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PROBLEMS OF BASIC SECURITY IN ASTHMATIC CHILDREN

By

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In a publication concerning a previous investigation (*Voorhorst-Smeenk* 1967) the parents of asthmatic children were subdivided into six groups, characterized as follows:

- Group 1: Incidental problems in normal family relations. These can arise, for instance, as the result of stress caused by the imposition of tasks which are too difficult for the child in question.
- Group 2: Relatively inadequate parental insight. The child's illness unduly complicates his upbringing.
- Group 3: Low mental social level, leading to inadequate differentiation in the upbringing of the asthmatic child.
- Group 4: Low mental level with higher social level. These are often families with little cultural background, recently improved circumstances, and dogmatic opinions.
- Group 5: Infantile mothers.
- Group 6: Disturbed personality of the parents, with and without visible consequences. In this group the problems for the upbringing have the most serious consequences.

INTRODUCTION

This second study was primarily concerned with the children. The group of asthmatic children seen by the pedagogue was of course not representative of the asthmatic patients treated in a Department of Allergology as a whole, but this does not mean that all the patients not seen by the pedagogue were more fortunate in the circumstances of their upbringing. Some parents prefer to avoid the pedagogue despite the doctor's opinion that in connection with the medical treatment they should see him. So the selective process occurring by virtue of the fact that only certain asthmatic patients are sent to a Department of Allergology, is furthered when pedagogical advice is also asked for the children.

The reason for asking the advice of the pedagogue was invariably that the physician in charge (of the department) had less success with his therapy than he might have expected. From a medical point of view, something had gone wrong. Often the physician had become aware of some of the complicating factors, e.g. difficulties in school, enuresis nocturna, strained circumstances in the home, but these were as a rule beyond his scope. If in such cases the physician's insight into the patient's situation can be increased by the pedagogue or the psychologist, he will often be able to give the parents valuable tips, and in this way reinforce the course of action adopted by the pedagogue.

Close cooperation between the physician and the pedagogue is a *conditio sine qua non*. The pedagogue can support the medical treatment, but he must be careful not to interfere with the medical therapy, which may happen unintentionally when there is insufficient consultation between the physician and the pedagogue. The primary aim of their collaboration should be achievement of the best result from the medical point of view. Physical health is the most essential condition for the proper development of the child's personality. The first sign of success is therefore, for the pedagogue too, the improvement of the child's physical condition.

THE APPROACH TO THE PROBLEM

As our starting point, we took the picture of the child provided by the psychological examination. In doing so we wondered: is there a central problem with which the child is occupied either consciously or unconsciously, and how does the child attempt to solve this problem?

The available data showed that the feeling of security had always been affected. This is only natural. Children who suffer from a chronic illness (i.e. asthma) need more care because of their greater helplessness. If the illness is serious, this amount of care cannot always be realized. However, we discovered, as will be clear from the following, that in a remarkably large number of the cases the illness was not the most serious threat after all. This was possibly due to the way in which the doctor had treated and selected these patients for referral to the pedagogue. Many of the children had already been considerably improved by the medical treatment.

THE FEELING OF SECURITY

What do we mean by a feeling of security? When a child is technically well cared for but this care lacks any warmth, something is wanting. The child needs the personal love of his educators, and only if he experiences this warmth will he feel secure. This implies that within the environment in which he is growing up the child must himself have achieved a degree of socialization, fulfil tasks himself, and be criticized; in short, he must satisfy certain externally imposed requirements. In this way he learns how to conduct himself and behave both at home and away from home. Only when the child has a strong enough sense of security will he explore the world and achieve emancipation (want to be a person in his own right; see: *Langeveld* (1954a, 1956b, 1961) and *van der Zeijde* (1962)).

The younger the child, the easier it is to create conditions that will guarantee the sense of security necessary for normal development. Even then, circumstances may be present which

prevent the child from expanding his world sufficiently, such as being spoiled, or cared for without warmth, or chronic illness. Again and again such a child will be confronted with frightening or frustrating experiences which threaten to disturb his feeling of security. If the child is basically secure he will have sufficient resistance unless the menace becomes too great as, for example, in the case of intermittent serious attacks of asthma. The degree of inner security is then inadequate for the degree of helplessness, in medical terms: the psychosomatic well-being is disturbed. From the foregoing it is clear that the concept "sense of security" is a dynamic one, depending in each situation upon different factors such as the age and disposition of the child; the practical attitude, religious belief or philosophy of the parents; in short, a variety of factors influencing the child's life.

The older the child becomes, the more complicated the task of giving meaning to his life. The child meets children of his own age, gets to know their homes, goes to school, etc. His world has boundaries beyond his home now, and is therefore partially beyond the direct influence of the parents. This is not serious, for others—including the child himself—take over the part of the responsibility (for example the teacher).

There is another development observable in the child indicating that he is outgrowing the situation of childish security. By this we mean what *Langeveld* (1954b, 1956a) calls "l'endroit secret", where the child can give form to his own world within the security of home. He can be quietly on his own, without being disturbed by his solitude. For instance: the attic can change into an ocean where everything is possible; the space behind the curtain can become an observation post permitting distant participation in the lives of the grown-ups; the future can be dreamed about. The child has a dawning notion of the personal and illusive character of all this; it is a personally constituted space. "I fill it with myself, but at the same time as I live through it, the unknown scene of my existence reveals itself", says Langeveld. That is why in "l'endroit secret" one can be imbued by a feeling of inwardness, mystery, and perhaps even sacredness, a sense of vocation may arise.*

* Seen in this light "l'endroit secret" remains of importance even for adults.

Perhaps we may say that in "l'endroit secret" the context of the old form of security is relinquished for the first time, however briefly for a short while, for something that will finally lead to a new view of the future for the individual. What is only illusively "played" (*Vermeer* 1955) in "l'endroit secret" will crystallize in adolescence into an acceptance of what is felt as an ethical duty. This, however, demands the devotion of all our mental powers in the form of patience, courage, confidence, hope, (*Plügge* 1954, 1967), and love. This development is essential for growth into a personality (*Bollnow* 1958, 1960). Where the former childish security could be reduced to a certain feeling of well-being, this "new security" is identical with acquiring and holding on to an adequate view of the future. But this cannot happen without great effort, although it is later experienced by us as having been bestowed upon us. This form of personality development is especially important for the asthmatic patient, because it gives him the mental power to cope with the asthma in his life, in such a way that he can accept the restrictions it imposes. If, however, the path to maturity ends in infantile, socially rigid, or neurotic behaviour, the prospects of the asthma being cured are much smaller, on account of inability to achieve the necessary change of behaviour upon which effective care of the illness also depends (*Menges* 1967).

Therefore, it is of the greatest importance that the utmost be done to obtain the most favourable personality development for the asthmatic child, not only for the present state of affairs, but also for later. On account of the youth of most of our patients, we were mainly occupied with the first form of security. Chronologically there was even a relative retardation. This led to the question as to the degree and way in which the security of our children had failed and the function of the asthma in this respect.

In our material the following groups could be distinguished:

I. *Insufficient Security*

a) Peripheral weakening of the sense of security under normal family relations, due to relatively excessive demands on the child.

b) Excessive desire for "warmth" among asthenic children with moderate to severe asthma.

c) Lack of security due to inadequate provision of clear-cut limits in the upbringing.

d) Lack of security in children whose I. Q. is relatively high whereas the social level of the family is low.

e) Lack of security due to parental pre-occupation with their own problems.

f) Lack of security, due to parental egocentrism: parents put their own affairs first and the child feels superfluous but does not accept the situation.

g) Lack of security, because the care given to the child is too impersonal and/or too meagre or too authoritative.

II. *Conditional Security*

- a) The snug, thoroughly middle-class family.
- b) The hospitable, stylish, sporty family.
- c) The pseudo-intellectual family.

III. *Pathological Derailment of the Parental Care*

I. INSUFFICIENT SECURITY

- a) *Peripheral weakening of the sense of security under normal family relations, due to relatively excessive demands on the child*

Our examination showed that these children had had only incidental difficulties at school or work attributable to their lack of capacity. Their medical treatment could be carried out successfully as long as the stress from outside did not become too great. Parents and children had become sufficiently accustomed to the illness; the asthma was only a factor of secondary importance in the difficulties of the child. These children's sense of security had only been superficially attacked. The potentialities of the children in this group appeared to be lower than the level of the family. Initially the child's failures had been ascribed more to the illness than to inability. Gradually, however, stress developed. Pedagogically, this situation could easily be corrected by a reduction of the demands put on the child either by slowing down the pace or by changing his school* or work. The parents understood the

* It has struck the doctors in charge that for most asthmatic children school is a considerable burden. Especially in secondary school, the lack of exercise in previous years (due to frequent absences from school) takes effect. Repeating a

situation and immediately took steps to relieve the child (group I, 1966). Most of these parents had implicitly felt the need to seek advice. There was wide variation in the severity of the illness, the level of the family, and the potentiabilities of the child.

b) *Excessive desire for "warmth" among asthenic children with moderate to severe asthma*

It is not easy for parents to give a child who is chronically ill enough sense of security, but this becomes even more difficult when the child makes additional demands on them because of his asthenic constitution. The intermittant illness caused by the asthma undermines his physical security and he also experiences anxiety because of the specific tightness in the chest (which with good medical treatment need not occur too often). There are also associated anxieties related to social contacts, for instance in visits to the doctor, or at school, where there is a fear of nonacceptance by the group. These children often withdraw in advance when a situation seems threatening. When the parents (group II, 1966) give in too readily to the child's reluctance to face the situation, his vulnerability and dependence are increased. These children are occasionally rebellious at home, but as a rule they are obedient. Their anxiety inhibits their exploration and emancipation.

This anxiety is usually also the reason for their being taken to the pedagogue. We then see a child for whom the whole world is terrifying. These children cling to what is known and trusted, and only wish to remain as close to their parents as possible. At night in the dark they hardly dare to go to sleep unless they know a grown-up is nearby.

class often gives the child a chance to build up its physical reserves. This field has not yet been explored scientifically. For asthma therapy it might prove very important if lacunae in school work were identified promptly and suitable remedial help could be developed (see also: *Alexander et al.* 1957).

One of the boys in this group, for instance, was in terror of hell and purgatory as he lay in his bed, because he might have committed a "deadly sin" by not having gone to church twice on Sunday. He had a feeling of being strangled. His parents were unable to talk him out of this fear. Other children were afraid of burglars, fire, and the like.

The parents do not know how to handle these fears, and cannot help the child sufficiently. Often, these parents are constitutionally asthenic themselves and their condition has sometimes become aggravated by the child's continual worries, so that they are apt to give in to the patient. In these cases it is the parents who are most in need of help; they could probably have managed with a physically healthy but asthenic child. Their concern is honest, but the security they have to offer the asthmatic child is inadequate because of the shortcomings in their understanding of this illness. That is why their ability to give guidance is insufficient.

They will have to learn on the one hand how to stimulate the child when he shows creativity (e.g. by giving him material from which he can make something himself, such as clay or pieces of cloth to make doll's clothes) and on the other hand how to increase the demands made upon him without jeopardizing his basic security. To achieve the latter, they must begin to give in to the child a little less each time than he would wish, but without frustrating him too much. They will also have to show the child that there are several ways to gain the same ends, and that this security does not depend on one fixed way of doing a thing.

By objectivising ordinary daily happenings, the child will tend to reduce his hypersensitivity. As a result, his vulnerability will be decreased, his tolerance of frustration increased, and his courage strengthened. In the first period of the treatment the parents will feel that the security of the child is endangered, because they are overanxious and too accustomed to a weak approach. Although the opposite is true, they must experience this before they can believe it, which requires careful guidance. These anxiety-ridden children must be handled with great caution, and the success of the medical treatment is essential. The reduction of the severity of the illness removes one of the worst threats experienced by these children. Some children will have to be helped individually as well to cope with the anxiety caused by the illness. This can of course never be done completely, because some anxiety and insecurity is inherent to normal human life. Usually, however, interference with it can be reduced so far as not to interfere seriously with the personality development. What we see then is

that the child (often together with the pedagogue in the playroom) (re)discovers "l'endroit secret", and that the path leading to the future has been reopened (Lubbers 1960 and 1967, Langeveld 1955, 1956a, and 1964).

When the child's constitution is more sthenic and he makes fewer demands on his parents in this respect, success in this group can often be reached without pedagogical help, unless the cultural level of the family is too low (as in the next group).

c) *Lack of security due to inadequate provision of clearcut limits in the upbringing*

This group includes relatively more sthenic children; they too are predisposed to anxiety, but they do not try to obtain security primarily, from their parents, probably because the latter do not have enough to offer (group III, 1966). These children are very active physically and mentally, restless as though they are trying to escape their own anxiety. They cannot relax, are quickly excited, have difficulties in falling asleep and often wake up at night in terror. During the daytime at home they are often disobedient, easily feel wronged, and behave provocatively.

They are mischievous, play with fire, run away from home, etc. In unusual situations they panic easily. These children are often both spoiled and sometimes unreasonably punished. Their parents have yet to learn that they pity the child too much, which makes their conduct unfortunate, however well meant. Even an asthmatic child must satisfy reasonable demands, and the parents must be trained to give the child more certainty by themselves maintaining a more stable attitude. So here too, guidance of the parents is necessary and must even be given priority. These parents must conform to the same educational principles as must those in the preceding group. In the beginning the objectivation of normal daily matters is the most important factor in the self-education of these parents. Only when this has been achieved can they be expected to give better guidance. From the child's point of view this means a greater

display of authority on the part of the parents, in whom this was previously deficient. These children need stricter guidance.

We also observe this during examination and the therapy sessions in the playroom. These children are best helped if they start with games that have rules and regulations, such as lotto, or require practice to attain skill, such as "Guide It". Only when some order has been achieved in this way and the child develops confidence in the pedagogue, can thematic playing grow in the playtherapy and the aggression (which these children always have) be assimilated. But this treatment can only be effective if the child's circumstances change at home and at school at the same time. In these cases playtherapy usually only cures the child's symptoms and thus primarily serves the guidance given to the parents. Because of the low mental and cultural level of the family, the chance of better therapeutic results is as a rule not very great.

In cases in which the severity of the asthma is so great that it is quite impossible for any parent to give enough security (group II, 1966), emphasis must be placed on combined medical-pedagogical treatment of the child. In these cases individual playtherapy gives better results.

In one of our cases, for example, the child at first sought security in compulsively arranging the material (*Vermeer* 1955); without arriving at thematic play his activity increased without deepening. But during periods in which the child made good clinical progress, the treatment led to resumption of his personality development. In this case the central difficulty was not rebellion against the parents, but the anxiety about his illness, which he tried to control by his activities. In this case the success of the pedagogical treatment was closely related to the expectation of physical improvement.

d) *Lack of security in children whose I.Q. is relatively high whereas the social and mental level of the family is low (group III, 1966)*

When the parents are not capable of understanding the child adequately and the social isolation of the family persists, things become rather difficult for certain children with an asthenic disposition combined with good intellectual capacities. The parents of these children reached a slightly higher place

on the social ladder than their own parents without any change in their attitudes. These people were honest enough to be willing to pay for their ambitions with hard work, but they did not realize that a price must also be paid for mental emancipation (e.g. not being understood by their relatives). This is their mental and moral asthenia. The main difficulty faced by their children is that they can only satisfy their parents' ambitions if they can free themselves emotionally from the situation at home. If this leads to ambivalent feelings toward their parents the resulting feelings of guilt are difficult to eliminate, the more so because the parents have acted with the best of intentions inadequate though these were. These children remain existentially bound to their parents. Their basic attitude towards life is an anxious groping one combined with a suppressed tendency toward revolt.

We have seen in this group children with speech problems and a few cases of enuresis nocturna. When the children were asked to do something too difficult for them, they withdrew within themselves in panic and the investigator felt as if he was working in a vacuum. These children are difficult to reach, unless they are helped to bring order into their mental and emotional world. They feel secure only when they conform to the primitive emotional level of their family. When they have higher aspirations, they are completely defenceless and lonely, unless pedagogical help opens new perspectives that they can assimilate. The most favourable experience for these children would be to reach early independence by identification with other persons but without breaking with their parental home. One of these children, who in our opinion required playtherapy to resolve the great discrepancy between his abilities and those of his family, expressed his inner distantiation in a drawing (Fig. 1) showing a decrepit old house which was being demolished except for the façade (which was to be kept as a historical museum) and the move to a new house. This change was a great effort for the tenant (our patient), but once he had got used to the idea he did not want to return to the old house.

Only after this conscious choice did the child become capable of exercising a little initiative. He also began to be able to show some aggressiveness. All this continued during a stay at a summercamp lasting six weeks. It need hardly be said that for such a child suitable professional training must be found.

The parents of these children are virtually too limited to be helped. In principle, they are willing to cooperate, but only

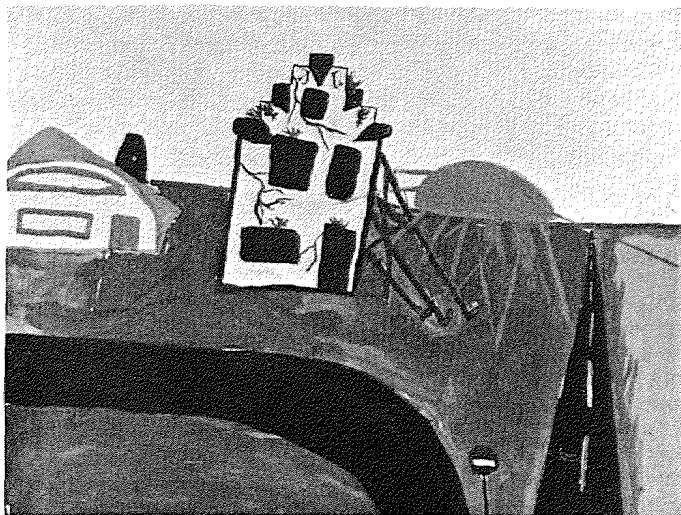


Fig. 1.

when the plans are not in conflict with their own affective attitudes (for example a change of school, or sending the child to a camp). Both the pedagogical guidance and the medical treatment of these children is very difficult to accomplish, even in cases with less severe somatic complaints.

e) *Lack of security due to parental preoccupation with their own problems*

These parents are so greatly occupied by their own problems that the child does not receive sufficient attention, even though the parents do not involve him in their problems but do accept him as a child. This group somewhat resembles the preceding one, in which the lack of security in the children is also due to a shortcoming in the parents. The difference, however, is that the children of this group do not feel wronged, they share the family problems and experience the consequ-

ences secondarily. All this occupies them to such a degree that they cannot live their own lives.

For instance, we saw a girl of $9\frac{1}{2}$ years who more than once had witnessed a very serious traffic accident with fatal results. In one of these cases her father had been found guilty of causing the accident. The whole family was exclusively preoccupied with this for some time. In this case the child could be helped easily by playtherapy (group I).

In cases in which the whole familystructure has been affected, however, things are not so easy. This can happen, for instance, when parents with unsolved conjugal problems nevertheless retain a positive attitude towards their children, although these may become too great a burden. In one case there were additional problems. The child saved up his little pocket money to be able to buy a food basket for his mother as a Christmas present. In such small ways he constantly tried to improve a situation far beyond his capacity to cope with. Such a child cannot develop a personal future as long as he is absorbed by the problems of his parents on whom he remains emotionally dependent (group VI).

These children are more depressive than filled with anxiety. As they grow older their retarded exploration and emancipation may be accelerated, for instance, when they leave home to continue their education. Occasionally the home situation may become more favourable. When the opposite is the case, the child may experience his problems as frustration.

When the child grows up in a somewhat higher social milieu, contact with culture may help him to find his way to independence, especially when at least one of the parents gives some sign of the same appreciation in his own life. We know of two such cases, both girls of secondary school age, who had enough talent to go on in this direction while remaining sympathetic with regards to family problems. This often put them under stress, but intellectually they could manage. For the doctor they were difficult to help, because they did not give their health problems precedence. This was also the reason why their school results did not reflect their abilities.

f) *Lack of security due to parental egocentrism: parents put their own affairs first and the child feels himself superfluous*

There is only one basic difference between group e and group f: when the parents put their own affairs before their

children, the children, especially the more sthenic ones, do not feel accepted. These children received too little attention and revolted repeatedly when they felt neglected especially when they saw their parents showing interest in others. This was sometimes promoted by his position in the family constellation, a sense of isolation being sometimes enhanced by the child's sex, abilities and age. They could often do what they pleased as a result of parental indifference. Their emotional development was often neglected, as they had no opportunity for identification with an emotionally mature adult. Despite severity of the asthma psychological examination sometimes showed that these children experienced the illness emotionally as only of secondary importance to the problems resulting from their hunger for security in family-life.

On one occasion a child in this group had a rather serious attack of asthma during the examination. The child did not panic at all; he was accustomed to facing the attacks alone and to deciding what medicine to take himself: It was remarkable that this child never carried any medicines with him, perhaps because he really wished to be helped for once. He sometimes said to his mother: "See what happens if I do not get my medicines in time", or: "See what happens if the whole house smells of frying". (And yet everybody knew that he was not simulating and that he would not force an attack; on the contrary, he did all he could to avoid them.)

All the children in this group are extremely "brave", but in human relationships they were always on their guard, because *their fundamental security was too limited*. These children were sometimes able to clearly express their feeling of not being accepted. The parents confirmed this to a certain degree; since they said that the child was an unsympathetic type, or that the father did not have enough time for the child or was made nervous by him; one rather young mother talked of our patient as: one of the two "afterthoughts" born some years after a forced marriage. Sometimes the parent tried to reserve a little more time for the children and also to be more consistent in their attitudes, but this raised many difficulties. Rationally they wished to do so but they could not do so spontaneously.

In this group, the boys had more problems than the girls. The fathers were too pre-occupied with their careers or other things, and were only too glad to leave the upbringing of the children to their wives, who in these cases were not equal to the challenge. It is clear that from the pedagogical point of

view the therapy should start with the parents, usually with the fathers, who must learn to give not only more attention to the children, but also support to their wives (groups V and VI, 1966). This really means that the parents must acquire "another philosophy of life", as one of the fathers expressed it. In this case a long period of guidance for the parents with occasional help to the child was sufficient. But when the parents are not willing to cooperate, the prognosis is poor.

The children in this group, so rebellious at home, were most cooperative during the examination and in the playroom, because they appreciated the attention given them so much. But there is no therapeutic benefit as long as the child experiences the same old troubles once he is home again. Sometimes it is best to arrange to have the child sent away from home, when there is a chance of finding the right persons with whom he can identify.

g) *Lack of security because the care given to the child is too impersonal and/or too meagre, or too authoritative*

Children who grow up in a milieu lacking in warmth and who are subjected at the same time to very strict discipline, are forced to learn to take care of themselves very young, especially where their asthma is concerned (whether because the parents cannot cope with the problem due to an inability to achieve differentiation in affectivity or because the parents consider asthma to be purely psychosomatic and therefore think it should be ignored; groups III and IV, 1966). Because of the limited emotional contact they experience at home, in these children the need for security is artificially held at a low level. As a result, they attempt to adopt a rational approach to their surroundings, and panic if this attempt fails (for instance when someone speaks to them with feeling or when they are confronted with the unfamiliar, as sometimes occurs during a Rorschach test). Their lack of security then becomes evident, but they do not experience this feeling as such; they only feel themselves as strangers in the world, threatened from all sides. To increase their security, they often try to concentrate on achievement. They strip reality as

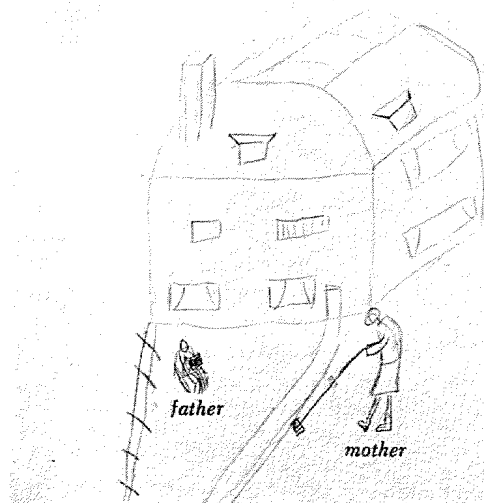


Fig. 2.

Figs 2 and 3.

These drawings were made by a girl, 13 years old. The father (Fig. 2) is reading the newspaper; he does not participate. The mother—a much larger figure—is using a rake which has been lengthened. They have a little boy who is not at home; he has gone to his tree, but he is not very attached to it because he is not allowed to keep the fruit himself. (Fig. 3). A somewhat depressive down trodden child who does not feel at home anywhere.

bare as it seems to them to be, and regard their asthma fatalistically. They have of course a tendency to be depressive. They always attempt to be “brave” and impose their rationalization before they can undergo an experience. In a severe attack they sometimes panic, unless they can manage to rationalize, which in these cases means reduce it to something trivial. In familiar surroundings they reach considerable stability, but outside them they are highly vulnerable unless they can supply the right answer or succeed in withdrawing from the situation. Although these children are not emotionally bound to the

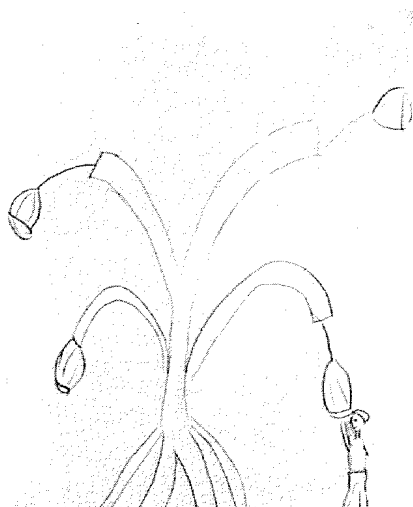


Fig. 3.

parental family, they usually continue to follow the same pattern of life unless mental development is resumed at a later date (Figs 2 and 3).

II. CONDITIONAL SECURITY

The parents belonging to this group did not see their child enough as a person. They were too dominating and so also too dependent on their child. It was not always possible to distinguish between the elements of behaviour which were primarily the child's and which were induced by parental domination. In all this, moreover, the severity of the asthma was a complicating factor. The parents' values—usually based on standards for which the child was much too young—are reflected in the child's behaviour patterns. In such situations it makes a difference whether the parents' values mainly concern morality, *i.e.* honesty, duty, and reliability, and they them-

selves attempt to act according to the same norms as they pose for the child, or whether they are only concerned with playing a role for the world to observe (groups IV, V, and VI, 1966).

In the first case the child's conscience is formed in accordance with the emphasis laid upon duty and becomes rigid and dogmatic. In many cases the parents have taken over their norms from others without modification, and force themselves to tread the path of rigid respectability. Thiemann's term (1958) "pseudo-ideals" would be applicable to them. These parents have no idea of mental freedom and therefore lack differentiation in their attitudes. The children sometimes develop coping mechanisms whereby adjustment tends to remain confined to a formal plane. In the second case, in which the preservation of a façade predominates, the essential point is what kind of a façade the parents maintained and what means they use to impress the pattern on the child. It is characteristic of this group that the parents expect high rewards for little investment, and often do not understand that more is required (because they cannot grasp the complexity of the situation). The growth of conscience in this group of children is a precarious matter. There is a transition from inadequately assumed dogmatic patterns, via formal satisfaction of these demands, to the more or less deliberate playing of a role (façade).

During the investigation we asked ourselves which of these alternatives provided proved to be the most decisive for the child's attitude. When a dogmatic mother is married to a man whom we would place in the façade group, and the mother's limited, dogmatic personality accords with the façade image, then the mother's influence will predominate. The reverse is probably the case if this type of man is married to a woman who offers the child no sense of security because she is so pre-occupied with her own problems.

a) *The cosy, thoroughly middle-class family*

The children in this group are given security on condition that they conform to the family pattern, that they be truthful

and open, that they get good marks at school, and so on. The imposition of these high standards impedes the free development of the child's personality. The children are not regarded as such, and the parents do not entirely practice what they preach. No matter how rigidly they try to do this, they repeatedly fail in their attempts and the child loses its spontaneous trust in them.

We saw some asthenic children in this situation. They formally did their best to seem to fit into the family pattern. Two of them were bed-wetters, and all of them were under too much pressure because they sensed that they were too heavy a load for the parents, who were already oppressed by their own dogmatic basic attitudes. Although the parents attempted to conceal their difficulties, they repeatedly failed to do so.

A number of examples will illustrate this situation. The parents cited everything they did "just," for the child, but in doing so revealed that they were often tempted to satisfy their own wishes at the same time, for instance by buying a too large and too expensive refrigerator "because the doctor says our child must have fresh food"—which was certainly not the doctor's intention—or by demonstrating their great willingness to make sacrifices by carrying the bed of a bed-wetter downstairs to the livingroom ("because on doctor's advice he ought to sleep alone") and then carrying it upstairs again next morning with loud sighs, and so on. This behaviour seems forced and artificial, the more so when more essential needs of the child are neglected. These parents give the impression of sub-consciously wanting to demonstrate how much they do for the child, perhaps to quiet their own conscience that reminds them that they are not really helping the child. It is very difficult for these children to work themselves out of such a situation, because on the one hand the parents impress on them the rationalization with which they fool themselves and on the other hand actually do a great deal for the child.

If the children sense in themselves even a faint doubt about their parents' honesty, they develop feelings of guilt, as do the parents if they feel that the upbringing of an asthmatic child is too much for them. This leads to a mutual dependence, especially in the relationship of the child to the mother. The mother strains to satisfy the dogmatic mother-image and expects appreciation as a sign that she has succeeded. The child thus develops an ambivalent attitude* towards the mother (in

* In the more sthenic of these children the ambivalence turns into rebellion

our cases). This problem can sometimes be solved by placing the child in another home or helping it to become independent very early. The problems involved in the parent-child relationship dominate so strongly that in the child's experience the asthma becomes secondary and functions mainly in the relationship to the parents.

One of these children, who suffered from feelings of guilt arising from understandable ambivalence, hoped passionately that she would not wheeze during her mother's visit to the asthma institution in which she had been placed, because that would be so hard on mother. In this case improvement in the asthma justified placement in the centre for both parties (the same unhealthy dependence between mother and child can also occur in other groups, e.g. group 1 b; in one case in this group an attitude of self-sacrifice on the part of the parents was enhanced by the child's "gratitude" and vice versa).

b) *The hospitable, stylish, sporty family*

Parents who wish to obtain access to a "chic" or other group on the basis of manners, sport, or cultural activities, train their children mainly in conformity to their own social or leisure-time activities. The children must be able to blend into the world desired by the parents for maintenance of self-esteem or business relations. This even makes the parents dependent on the children, who give the impression of being somewhat spoiled and unaware of the real reason for their way of life. Difficulties also arise from the fact that the children do not do well at school. This is, of course, a source of conflict at home, since the parents cherish too high ambitions for the children. The parents nevertheless fail to appreciate that the attitudes developed in the children at home do not correspond to this. Conflict of authority at home are a result. The children in turn wish to be authoritative outside the home and to stand up for others less able to defend themselves, but cannot accept any authority whatsoever themselves. In this group the sense of security is mainly affected by an underdevel-

and hatred, especially when the façade becomes transparent or disintegrates (e.g. 2 cases of parents' divorce).

opment of the child's emotional and intellectual capacities. If such children are able to find a profession or occupation in which this is not a serious disadvantage, they can get along, particularly if they can leave the responsibility to others without playing an inferior role themselves. Although the children were not aware of it, these parents had once had to work hard to achieve their status. But for these parents the primary concern was a superficial adjustment to a higher standard of living. They were quite satisfied with outward conformity on the child's part. Some of our asthenic children easily achieved a pseudo-adjustment. They were not required to assume any responsibility and were able to get away with this. Initially, these children have fewer difficulties because the family pattern is adjusted to the immediate surroundings. The difficulties arise when demands are made upon them and they are called upon to tackle things receiving little interest at home and for which the child is not prepared to make a great effort, such as school work or taking up a profession. When circumstances compel the child to attempt to achieve something, the resulting stress is so great that he fails and his somatic complaints increase.

Somatically, these were not severe cases, but the complaints of the illness persisted. In their free time these children sometimes throw themselves into a sport or game for the sake of their selfrespect, which is sometimes seriously shaken once in a while, and perhaps also to temporarily escape the conflict situation at home. This excessive effort sometimes increased the stress appreciably, and made the remedy worse than the disease.

c) *The pseudo-intellectual family*

Other families' greatest wish is to belong to the "intellectuals". The parents are usually intelligent and wish to give their children a good "chance in life". They themselves are already living slightly above their mental level and expect a good deal of their children because they have placed them in a "privileged" position which they themselves were denied. These children lack adequate security because the achieve-

ment level set for them is too high and too strained. This tension usually arises more from superficial mental approach than from lack of capacity. The status has namely become the real goal, whereby music and sport are sometimes also urged upon them, simply because they are proper to certain social levels. This does not do sufficient justice to the child himself as a person. The child does not want to disappoint his parents and therefore plays the role they also pretend to play. Some of these children tend to be boastful, and always have a rationalization ready to cover any lack of information. The inner uncertainty underlying this behaviour causes the children to continue to seek security from their parents, which is little help in the outside world because the parents are not realistic. As a result, the children have a mistaken idea of their own capacities.

Their "body-schema" may also be inadequately developed, or even distinctly disturbed. We have the impression that these parents often discount the child's own observations of its body, interpret his complaints in such a way as to suit their own ends. In this way, the child neither achieves a satisfactory attitude toward his own body nor toward his illness, and the formation of his personality is also endangered.

III. PATHOLOGICAL DEVELOPMENT

In a few exceptional cases we were confronted with disturbed parent-child relationship, in which a kind of "symbiosis" developed. The excessive mutual dependence of parents and children was initiated by the former as a result of their own emotional problems (*e.g.* marital incompatibility). In this situation the children lost their natural spontaneity and the freedom to distance themselves from the parents. The parents continually sought their children's approval, sometimes by giving them presents.

One of these cases was a girl of seven who seemed to have little knowledge of normal parental care. The mother's contact with the child was too formal, compensation being sought

*Fig.4.*

for this in external forms. Even when the child played outside, she constantly came back indoors for a few moments to climb onto her mother's lap. With men she became confused, turned coquettish, and began to show off. This behaviour also occurred during examination. She appeared to experience her father more as a man than in his function as security-providing father figure. The mother declined further contact with the pedagogue "as the child's medical complaints were so slight".

A second child also showed a disturbed relationship with

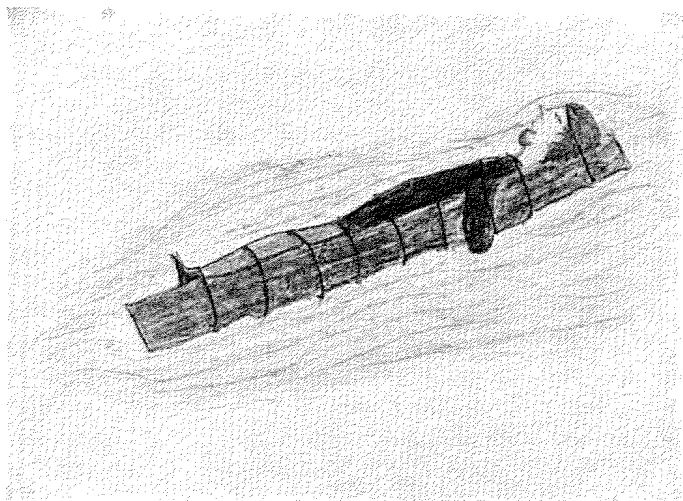


Fig. 5.

Figs. 4 and 5.

The "dream-tree" (Fig. 4), which gives an impression of hopelessness with its raised arms, a cap resembling a crown, and roots with the appearance of legs nailed to the ground. Fig. 5 shows the hero of the story tied to a tree trunk and thrown into a river, at the mercy of natural forces.

her parents. Both of them accompanied her when she had to go to the doctor. Although the child was over 10 years old, the father put on and took off her coat, held her on his lap in the waitingroom, and when she was to stay longer for testing kissed her goodbye as though the separation were to last for years. Emotionally, the child was highly labile, had bouts of laughing and crying, and a long series of vague physical complaints. She often went to bed during the day on account of stomach ache. These parents, too, refused further contact with the pedagogue. When the father's military career required him to spend several years abroad, the child showed some improvement.

A third case was a boy of 15 who as a small child witnessed

many quarrels between his parents. His mother was still closely tied to her parents, with whom the family lived at first. This situation led to difficulties between man and wife. Later, when they had a house of their own, the situation improved somewhat, but the child continued to cling to his mother and rarely played with other children of his age. During adolescence he wished to be more independent and spent much time in his own room, but both his parents continued to compete for his attention. They loaded him with presents, and his wishes were fulfilled almost before he knew he had them. The parents said they were willing to cooperate with the pedagogue and give the child more freedom, but in reality they never did so. The boy came occasionally for therapy, but his appointments were repeatedly cancelled, under pretext of illness or for some other reason. During this period he wrote a story in instalments which reflected his situation very clearly; two of the illustrations he made for it are shown in Figs 4 and 5. Just when the conflict situation was becoming more explicit for the child, the treatment was unfortunately broken off.

ASTHMA AS A TASK

The practising pedagogue must realize that for very many young asthma patients it is not enough to prepare a report after a psychological examination of the child and a talk with the parents. Like the physician he must provide guidance. We are of the opinion that in these cases much stress is the consequence of the child's cramped attempts to find more security. For older children realistic envisagement of their future is an important stabilizing factor. In many cases successful pedagogic guidance leads to an appreciable improvement in the physical condition; the child sleeps better, is less anxious and restless, has fewer conflicts with the people around him, and does better in school. It is obvious that these changes must have their consequences in the "purely somatic" sphere. We believe that this is the root of the matter in the psychosomatic aspect of asthma.

The foregoing of course implies that a well-considered somatic guidance by the physician is of primary importance. In uncomplicated cases the improvement of the child's somatic condition can in itself provide a greater sense of security and make the future seems more hopeful. In such cases little is required of the pedagogue.

In other cases, quite apart from the somatic aspects, the physician and the pedagogue must work in close cooperation to achieve the maximum results on both the psychosomatic and mental levels. Especially at this point, contradictory advice is disastrous. The physician, who has usually had too little training in this subject and is always pressed for time, is faced with many difficulties and will have to permit the pedagogue to coach him, since the latter has specialized in this field and has more time for individual treatment of difficult cases.

In the light of the foregoing it may be mentioned that we are not very happy with the slogan frequently heard at present: "Learn to live with asthma". It is true that appropriate measures can help a number of asthma patients especially anxious ones to achieve better. It is not wrong to "harden" the patient if the proper limits are observed and no risks are taken with the disease. An excessively weak approach is certainly not correct. But the danger involved in this slogan is that the doctor, the parents, and the patient accept the idea that asthma is a life-long disease and is essentially incurable. The chance is then great that many will not muster the maximum energy and ingenuity to achieve a final cure.

An unfavourable course in young asthma patients can usually be ascribed to one or a combination of the following factors:

- 1) The medical assistance is inadequate.
- 2) The physician's directions are not properly followed.
- 3) The situation in which the child lives is so full of problems and stress that the medical treatment cannot succeed.

We do not believe that, as is often said, these patients need the illness and will not give it up, certainly not in the case of children. Another misunderstanding concerns a remark we often hear from the parents (and occasionally from the patient): "We are satisfied with the present condition; if only the illness does not become worse, we can accept it". A human being and especially a child can be persuaded to accept a great deal, but the misunderstanding lies in the failure to understand that no one has the power to keep the asthma at a particular level. If the patient's circumstances worsen, if he catches a cold or the exposure to allergens is intensified, severe complaints will probably develop. Consequently, rather than say "learn to live with asthma", we would put it "regard asthma as a task" with which we must deal cooperatively. This holds good for the physician and the pedagogue as well as for the parents and even for the patient. But we must not forget that, as has been shown above coping with the asthma itself is not the only task, and sometimes is not even the most important one. Life with its many tasks must continue; yet it must be borne in mind that if asthma gets out of hand it can become so serious that it indeed becomes the most important problem.

Lastly, a few words on the concept of "counseling" of the asthma patient. We sometimes get the impression that every well-meaning person thinks he can guide an asthma patient and that the physician often expects this, for instance, of a social worker or semi-medical assistant. It must be emphasized that the guidance of an asthma patient should be given only after an integrated program has been set up on the basis of the results of a thorough examination. Guidance of the asthma patient is a highly specialized art, and the necessary knowledge and experience are difficult to acquire. The aim must always be to solve the problem of the asthma within the framework of the child's life.

S U M M A R Y

An attempt has been made to review the pedagogic difficulties presented by the asthmatic child on the basis of the inadequate

sense of security we have found in all the children referred to us. The asthma was not mainly responsible for this lack in many of these cases, and could only be assigned this responsibility when the asthma was severe and of long standing in a basically healthy pedagogic situation. In most cases a variety of factors (of which the disease was one) played a role. Sometimes simple practical advice sufficed to make life supportable for the child. In other cases it was necessary to offer very intensive help in order to increase the child's sense of security. It was found that the asthma and other threatening factors could activate each other. When this effect could be brought under control, the illness could be treated more successfully.

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