychoanalytic Study of the Child*. Imago Publishing Co. Ltd., London.
- STURM A. (1948) *Die klinische Pathologie der Lunge*. Stuttgart.
- TROUSSEAU A. (1878) *Clinique Medicale ed l'Hotel Dieu de Paris*. Vol. 3, Paris.

