The Contribution of Psychodrama to the Understanding and Treatment of Asthma

by Peter Parkinson

Peter is a Family Physician in practice in Auckland. This article was recently accepted as Peter's thesis by ANZPA and is the fulfilment and completion of his training as a psychodramatist.

THE RESEARCH QUESTION

What contribution does psychodrama make to the understanding and treatment of asthma?

PREFACE

The matters I discuss in this thesis relate to 30 years of work and research starting in Palmerston North, New Zealand, then in London and later in Thames, New Zealand. Over this time I found it necessary to own my own personal and professional dysfunctional roles and to forge and role test new ones. I have reported on some of these experiences in the body of the thesis and in the appendices.

Asthma in My Family

My first involvement with asthma was as a 9 year old child when I witnessed my mother having an asthma attack. It appeared to be the result of the cold night and responded to her warming herself in front of the fire. It is only after doing the work that is embodied in this thesis that I now perceive that a shift in herself between one relationship and the other was probably a major factor in the resolution of her ailment. This change is reflected in these statements of hers:

> *"I was so angry with your father that I couldn't tell him and I had to walk away. You won't tell anyone about this, will you dear."*

and later:

> *"I cured my asthma by divorcing your father!"*

When she did marry again, she had changed her response to her own indignation as indicated by this statement:

> *"He was so rude to me at the bridge table that I balled him out in front of everyone. I told him that I would never play bridge with him again if he behaved like that. I didn't mind who heard dear, I just was not going to put up with it!!" Both were American Life Masters of the game. This scene took place at a major bridge tournament in the USA.*

She never had asthma while she was in that relationship.

Patients with Asthma

Throughout my professional life as a hospital physician, intensive care worker, family doctor and more recently as GP/Psychodramatist, I have worked with people who have suffered from asthma. Many attempts have been made by myself and others to find a cure for asthma. With my patients I tried drug therapy, physically washing the lungs out and various forms of psychotherapy, and I observed the effects of spiritual processes. I discovered that zealous attempts to cure asthma either through drug treatment, complimentary therapy or casually performed psychotherapy would prompt suicidal attempts. (Appendix 1) Findings of Dr Rex Hunton (Personal Communication) were the same and Dr W. Roe (Personal Communication) learned from the parents of those children that died of asthma that each had left some form of will.

I became disheartened by the limitations of the medical paradigm. Those patients I treated did not get better. They continued to be asthmatics and were now taking drugs. Even more disheartening evidence is reported in the review of the literature regarding the relationship of increased mortality and incidence of asthma when anti-asthma medication became more available and more potent.

I was therefore driven to explore other possibilities about the origins of asthma that would explain these apparently bizarre phenomena, with the hope that treatment would then become both logical and effective. This thesis outlines the contribution that psychodrama has made to my comprehension and treatment of the asthmatic patient.

I wish to acknowledge the courage and trust of those people with asthma with whom I have worked. You have helped me move from thinking that I knew, to realising that I am a journeyman in the world of the unknown. I wish to pay tribute to Dr J. L. Moreno and to Dr W. Roe whose work is an integral part of this thesis. To Dr Murray Kirk who was largely responsible for seeding my interest in the quest for the resolution of asthma. To Dr G. Max Clayton as my Primary Psychodrama Trainer, for his encouragement in my work in Thames and for his major contributions in role theory. I want to make special mention of Sally Christie who, as practice nurse, created a team in which we forged new ground. Aila, my wife, off whom I have bounced idea after idea, has hung in and knows more about this project than anyone else. Without her this would not have happened. To Dr Joan Chappell, Rex and Valerie Hunton and Dale Herron I say thanks, it needed us all.

INTRODUCTION

A paradigm is a way of perceiving something. It is a way of charting the ocean that one is in. If one tries to use a chart of the approaches to Auckland to enter the Port of Sydney one might end up on the rocks.

With asthma my profession has utilised the paradigm of disease and cure. Using this paradigm many rocks have been encountered. For example, the incidence of asthma has soared and now there are claims that 28% of New Zealanders have the disease as compared to 1.9% in 1966 (McQueen 1995). Another example is that the more potent the therapeutic agent, the higher the death rate from asthma (Parkinson

1995.1).

The body of this thesis tracks my evolution into utilising the paradigm of psychodrama, especially role theory, as a much more adequate chart for these incredibly stormy waters.

I have considered wheezing as a **psychosomatic role,** along with eating, elimination, breast feeding etc. I have then looked at asthma being utilised as a **psychosocial role,** with a social purpose in those who, devoid of mirroring, were in need of recognition. I propose that asthma is the outcome of the individual's spontaneous and creative genius under duress. I have not been able to see asthma as a **psychodramatic role** because it does not express the psyche of that person. However it will be demonstrated that motivating the creation of the psychodramatic roles of the **Secure Interacter** and the **Congruent Expresser** leads to exciting and successful outcomes in asthma treatment. This paradigm also encompasses the paradoxes outlined in the preface and the hormonal changes that occur in the body.

STATEMENT OF THE THEME

The theme of this thesis illustrates the roles that we utilise to conduct the space that surrounds us. I have arbitrarily divided this space into an inner circle of influence and an outer circle of influence. Around each I have placed a personal boundary. This space, which one might call one's spiritual space (that area which one occupies that is not one's body), governs the construct of our social atom and thus our experience of the world. The finding that asthmatic and depressed people are both deficient in these boundaries, yet the asthmatics were not depressed until the asthma was annihilated, caused me to think that the asthma had the function of allowing that person to be noticed in the absence of achieving the recognition of one's unique self.

This thesis explores this possibility and a psychodramatic hypothesis for asthma is formulated and tested.

REVIEW OF LITERATURE

Mortality, incidence and relationship to drug treatment

The incidence of asthma, particularly in New Zealand, is increasing. McQueen (1995) reviewed New Zealand incidence rates reporting an increase from 1.9% in 1961 to 28% in 1995.

Asthma has, from the turn of the century, changed from being an innocent, albeit distressing condition, into a potentially lethal condition (Beasley et al 1990, Roe, 1984). This coincides with the introduction of adrenaline as a therapeutic agent. "Epidemics" of asthma deaths have accompanied the availability of more potent anti-asthma medications and subsided on their withdrawal (Beasley et al 1990).

The treatment of asthma dates back 2000 years to a herbal bronchodilator administered by the Chinese (Beasley, Personal Communication.) It was in 1901 (Aldrich) that adrenaline was identified. In the ensuing years it was used by injection and inhalation, and often produced instant relief. Synthetically produced adrenaline-like drugs such as isoprenaline, salbutamol, aminophylline, fenoterol and others started to become available in the 1950's. Roe (1984) investigated the dangers of these and

the more sustained action drugs. His work was ignored and suppressed (Personal Communication W. Roe) and it is only in recent years that the dangers of the adrenaline-like drugs have become inescapably evident. Epidemics of asthma deaths accompanied the introduction of more potent inhalers (Beasley et al, 1990) and declined on withdrawal from the market of these preparations.

In the 1950s steroids became available in tablet form as prednisone. Steroid inhalers were soon to follow. Their effect is not in reducing the spasm of the bronchiolar muscles as the adrenaline-like drugs do, but by reducing the inflammation of and secretions from the bronchiole (the smaller airways). These proved to be very effective in limiting both the severity and occurrence of asthma.

Lessons were learned. Steroids produce side effects. Infections occurred, the face turned into a moon, bones softened, people died because they bled from gastric ulcers, and they couldn't survive when the drug was withdrawn. In other words people rapidly became dependent on a hormone-like preparation administered as a drug. This is attributed to their inability to produce their own hormone as the adrenal gland wilted from disuse.

It is claimed that the inhaled steroids produce their improvement without risk. Roe (1984), among others, doubted this. He claimed (Personal Communication) that asthma, like many other childhood ailments, is best left to take its own course. His results certainly gave weight to this theory. He performed a timely, yet almost totally unrecognised, study. In this study he treated all wheezing children who entered his ward in Nelson Hospital with steam, stress reduction and by changing the social environment. His results were astoundingly good in contrast to the rest of New Zealand.

Roe (1984) states that there is no report of an adequate study of the natural history of untreated asthma. This I can confirm. Sir William Osler commented in his textbook of medicine "death during an attack of asthma is unknown". Nine other textbooks also from the end of last century made the same or similar statement. Various reasons were proposed to explain the development of lethal asthma from the beginning of the century, including inaccurate recording by the 18th century physicians and a change in the Natural History of the disease. None but Roe (1984) commented on the correlation of mortality with the introduction of hormone-like drug treatment when adrenaline became available in 1901.

Associations between asthma and emotion

In their review Leher et al (1993) stated that the literature contained many reports of correlation between negative emotions and asthma, and a strong correlation between asthma and unexpressed emotion, especially anger. It is postulated that the negative emotions produced their effect in the lungs via the para sympathetic nerve, the Vagus. Drugs antagonising the vagal effects are available. They are minimally effective and also appear to be side effect free.

A demonstration of inadequate spontaneous adrenaline response to stress in asthmatic people came in a study by Wind et al (1985). In this study all non-asthmatic people who were admitted to a London Accident and Emergency Department showed 20-fold increases in adrenaline

levels. Asthmatics admitted at the same time showed **no** increase whatsoever. From reviewing the current literature they concluded that impaired adrenal release was the most likely cause.

Clarke P (1980) reported that wheezing can be produced by anxiety-induced hyper-ventilation.

The following therapeutic and training procedures were reported by Leher et al (1993) as being helpful:

1. Stress management
2. Psycho-educational programmes
3. Self-directed management programmes
4. Matching certain forms of asthma with specific therapies.

Studies reviewed in this article identify emotion as the possible culprit (thus retaining the disease and cure paradigm). Attempts at curing emotion, as one can imagine, produced conflicting results.

They conclude: "Study is required of the relationship between specific psycho physiologic responses to fear and anger, and effects of these emotions on the airways. A number of hypotheses presented above relate to this model **and indicate the need for future research on the relationship between emotion and asthma."**

Clarke et al (1993) states: "Elaborations of the Health Belief model . . .deserves further attention." and they carry on to say: **"Combatting increases in asthma morbidity and mortality necessitates an understanding of social and behavioural aspects of the disease. Considering the bewildering increase in both morbidity and mortality, gaining this understanding would seem quite urgent."**

2000 years ago Plato admonished the medical profession of his day when he stated: "The greatest mistake physicians make is to separate the body from the mind." This schism and the concerns of Clarke and Leher are being addressed in this thesis using the psychodramatic method of Dr J. L. Moreno which considers:

- the social circumstances, present, past and projected
- the interaction of thought and emotion, together with action in role theory
- the principles of spontaneity and uniqueness and
- spatial appreciation.

The comments of Annette Rose (1990) will assume increasing significance as the thesis unfolds "... I am not sure that children do 'grow out of' asthma and other childhood dilemmas. Perhaps they 'grow into' more effective ways of revealing their emotional worlds as their skills in drawing, writing, play etc., increase with age?"

PROCEDURE – PART 1

Theory and Implications of Personal Boundaries

In my early work I found that patients developed suicidal tendencies, or else discontinued our relationship, when a successful treatment for asthma was suggested or attempted. These are reported in Appendix 1. Dr Rex Hunton (Personal Communication) had noted the same. This appeared to relate to W Roe's comment (Personal Communication) that the parents of the children who died with asthma in the Nelson Hospital Board area, all reported that their child had left a will.

The first clues of an adequate

hypothesis to explain the illness of asthma came to me when I went to my first Australian and New Zealand Psychodrama Association (ANZPA) conference and psychodrama training workshop in January 1982.

I was an auxiliary in a drama in which the protagonist, who had done years of training and personal work, reintroduced himself to the world. It was as though he was giving birth to his own self. As his new being came into the world he set out a line around his personal space. On this line and inside it he would feel threatened if someone untoward approached it. In response to this he had his Lion. A gentle lovable creature capable of roaring into life should the space need defending. (I saw this as a stimulus to the adrenal gland. These glands, which secrete the fight and flight hormone adrenaline, sit on top of each kidney. Adrenaline and its related compounds are the drugs that are used to relieve acute asthma.) The role was that of the Self Defender of one's personal space. Beyond this he drew another circular line. At this line he experienced anxiety and unease at approaching an intruder. I observed that anxiousness caused him to negotiate effectively. I adapted this into the formalised role test which follows. Since then I have used this to assess personal boundaries.

Personal Boundaries Test

This test requires a space of about 4m square, the person to be tested, the person doing the testing and an auxiliary. The latter may be the director, as in psychodrama au deux.

The protagonist (the person being tested) and auxiliary take opposite ends of the room.

I ask the protagonist to become aware of a zone around themselves which they regard as their own personal space. Around that I tell them to place the first imaginary line. I find that there is no need for them to declare where this line is. I pause and wait for an indication that they have completed the task.

I instruct them to create, beyond this, another zone of a less personal space. An area that is their own, but which they are more prepared to share. Around this I instruct them to place a second imaginary line.

At this point I decide to test either the positive or the negative aspects. I usually start with the negative aspects so that the assessment ends with a positive warm-up .

Negative aspects

Warmup:
I ask that the auxiliary be identified as someone who the protagonist does not like and does not want to have around. S/he indicates when s/he has accomplished this task.

Experiential Testing:
I ask that the protagonist observe how they feel during the test but not respond. Once they have indicated that they have the auxiliary in role, s/he (the auxiliary) starts to walk nonchalantly around the room. By and large s/he ignores the protagonist's presence. The auxiliary goes close to the protagonist, may bump into her/him and returns to the corner.

The protagonist's experience:
Next I enquire about the protagonist's experience. Anxiety and discomfort are the responses of the healthy individual at the outer boundary and threat at the inner boundary.

Response testing:
In the next part of the test I instruct

the protagonist to respond. The auxiliary representing the unwanted influence again strolls around the room as s/he did before.

The Protagonist's Response: Approaching the outer boundary will elicit the role of the negotiator in the normal protagonist eg "excuse me, what do you want?" Approaching the inner boundary causes the integrated protagonist to come forward to this boundary. In some reasonably effective way s/he prevents the auxiliary from crossing. There is usually no hesitation to employ physical power in the form of outstretched hands.

Positive aspects:

I now ask that the auxiliary be identified as someone that is cared about or is cherished, and I repeat both the experience and the response parts of the test either apart or together.

On the outer boundary the normal protagonist experiences a feeling of warmth and welcoming and on the inner boundary a feeling of loving and lovability which may become quite powerful. Responding to these feelings is the ability to welcome, hug and express loving to the depth that it is experienced.

I often choose not to separate the experiential part of the test from the response.

Personal boundaries and the value of life

I believe that this test provides an impression of the skills that a person has of evicting and discouraging the unwanted and attracting the advantageous into their world. For a person with intact personal boundaries, who is living in a system that is able to respond to them, a sense of fulfilment would be natural. Experiences of frustration, disenchantment, rage, anxiousness and dissatisfaction, when they occurred, would be temporary and solvable.

On the other hand, those whose personal boundaries are not that well set up do not wander around in a charmed bubble. They experience the opposite and feel that, to others, they do not exist. Or perhaps they do exist but that "they don't care." If this negative experience increases and the value of life deteriorates, I believe that depression ensues. If the value of life gets so low then the value of death may well become the greater and can creep in through the doors of increased risk of suicide, accident or disease.

Figs 1 & 2 (see page 8) are spatial diagrams depicting the concept of the personal boundaries around an individual's circle of influence. In studying these, I invite you to place yourself in the role of someone who is approaching the protagonist in her/his everyday life. Consider each figure separately and imagine yourself to be both a positive and wanted influence in the protagonist's life (approaching from below the illustration), then as a negative, unwanted intruder (approaching from the upper area of the illustration). Experience the roles that you would meet when approaching the protagonist that is depicted in each illustration.

Here, where the outer circle is intact, an approaching person will experience the roles of the Fascinated Attracter or the Anxious Negotiator.

Theoretically this individual should feel either threatened or overwhelmingly loving when someone approaches. In other words they will come on either very hot or very cold as they present the roles of

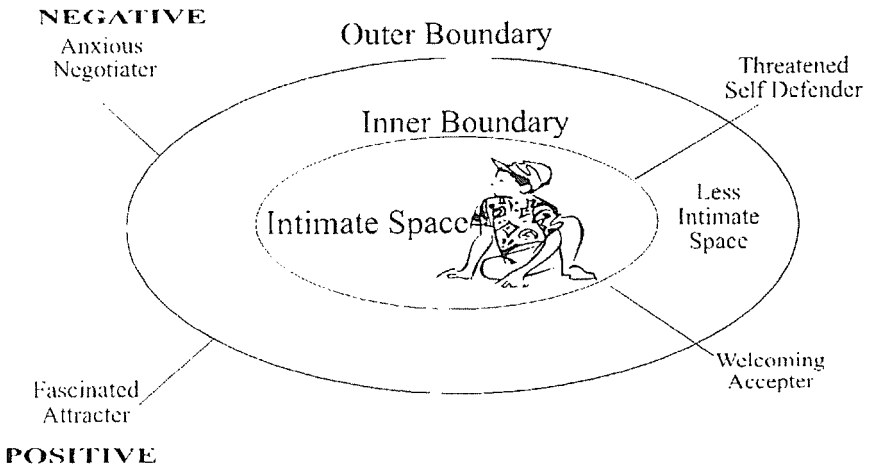


Figure 1:
Spatial diagram of intact personal boundaries and associated roles

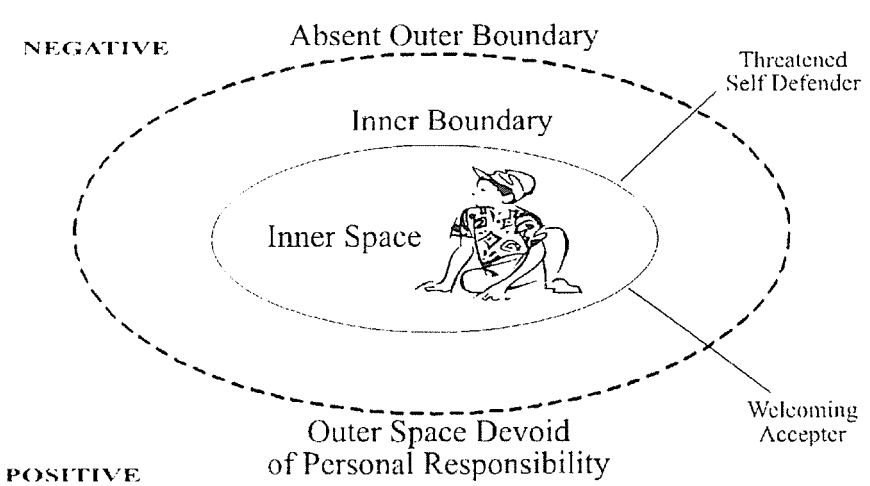


Figure 2:
Spatial diagram of an individual devoid of the outer boundary

the self-defensive lion or the welcoming accepter. The person may feel that they have often gone into a situation a bit deeper than they would have wished. This is the sort of response that children have. That is, of course, what is to be expected because they are in the process of developing their personal boundaries. Yelling, screaming, crying and frustration are normal developmental processes.

I believe that the level of maturity of the internal roles governing one's personal boundaries contributes to the creation of that person's social atom and, therefore, their experience of life.

Application of the standardised personal boundaries role test to asthmatics

I applied the test to many of my asthmatic patients. Whereas many people were able to defend their own territory, each and every asthmatic that I tested was unable to respond and stand their ground when they felt invaded. Most asthmatics I tested chose to (or felt that they had no option but to) leave their own space by turning around and/or backing off.

This is where I propose that asthma is an ingenious solution as illness behaviour and a sickness role. Because, for the one who wheezes, the whole world sits up and takes notice. Suddenly his/her existence is recognised. (See Fig 3)

Asthmatics usually present little in the way of indications as to their preferences and this is confirmed by performing sociograms with asthmatics. (See pp 23 "case study") The evolving asthmatic should, theoretically, behave like a developing child. In other words bewildering those approaching by not advertising their presence until they are a bit too close to them. Then they come on either very hot or very cold. On asking those who have lived with asthmatics, this phenomenon is often recognised. The converse is also true, that being without personal boundaries the asthmatic is unable to appreciate those of others. This was a feature of my own upbringing.

If we accept the evidence that the asthmatic has breaches in their personal boundaries, then they are reliant on asthma, or some other form of aberrant behaviour, to form another innermost boundary. By wheezing the asthmatic presents another boundary of protection. This boundary provides an emergency

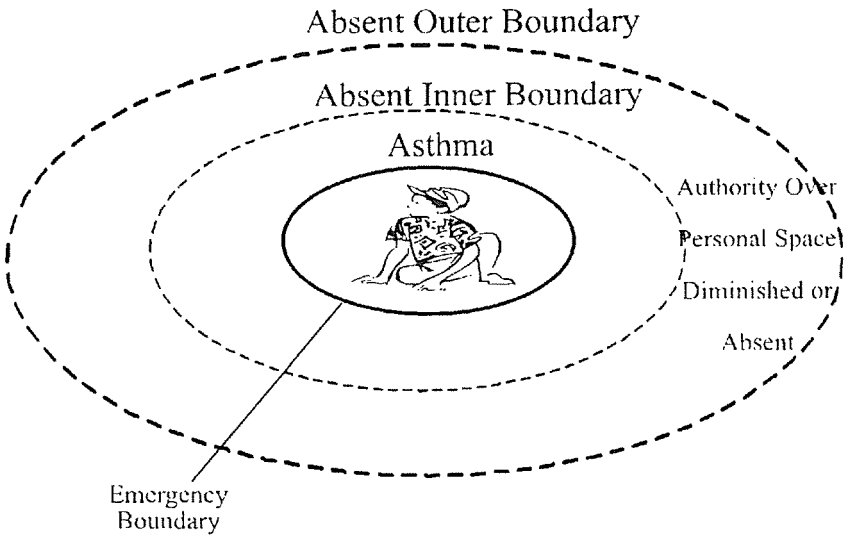


Figure 3:
Spatial diagram relating the territorial concepts of personal boundaries and asthma

form of recognition which is clearly better than nothing at all.

In clinical interviewing I take this into account. In initial interviews I reassure and I repeat the reassurance that I will not threaten to remove their asthma. I can stand alongside while they develop options, but the option to have asthma will always be theirs. This approach brings a mixed response of intellectual bewilderment and a feeling of deeper reassurance. They appear unthreatened and willingly return for another appointment.

Case Comment

I asked D, who is a severe chronic steroid-dependent asthmatic, to make a future projection of herself without asthma. Her comment was "I feel exceedingly anxious!" Within the personal boundary paradigm this could be seen as her experiencing the stimulating experience of anxiousness in the absence of the ability to respond because of an absent Negotiator component of the role.

This relationship between the inability to act and the build up of anxiety was noted by Moreno (1953):

Spontaneity, Anxiety and the Moment

Anxiety is a function of spontaneity. Spontaneity is, as defined, the adequate response to a present situation. If the response to the present situation is adequate "fullness" of spontaneity, anxiety diminishes and disappears*. With decrease of spontaneity, anxiety increases. With entire loss of spontaneity, anxiety reaches its maximum, the point of panic. In the "warmup" of an actor to a present situation, anxiety may move into two opposite directions; it may start with his striving to move out of an old situation without having enough spontaneity available to do so; or the anxiety may set in as some "external" force pushing him out of the old situation and leaving him hanging in the air. The terrifying thing for an actor is this wavering between a situation which he has just abandoned and to which he cannot return, and a situation which he must attain in order to get back into balance and feel. The infant, immediately after birth, is the illustration par excellence for this phenomenon. He cannot return to the womb, he has to stay within this new world, but he may not have enough spontaneity to cope with its demands. In such moments of complete abandonment it is imperative that he draws upon all his resources or that someone comes to his aid, an auxiliary ego ... Thinking through this process it is dialectically faulty to start with the negative, with anxiety. The problem is to name the dynamic factor provoking anxiety to emerge.** **Anxiety sets in because spontaneity is missing,*** not** because "there is anxiety", and spontaneity dwindles because anxiety rises.

As a physician, I believe that the maintenance of these boundaries relies, at least in part, on the adequate and appropriate secretion of adrenaline. Anxiety and threat are the stimulators of the adrenal response. The roles of the Negotiator and the Lion are mediated by the circulation of adrenaline. Adrenaline is nature's bronchodilator.

* This relates to the perceived anxiety of D on creatively visualising herself without the asthma.

** This explains why people commit suicide or leave when faced with treatment that may be

successful.

*** Spontaneity happens concurrently with adrenaline release!!! And this is diminished the more the exogenous adrenaline is given as a drug.

Personal boundaries and the logic of suicide

A credible paradigm for the genesis of asthma needs to explain why there is a suicidal tendency in those whose asthma is successfully treated or threatened to be treated. In the personal boundary hypothesis, removing this emergency inner boundary by obliterating the asthma leaves that person with no recognition. The value of life, therefore, vanishes leaving only the value of death.

Relationship between growing out of asthma and personal boundary repair

An important sequel to this is that those individuals who have grown out of their asthmatic tendency have, in my experience, repaired their personal boundaries. I find it useful to utilise this test in therapeutic planning and in the assessment of progress.

It is basic to this thesis on the origin and purpose of wheezing that we accept that recognition is an essential human need. By this I mean that those around us recognise us and the significance of the space in which we live (which is depicted by our personal boundaries). Furthermore, that within this space people behave appropriately.

Without such recognition we are left with the feeling that we do not exist. This experience is intolerable. If the experience of mutual recognition is not achieved then apparently bizarre forms of behaviour are adopted. If one of these prove regularly effective in achieving recognition it will be built into our automated role repertoire.

This automated response includes both apparently voluntary behaviour, and psychosomatic body functions. The latter are labelled as "conditioned responses". One example is Pavlov's Dogs. These creatures heard the ringing of a bell whenever their food was to appear. They were left with the problem of salivating to the sound of that particular bell, even though they couldn't eat it!

Case Study

A lady was referred to me who fainted every time that she entered her newly painted, teal blue, bathroom. It wasn't until she had undertaken successful deconditioning work that the origin of this bizarre reaction came to light. At the age of 14 she was approached by her employer in a soundproofed record testing booth. He threatened her with his sexual advances. She fainted and this caused the boss, who thought she had died, to unlock the booth and call for help. The booth was painted the same hue of blue as her bathroom!

Basic assumptions might include:

- Faint in blue room and you'll be safe.
- Salivate at the bell and you'll be fed.
- **Wheeze and you'll be recognised.**

The icons of asthma (the origins of allergy)

Just as I can click on an icon to gain quick access to a complicated function of this word processor on which I am writing, similarly the body has "buttons that can be

pressed" to bring on emergency recognition-demanding behaviour, one of which I postulate is asthma. These are conditioned responses to memories or factors such as smell, sound, pollen etc., that subconsciously stimulate the memory. Allergy could well be a conditioned response icon masquerading as an illness. The teal blue bathroom is a classical icon, this time for fainting. The bell is another, for salivation. For asthma, privet could be an icon, so could house mites, or the kapok of a pillow, depending on what went on when we were exposed to these factors earlier in our development. This is in keeping with the observations of Braun (1993) of people with multiple personality disorder exhibiting allergies in one personality and not in another.

Social effects of inadequate personal boundaries

Case Study

At the beginning of one workshop designated to asthma, I asked the asthmatic protagonist to set out her sociogram without speaking. She was aghast that those she cherished were at a distance. Some of those that she liked the least were close at hand.

During the course of the workshop she did some reparative work on her personal boundaries. At the end of the workshop I repeated her sociogram. On this occasion the layout was very much to her liking. She commented on how her feelings had changed towards some of the group members and that these changes had been reflected in the sociogram. One group member who knew her well commented on her improvement. In his sharing with her, he stated that in the past, he had come to understand that if she wanted his attention she became pale and wan rather that open and needy.

Based on my observations and these theories, I postulate that the asthmatic has a relative **inability** to select his/her associates and partners. Furthermore they are unable to indicate clearly their preferences to those with whom they share their life. As life proceeds, therefore, so do the "layers of the onion" of inappropriate choices and untoward consequences. Resolution, therefore, can be an exceedingly long-term and multifaceted business. The masking of asthma with long term drug therapy, in this light, could be a counter-productive thing to do. The advantages of drug intervention thus need to be carefully weighed against the possibility that the wheezing could represent a deep inner calling for help from the creative genius of that person.

Role assessment and ongoing evaluation of the personal boundaries are thus useful adjuncts to the standard indicators of progress, i.e. the improvement of the peak flow rate and the reduction of medications.

PROCEDURE – PART 2

Role Theory Applied to Asthma

1. Wheezing as a psychosomatic role

If suckling, breast feeding, urination, defecation etc., are defined by Moreno as psychosomatic roles, then what is the psychosomatic function of wheezing? Thinking in this way has helped to shake me out of an egotistical mind set that my profession is locked within. Let's

question: would the creator, be it Deity or Darwinian, have endowed us with many thousands of bronchioles (tiny muscle-bound airways), with the unique ability to go into spasm and secrete defensive fluids, for the sole purpose of producing an illness called asthma? Unlikely! I therefore propose that wheezing is a normal and naturally occurring **psychosomatic role**. It has, I believe, the **purpose of protecting the alveolus**. This is the air sack at the end of the bronchiole, which has walls that are so fine that they facilitate the exchange of oxygen and carbon dioxide between the air and the blood in a fraction of a second. There are thousands of alveoli in each lung. Spread one lung's alveoli out and you cover a tennis court. Destroying the walls between them leads to emphysema and shortness of breath because you end up with only half a tennis court to breathe with. Each alveolus has a bronchiole as its gateway. Around each bronchiole is a circular muscle capable of closing down the bronchiole. Such a muscle is called a sphincter, the most renowned of which is the anus. Unlike the anus, the bronchiole normally remains open. When the bronchiole closes down wheezing is heard as the air is forced through the narrowed openings.

Something as delicate as the alveolus is worth protecting from dust, infective organisms and other particles. The first element of the psychosomatic (alveolar protective) role of wheezing, I believe, is physical. This is bronchospasm – the narrowing of the tube caused by constriction of the sphincteric muscle. The second line is also physical. These are the secretions (another aspect of asthma) that stick foreign materials to the bronchiolar wall so they won't drop into the alveoli. Bronchospasm, by easing on inspiration and increasing on expiration, ensures that the air velocity is always greater going out. This causes the foreign material to be blown out, rather than being sucked or passively sliding in. Finally, there are white cells and antibodies in the secretions which combat infection and sponge up the debris. The cilia in the bronchiolar walls can then waft the rubbish upwards to be evicted with a cough.

Both the irritation and the wheezing would cause that person concern. Adrenaline might, therefore, be stimulated because that is what happens when one is concerned. This would normally cause the bronchiole to dilate. However this would not happen, both because the stimulus is relatively small and its effect would be overpowered by the effect of the local irritation. This irritation causes release of the cytokinins (the substances which circulate in the bloodstream and cause bronchoconstriction). The irritation should come to an end when the irritant is blown out. The adrenaline should then have a chance to work, dilating the bronchioles and permitting coughing to be more effective because of the increased and unobstructed volume of air behind it. The unwanted garbage is thus expectorated and the psychosomatic role of wheezing is completed, having achieved its purpose.

2. Wheezing as a psychosocial role

If wheezing is a psychosocial role it is either learned behaviour or else it is developed for a very good reason.

Role requires thought, feeling and action. Action involves adrenaline.

Malcolm Carruthers and Peter

Taggart (Taggart et al, 1972) were among the first to measure adrenaline levels in the blood. In my work with them in London we discovered three circumstances in which people **lost all trace of their adrenaline** from their blood stream. One was when people fainted when having blood taken. Another was in a parachutist novice, when he broke his ankle on landing. The third occurred when people watching "The Clockwork Orange" saw a human breast being hacked off to the accompanying music of Beethoven. It was mooted that in all these circumstances a "lie doggo" or inactivity role could be seen as ancestrally advantageous in order not to be noticed when incapacitated or extremely threatened. The mind/body therefore saw fit to remove the adrenaline from the bloodstream. This is presumably what happened to the lady in the teal blue bathroom (see p 11).

This ability to manipulate and adjust adrenaline levels in apparently bizarre ways was also demonstrated in asthmatic people by Wind et al (1985) who demonstrated low base line (as opposed to absent) levels of adrenaline in asthmatics in a situation (casualty department) that evoked a twenty-fold increase in all others. There seems little doubt that emotional triggers can remove and modify the adrenaline level in the blood stream, both up and down, appropriately and apparently inappropriately, if the adrenaline adjustment is stimulated by a conditioned response.

It seems, therefore, that the action element of the role of "asthma" is **inaction** (if you can believe it) induced by a "down" modification of circulating adrenaline. Therefore if a role is the ingenious adaptation of a creative spirit, then there must have been good reason for that person to develop an inactive role.

Why develop a role with a major component of inactivity?

This thought caused me to question approximately 60 patients looking for a cause for this inactivity. The first of these interviews is recorded here. A few more are documented in Appendix 2.

"If people with asthma have learned a role which involves turning off their adrenal glands, then why did they do it and how did they learn it?"

The role of the Unknowing Enquirer had surprises in store for me. I was doing the weekend emergency doctor service during holiday time in Thames. I was in particularly good spirits and feeling a bit cheeky.

Case Study

A lady in her 30s sat in front of me in my emergency room and she said "I want a puffer of Ventolin because I forgot mine when I came away for the long weekend."

She looked like a fun-loving lady and I said to her "Sure, so long as you tell me why you turned off your own supply?"

It wasn't a very well put question. I don't think that she understood it. Inside I believe that she really wanted to say to me "push off with it and get on with your job."

Instead she said something to try and please me in the hope that I would stop my impertinence and produce the medication.

She responded "It's the privet. I'm allergic to it."

"Not good enough." I said, and I

explained a little more of what I meant. I talked to her about the hypothesis that children could switch off their anger if the need was great enough. I explained the connection between anger and adrenaline and its relationship to the blue asthma inhalers. I continued: "About the age of six I imagine." That was a guess.

She crossed her arms and turned side on to me. Her face was held in a tight-lipped fashion. She then looked around at me and said "My mother died. Is that good enough?"

I could have been tempted to back off with an apology at this stage. She was certainly on the wave length. She was also quite clearly holding back on me. Acknowledging a certain sense of fun I said:

"Getting better, but no, not good enough yet."

She was aware that she was going to get her puffer and seemed to be enjoying the banter that was going on between us.

"Then Dad married the babysitter. Now is that OK?"

"No, I am sure that you can do better than that!"
"Then she divorced him and we lost the house and everything that we had. Silly old wet sucker that he was."

She actually finished the interview by saying:"I wanted to kill him but he was all I had!!"

I gave her the script for puffers and I obtained her permission to use her story one day to illustrate my work on asthma.

I deduced that a childhood living with a father with whom she had the act hunger to kill him would be excellent training for adrenal shutdown. It would be prudent not to kill her primary resource. She was down visiting him that weekend. Allergic to the privet?. . . or was she simply wheezing in response to the unresolved memories of her experiences with her dad? An Icon for asthma.

This story and those in Appendix 2 relate to people who have been exposed to significant trauma. This trauma can be extreme and requires time, team work, and a stable and safe environment within which to work. The stability of the Primary Health Care Unit with its groups and support systems that I ran in Thames went a long way to providing this.

On the other hand there were those from whom no story of significant trauma could be obtained. In these people there was developmental privation (Joan Chappell, Psychodrama Thesis and Personal Communication) with significant absences in their childhood. For example:

Case Study

I was working with a man in a demonstration group that I was conducting on the principles of growing out of asthma. His ability to demonstrate defensive outrage was absent. He was, in fact, the big strong muscular member in a family of tiny intellectuals. There was little or no mirroring given to him as a child, especially when exercising his strength or when showing his indignation. This left him being terrified of what his size and strength might do if he unleashed the fullness of his outrage. He was very different once he had a good push and a wrestle with a number of stronger members of the group.

Similarly the comment: "No one raises their voice in our family", is often heard from the privated individual.

In my experience it is rare not to elicit a story of significant trauma or privation from an asthmatic person. It would, therefore, appear that

developing the ability to expediently turn off the connection between an outraging experience and the acting out of one's adrenal response, or not to have developed it in the first place, are pre-requisites for psychosocial wheezing. I call this the role of **The Expedient Inactivist**.

The fact, however, that there are Expedient Inactivitists without asthma means that there is more to the story. This becomes clearer as role theory is applied further to the phenomenon of wheezing.

Why choose asthma?

If one considers that a personally created role is the product of the creative genius of the individual, then there must be a perceived advantage derived from the role. If asthma involves psychosocial roles, then the advantage will be social. I therefore utilised the role of the Case History Taker to ascertain some evidence, positive or negative, about this theory.

Case Study

Leigh, I believe, learned to switch off her adrenal response at the age of three, when the doctor, nurses and family said that her emotions would kill her chronically ill father. She did not, however, develop asthma until she was married.

She was in a relationship that she experienced as un-caring, and emotionally and physically abusive. She developed the flu once. With this she began wheezing. I would regard this first attack as psychosomatic wheezing. The response to this was that her husband contacted the emergency doctor who noted her wheezing and diagnosed her as asthmatic. The husband was instructed on how to care for her when she was asthmatic. From then on, when she wheezed, she had breakfast in bed, was asked what she wanted, and she was cuddled and treasured. Her asthma had an important psycho-social function. It became a frequent and chronic ally.

Case Study

Aussie Malcolm (who requests that I mention him by name in respect to this matter) was the Minister of Health in New Zealand in the 1980s and thereabouts. He initiated a committee which Bill Roe recalls being designated to "kick the arse out of asthma." Aussie ensured that Bill was on that committee.

Aussie's impetus with respect to asthma was driven by personal experience. About the age of 12 he was aware that he could wheeze a little when he got a chest infection.(Psychosomatic role) One Friday morning he was facing the dilemma of going to school without having done his home work. He was facing inevitable corporal punishment. He wheezed that morning, in association with a minor sore throat. His mother became concerned. She called the doctor. Only near death situations called for the doctor's visit in that household. Aussie thought: "I know nothing too much is wrong with me!" but cherished the attention.

On diagnosing asthma the doctor prescribed four days rest as part of his therapeutic plan. In this particular instance the knowledge that the wheezing had a social advantage was conscious. It was to be 4 years before Aussie grew out of his asthma. It is about the age of 16 that the threat of caning was abandoned by his teachers. The custom of caning applies only to people smaller than oneself!

This phenomenon of illness or dysfunction being a psychosocial role is acknowledged medically as

"secondary gain" and in transactional analysis as "pay offs".

Hypothesis for the genesis of asthma:

I propose, therefore, that psychosocial wheezing requires both:

a. The circumstance and the training for the individual to turn off the adrenal fight and flight reaction **and**
b. A social advantage which is first learned during a bout of normal psychological wheezing (i.e. the normal wheeze that protects the more delicate parts of the lung.)

The psychosocial purpose of wheezing, I believe, is to achieve the basic need of recognition. This is done by utilising the enormous social power of asthma.

PROCEDURE – PART 3

The Interplay Between Anatomy, Physiology, Endocrinology, Psychodrama and Personal Boundaries

If the psychosocial role of wheezing is to be left behind or rendered less necessary then what are the psychodramatic roles that need to be engendered and developed?

Psychodramatic roles express and create the uniqueness of self. The central creation is our social atom (our personal social system). Basic to the development of a functional and nurturing social atom, within which one's needs are met, is the psychodramatic role of the **Congruent Expresser**. Without this role, one's moment to moment needs are not advertised, and one therefore has no chance of those needs being considered or met.

Without the role of the Congruent Expresser, therefore, recognition is not achievable.

The cod fish lays ten thousand eggs,
The homely hen lays one,
The codfish never cackles to tell of what she's done,
And yet we spurn the cod fish,
The homely hen we prize,
Which therefore shows to you and me . . .
It pays to advertise.

A poem my mother recited during her recovery from asthma.

I consider that congruent expression is the first step towards the fulfilling experience of **the catharsis of integration**. This embodies not only expression but also adequate perception of what one has portrayed. The final experience of **recognition is achieved through the perceiver acting as one's mirror.** For individuals "me" and "you" who are developed in the areas of congruent expression and mirroring the following course of events **has the potential** to take place.

- A catharsis of abreaction of "me" to "you". (I let "you" know, in a comprehensive and understandable way, what is going on for "me".)
- Perception of the catharsis by "you" and skilful mirroring of same back to "me." ("You" pick up what "I" shared with "you" and "you" ensure that "I" know that by showing and telling "me" in your response)
- "I" recognise myself in the mirror that "you" provided. (What "you" are doing in front of "me" rings true.)

And in reverse there occurs:

- A cathartic response by "you", which is in turn received and mirrored by "me" and . . .
- Perception and inner matching by "you". (Given the chance, "I" do the same for "you" as "you" did for "me".)

The effectiveness of this process governs the degree of mutual recognition. At its zenith is the catharsis of integration – the overwhelming expression of joy and the inner explosion of energy that comes from spiritually connecting with another. In Maoridom this is "The Ihi", the coming together of Earth and Sky. The joining together of more than one Mauri or Life Force. This Maori perspective was first shared with me by Betty Williams of Huora Te Awhina, Manaia, Coromandel (see Appendix 3).

Do you know who I am?
Do I know who you are?
See we one another clearly?
Do we know who we are?

(Song from Guinea Village People in Africa adapted and sung by Harry Belafonte and The Muppets.)

Without the Ihi or ongoing catharsis of integration, life is flat, depressing, mundane, uncreative and incredibly insecure. One hangs onto what one has (in asthma this is recognition through wheezing), albeit unsatisfactory and out of date. This, I believe, is the experience of the person who is asthma-ing where there is dysfunction of congruent expression in an environment lean on mirroring. Included therefore, in those who wheeze, are some isolates and dysfunctional and creative narcissi.

Boundaries versus barriers

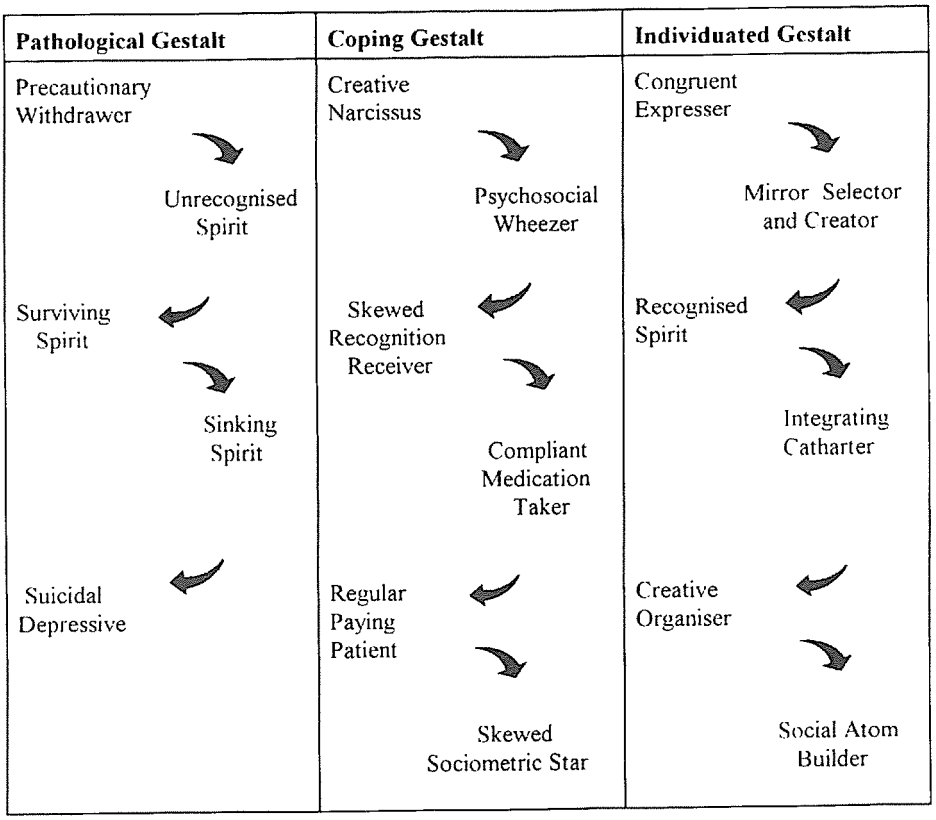
This phenomenon of deep insecurity and hanging onto what is there makes sense in terms of the personal boundary proposal that I have presented. In other words, one cannot afford to relinquish those that one has within one's personal boundaries, if one is devoid of the ability to attract anyone else in. Without the Role of the **Selective Attracter** there is a real risk that the newcomer will be worse than the one that was just evicted.

What are personal boundaries to some are, therefore, barriers to the asthmatic. Healthy boundaries are semi-permeable and sensitive. They adjust, depending on our personal needs, and are considerate of others through role reversal. Barriers hold on to what is already there and reject that which is new. Role reversal does not occur. The individual operates from an assumption of fear.

I find this visual concept of personal boundaries both grounding and valuable.

Psychodramatically, the inadequacy of the Threatened Self Defender and the Anxious Negotiator leaves the person in the role of The Unrecognised Spirit. The social atom is thereby filled with inappropriate others adopting inappropriate roles. The absence of the roles of the Attractive Lover and Fulfilled Beloved leads to an absent Believer in Intimacy. This culminates in the Anxious Controller manipulating others into Reactive Puppet roles rather than role reversing and recognising the Free and Loving Spirit in them. This excludes the potential for the Catharsis of Integration. This stimulates the Creative Narcissus to Generate the Psychosocial Wheezer

Role Diagram of an Evolving Psychosocial Asthmatic



which brings about an experience of skewed recognition. In the role of the Compliant Patient the very hormones the Creative Narcissus has turned off to make space for the Psychosocial Wheezer are administered, which reduces the effectiveness of the Psychosocial Wheezer. The Creative Narcissus usually organises a resistance to the treatment at a physiological level and a worsening of the disease, thus achieving its purpose and at the same time creating a downhill, possibly lethal, spiral.

The value of the mirror in achieving recognition

In our development we need to match our inner experience with our outer expression, otherwise what we feel within cannot be noticed. Having our eyes and ears the way they are, we are not able to see ourselves or hear ourselves the way that others do. We are thus forced to live interactively. Moreno referred to "plucking out my eyes and putting them in your head", a rather macabre concept. Jim Henson created a witch in the Dark Crystal that could pluck out her eye and wield it manually in all directions. Robbie Burns simply said in the poem "To a mouse":

> *"O wad some pow'r the giftie gie us*
> *To see oursels as others see us!*
> *It wad free mony a blunder free us.*
> *And foolish notion."*

Therefore, in order to make congruent our inner being and our

outer self, we need:

- adequate human mirroring in order to perceive ourselves the way others do, and
- the ability to vary our response when the match between what we perceive and our inner feeling does not occur, and
- a patient, persistent and loving mirror so that we can continue to repeat the process until we achieve satisfaction and match our inner feeling with that which is represented outside thus enabling us to develop the role of the Congruent Expresser.

The effect of inadequate and manipulative forms of mirroring

"In accordance with Dr Moreno's observations the stage of the mirror is one of four stages of personality development. The stage commences as the individual starts to become aware of itself as a separate entity with a body and impulses of its own. Any behaviour by others to enhance that person's awareness of their physical body, impulses, emotions, and feelings will further autonomous development at that stage. Evaluative responses will likely produce a confusion." (Clayton 1991).

Unfortunately there is little awareness of the value of mirroring in the everyday world. This is one way that one's development can get skewed. Many settle for a second best form of recognition. In other words some recognition is achieved through doing something quite weird. One example is stretching the body's ability to dangerous extremes like in boxing and athletics. Or the mind, in academic pursuits. Or both, as with anorexia nervosa. Some seek pain, in one form or another, and in this way achieve recognition. Laetitia Puthenpadath (1995) states "distorted mirrors fragment the psyche". Once the skew process is under way, the ability to vary ones responses becomes lost and is replaced with an obsessive compulsiveness of doing the same thing repeatedly and more aggressively. This is especially so if it fails to achieve its purpose of fulfilment of the recognition of the true self. As this is impossible, because what we are putting out has nothing to do with our inner self, a vicious cycle is inevitably set up.

Nurturing the adrenal gland

How is it that the secretion of the hormones adrenaline and hydrocortisone can be nurtured and encouraged using psychodrama? Psychodrama is the method whereby thought and feeling are put into action and the whole person is able to act in ways that are as big or bigger than life. It would seem well suited for the job.

By nurturing the adrenal gland I mean to encourage it to secrete its hormones in appropriate amounts at appropriate times. In other words I am asking the hormones to play their part in facilitating spontaneity in the production of adequate and appropriate roles. By doing this wheezing should be reduced to its psychosomatic purpose.

There are two parts to the adrenal gland:

- the medulla that secretes adrenaline and
- the cortex that secretes steroids (hydrocortisone among others).

The Medulla (adrenaline)

Extremes of adrenaline production are achieved in the **Congruent Expression of Outrage**. It would

seem prudent, therefore, to treasure this role in the development of a culture free of psychosocial wheezing.

In order to do this valuing, the attendant, usually the parent, requires adeptness in being both appreciatively attentive and an adequate mirror. This is described aptly in "The Vesuvius Session" of R & V Hunton (Personal Communication). The adeptness is achieved through developing the complementary counter-role of the "Keeper of the Stage" (L Clayton, Personal Communication). These roles comprise:

- Thought: The need to be auxiliary to the development of the role of the congruent expresser.
- Feeling: The need to be lovingly compassionate and sincerely interested in the totality of what is being shared. Even if you disagree!
- Action: Adequate mirroring and the maintenance of safety and confidentiality.

Justification for the outrage is clearly not an issue.

As mentioned before, adrenaline release is not restricted to fight and flight. It has an important function in co-ordinating the congruent expression in most of its assertive forms. It is also vital in day to day motivation. The studies of Carruthers, Taggart & Parkinson (1972) indicate that the amount of this hormone that is circulating is adjusted second by second. Mirroring of all activities, in order to fine tune the role of The Congruent Expresser, is, I believe, vital.

PROCEDURE – PART 4

The Psychodramatic Mirror in the Management of Asthma

Teaching mirroring to parents of asthmatic children

Even though I teach mirroring as a universal and essential parenting skill, I make a point of teaching it to the parents of asthmatics. This is offered in balance with other available options such as drug therapy, breathing exercises and avoidance of allergens. I use didactic instruction and modelling.

In so doing I maintain an awareness of the immense values of the mirror. I attribute such importance to mirroring that I will list these values here:

- It is a loving act.
- It is a gift to that person of who they are.
- It's a gift that can come in no other way.
- It has the purpose of allowing the individual to see for themselves how they are perceived by others.
- It allows that individual to assess if their expression (which they see in the human mirror) matches with what they feel inside.
- It gives the ability to adjust, adapt and modify one's own expression of the true self.
- It therefore facilitates the ability to reflect one's inner self out into the world.
- It gives the individual, child or adult a tool for self modulation and control.
- It changes parenting by reducing immensely the need to control the child.
- It provides an experience of recognition.

- It removes the skewed need of winning to achieve recognition, i.e. if there are 30 people in the race and only one can be recognised with a prize, 29 miss out. Even the one who wins is getting cultural approval rather than true recognition.
- The mirror has the potential to provide recognition for all people for all of their lives.
- Depression is less likely because there will be no lack of recognition.
- It provides the wherewithal to differentiate between those who provide recognition from those who don't.
- It is thus a basic ingredient of choice.
- It is the precursor to the catharsis of integration.
- It gives you, the person doing the mirroring, a fairly good idea of what she or he, (the person being mirrored) is feeling.

The child who is adequately mirrored:

- Learns safety while being angry.
- Experiences recognition immediately and does not need to repeat the performance (hyper activity).
- Has no need to adopt bizarre behaviour (e.g. asthma or a gold medal) in order to be noticed.
- Is on the road to experiencing the catharsis of integration.
- Is exercising the adrenal medulla in a wholesome and healthy manner.
- Is moving into adulthood with an intact and safe role of the Congruent Expresser.
- Is receiving an experience of self as worthy of love.

In talking to parents of an asthmatic child, I will ensure that there is adequate rapport and time. A full range of treatment options are offered along with the mirroring option. I include mirroring under the heading of what one can do oneself to help. Once the context is set, I will share with them the role of adrenaline in day to day life. I will then talk about the extreme end of the spectrum of adrenaline secretion, the tantrum. I will indicate how important it is for any person to be familiar with their anger before they grow to a size that they could do damage when out of control. I point out that it is unbridled surprise anger in the adult that is dangerous. I also point out that the danger is compounded if there is a cesspit of unexpressed anger, which has been built up over years, to hook into. I then state that a child is theoretically unlikely to wheeze if they have ample and appropriate circulating adrenaline in their blood. These points often require discussion and explanation. It is important to maintain an environment where the parent can weigh up the immediate value of inhalers in their day to day family life and the potential for adapting their parenting skills.

In this process it is necessary to maintain an awareness that they, the parents, are almost certainly identifying with most of what I am telling them. I keep a constant check on their guilt level, usually by asking them. I frequently refer to the fact that no-one is to blame for the asthma and, on the other hand, it would be great to discover ways of giving their child wheeze-free breathing which does not carry with it a lifetime of drug taking. I make sure that they are aware of the group and individual facilities that I have available should they choose to look into their own issues. This is all touchy ground, requiring delicate

and skilful handling. If their child is needing mirroring then it is very likely that they are too.

Once an agreement is reached to include this approach in the retinue I point out that all activity requires regular mirroring. If only tantrum and temper are mirrored it is likely to be perceived by the child as controlling and manipulative.

With respect to a tantrum I will say to the parent:

"Don't waste this moment!! It's the very moment we've been waiting for. This is Adrenaline. It's like having struck oil after months of exploration. Appreciate the value of what is happening and mirror it." While giving instructions on the technique of mirroring the body language and tone as well as selected verbal content I will illustrate it by modelling, usually with the child. The positive response of the child to being mirrored is a reassurance to the parents.

The effects of providing mirroring for the asthmatic child

Teaching mirroring to the parents was, I believe, the reason that I seldom started a child on anti-asthmatic medication. Parents were given a note (figure 4) to take to the hospital if they were concerned at night. This note served both to allay anxiety and to ensure, as much as I could, that the child was not given drug therapy automatically. They were told of our total availability during the day and that they could come in and help themselves to the nebuliser. They were taught how to observe their child for risk moments. This included the measurement of peak flow.

The effects of mirroring were seldom immediate and some children did need to go to hospital where they would first be given a nebuliser with only saline. This was often effective. Once in the ward of the hospital they would be subjected to their routine and were given drug treatment along with other appropriate supportive treatment. The hospital staff would give the instructions to use the treatment continuously in order to prevent a further attack. Without exception, when given the option, both the parents and the children preferred to spend a minimum of time on their medication. Offering the consumer this option created a tension between myself and the hospital which I have yet to resolve. Current custom is strongly drug-orientated, even though the emphasis has

To the Night Supervisor
Thames Hospital

Regarding Jane Somebody
DOB / /

Would you please administer Via the nebuliser Normal Saline 5ml and re-assess their peak flow.

If there has been no improvement would you then administer Salbutamol via the nebuliser and re-assess and arrange admission if there is any concern.

With my Thanks

Peter Parkinson

Figure 4

moved from adrenaline drugs to synthetic steroids by inhalation. Research demonstrates that this move in drug therapy is appropriate but in my search I could find only the article of W Roe (1984) assessing the advantages of **no treatment at all**. Although current opinion would be against me if an issue of this sort came to litigation, I believe that the evidence in the literature would exonerate my approach. This is especially so when one considers that I support the patients in making informed decisions.

The most common misunderstanding that I encountered in follow up after providing mirroring instruction, was that of using the mirror to control tantrums. The concept of facilitating a tantrum was, understandably in today's society, a difficult one for some to comprehend. There was usually the need to get the parents to provide mirroring for one another for them to appreciate its value.

Two years after leaving my practice I attempted to ascertain how those that I had taught mirroring had fared with their children. The person who succeeded me in my practice had reservations about this. As a result I was unable to do my review. He did tell me that there were two children that he had seen fit to place on regular medication. The parent of one of these children was a personal friend of mine. When I saw her in the street and without my asking she offered this comment: "It was only during a family crisis of some magnitude that he did wheeze and require medication."

During the eight years that I followed the above regime we had no asthma deaths in the practice and I was encouraged by comments such as I had from a parent of a 7 year old boy:

Case Comment

On detecting a wheeze I began to explain to the mother the principles of mirroring. She stopped me in mid-sentence saying:

"You showed us this three years ago ..."

My heart sank a little until she proceeded saying "... It worked like a dream, we just forgot to carry on doing it!"

PROCEDURE – PART 5

Adequacy of the Social Atom and the Adrenal Cortex (Hydrocortisone)

On the other hand there were some children who did not respond to having mirroring instruction given to their parents. It would have been easy to blame the parents as being poor or indolent learners. This, however, was not the spirit of my practice. We were committed to the concept of taking each and every apparent failure as a potentially magical learning moment. By opening myself up to this possibility, and from work with adults that involved group psychodrama, I became aware of three separate yet interrelated missing pieces of the jig saw puzzle which were:

A. The possibility that the body could be encouraged to produce its own steroids from the adrenal cortex rather that being administered as medication to treat asthma.
B. The appreciation of the practical application of a cycle comprising: nurturing, doubling, mirroring, re-approachment and back to nurturing in facilitating the adrenal medulla to secrete adrenaline and the adrenal cortex to secrete steroids. This cycle was shared with me by Dr Joan

Chappell when we worked together in my practice in Thames.

C. The potential for social atom repair in those asthmatic children that did not respond to mirroring.

These three led me to consider the roles and circumstances that might lead to adequate production of hydrocortisone. They also led me to solidifying a linkage between psychodrama and adrenal physiology.

A. Steroid Production

Medical textbooks describe illnesses relating to the extremes of steroid production. Addison's disease, which comprises low blood pressure, lassitude, pigmentation and death, is the outcome of no steroid production. Cushing's disease, with its characteristic face, hypertension and soft bones, comes from over production. I have seen no reference to what happens when adrenal cortical function is reduced but not outside the "normal" limits.

There have, however, been two occasions in my life when it would appear that I have had insufficient steroids to maintain me in a state of health and I will mention these because they are pertinent.

The first of these was when I was in my last two years at secondary school. I was living in a social vacuum. I had no effective home and little belief in either parent. I had lodgings in a lean-to structure attached to a green keeper's garage on a golf course close to the school. At school, I found myself without friends or mana thanks to an unfounded rumour. It was a threatening all-male environment. Recognition came from succeeding in sport or academic achievement. I was far from that. Mere survival was a triumph in itself.

During this time I developed severe eczema, especially on my face. When I awoke I would peel the pillow case off my face leaving behind the bleeding and raw skin. This condition continued for over a year. I was visiting the dermatologist every two weeks . When my eczema became infected I would be given an antibiotic which would return me to the scab of the eczema alone.

It was at this time that the hydrocortisone of cows' adrenal glands was being extracted, purified and sold in tubes as an ointment. The dermatologist that I saw gave me his first treasured samples. Miraculously my skin returned to normal.

Both before and after the steroid treatment time I was frequently invited to sail on board a 50 foot sloop, named Tawera (the Morning Star) and go to Man o' War Bay. This was at the east end of Waiheke Island. Man o' War Bay was my haven of peace and meaningful existence. Pohutukawa trees bowed down to the shingle beach. Small islands formed a protected sea. The seafood abounded. Above all this, I felt accepted, loved and cherished. Kitty and Scott, who owned the boat and the house that I went to on Waiheke, were tremendous to me. Just along the beach, however, were Cath and Charlie Scott. They were a Maori couple who meant the world to me. There is no doubt that they were my surrogate and spiritual parents in that time of need. I can remember the moment of walking along the beach and meeting Charlie at his gate.

"Gooday Pete" with a softness and warmth in his voice. We would walk up through their garden and sit in the morning sun. Cath would produce some fresh griddle scones, cooked on the coal range. We would

sit and chat. I feel nurtured even with the simple recall of these moments. Add to that collecting the mussels, catching the fish at night, the phosphorescence of the water and the cooking of Kai Moana (seafood) over the fire on the beach . Within hours of feeling the sand between my toes, my skin would clear.

From this experience I deduced that Cath, Charlie and the beach were able to produce in me the same hormone that the cow had bequeathed to the drug traveller's tube. That was the steroid Hydrocortisone. What's more, the social vacuum that my school and home life had for me, could equally well switch it off, for the eczema would be back within hours of returning to that environment.

Recently, again, my steroid level appeared to be less than what I needed.

Three years ago I sold my practice and left Thames, the town in which I had been living and doing my life's work. The things that had led to this decision were destructive. On top of this, there was the stress of the changes that were involved. Further, I was returning to the icons of my old home town and family .

Not only did the eczema return (in a milder form) but my blood pressure fell to low levels and my life energy was replaced by a feeling of total fatigue. It forced me to rest five times each day. These could be symptoms of adrenal cortical insufficiency. It was not until I had done sufficient past and present social atom repair work and established myself physically in Auckland that the Mauri (the life force, the hydrocortisone?) returned.

I come to the tentative conclusion that it is necessary to have a social atom that provides both recognition and nurturing in order for there to be adequate hydrocortisone production at times of stress and need.

B. Nurture/ double/ mirror/ re-approachment cycle

I have come to believe that living with this therapeutic cycle in infancy, and thereby picking up the habit to continue it into adulthood, is crucial to adrenal gland functioning. This culminates in the development, from infancy, of intact personal boundaries.

Description of the cycle

A. Nurture

This is the simple process of being held in a state of unconditional loving. An undeniable calming energy is developed. I propose that this warms up adrenal cortical function and the secretion of Hydrocortisone. Next comes:

B. The Double

This psychodramatic process of emulating from alongside creates a warmup to action. The build up of excitement, expectation, anxiousness, sweating, a pounding pulse etc., the degree of which depend on the magnitude of the forthcoming event suggests adrenaline secretion from the adrenal medulla.

The one being doubled experiences support, understanding and the presence of a mate or mentor to consider the action plan for the journey that lies ahead. The double's experience emulates the child's, thus deepening the empathy.

C. Mirror

Once the action of life begins then mirroring comes into its own. The

more skilful and unobtrusive, the better.

E. Re-approachment.
This is credit where credit is due. Appropriate to the age and circumstance.

For example: A hug, a cuddle to start the day. A chat about one's plans. Double to begin the next journey of life – be it a day at school, a day's work, a game of golf, whatever. Some mirroring on the journey for recognition and fine tuning of one's personal expression. A chat and postmortem of the day, with credit where it's due, on return. Let the cycle rotate again and again. One is then ready for coaching, criticism, growth and a big breath of fresh air.

C. The third piece of the puzzle

The third piece of the puzzle relates to picking up moments in the protagonists' lives where their adrenal function goes on holiday. It's that the functionless hole that we spend our lives avoiding because, if we get into it, we can't get out. Dr Joan Chappell refers to it as adrenal switch off.

When I looked at those asthmatic children that did not respond to mirroring alone and at adults, it was evident that they came from social atoms that were damaged and that other aspects of "the cycle" besides the mirroring were absent. It appears that when mirroring alone was effective I had chosen to work with those who had reasonable resources in terms of family and nurturing.

In working Psychodramatically with such people and their families, building their resources could well take years. In my practice the following were among the resources that we used:

- Existing special friends.
- New connections met in the groups or practice auxiliaries.
- Concretising memories of special people and places.
- The drop-in area of the practice and the connections that were made therein.
- Honouring the temporary, yet necessary, dependency that developed between the client and myself and the staff,
- Tokens and mementos, originating from either the client's resources or our own. Relinquishing a pillow, a soft toy or a picture from the wall of the surgery was a necessary part of the service.
- Music. The practice sported two guitars hanging on the wall.
- The role of the idealised parent (E.Sherrard, Psychodrama thesis) developed during the group and individual sessions.

Recently I have added to my repertoire of skills the concept of utilising the double to modulate expression rather than to simply maximise. Zerka Moreno talks of this use of the double, and Hudgkins and Toscani have furthered its use and coined the title "the Containing Double". This is especially applicable to asthmatics who, once warmed up, can deepen this warmup precipitously. It is clearly counter-productive to warm people to circumstances and emotions that they are not yet equipped to deal with. It is also important to guard against catastrophe at home being precipitated by unaddressed warmup that occurred within the group. Protagonist asthmatics are particularly at risk of doing this. The damage to their social atom can be disastrous. The safety and containment of the psychodrama

stage, after considerable preparation, is the correct place for practising the expression of one's indignation, as opposed to the risky, unprepared, outside world.

I find it essential to keep these principles in mind when dealing with clients with both acute and chronic asthma.

PROCEDURE – PART 6

Management of Acute Wheezing

Equipped with the contents of this thesis and the experience of getting to this point, I work eclectically with that which emerges in the moment when dealing with the asthmatic patient or protagonist.

Sir William Osler's statement from his famous text book of Medicine (1896) I find most valuable: "The attendant must keep a calm and confident atmosphere because, no matter how distressing the attack, the outcome is never lethal." I am not totally reassured by the last phrase of this statement because he was referring to asthma one hundred years ago. In this day and age, therefore, it is wise to have the drugs, nebuliser and the peak flow metre on hand and the security of hospital admission if needed. With these safe guards I allay my own fear and address the fear of others.

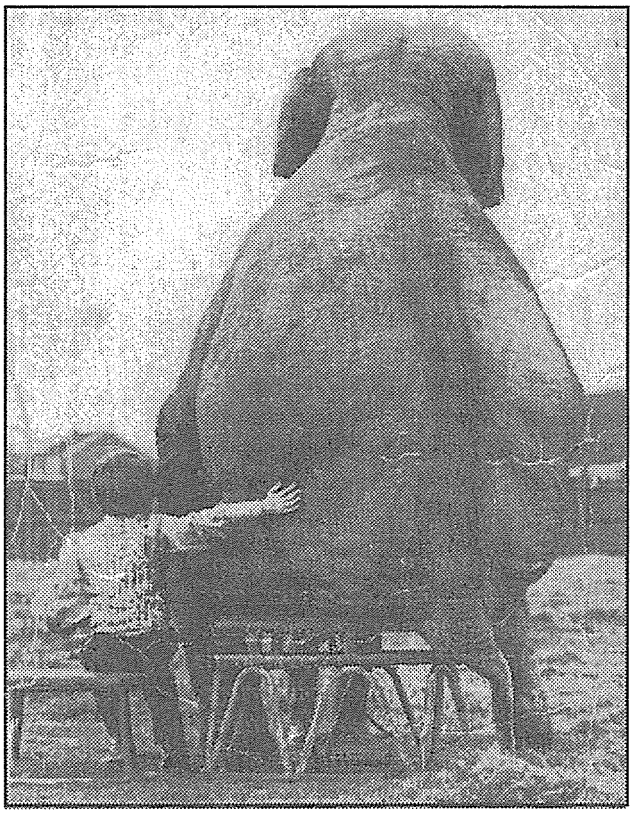


Figure 5: The Containing Double

Case study

Matty is a 9 year old friend of one of my daughters. She stayed in our home one night, along with another of my daughter's friends. I had repeatedly requested their assistance and co-operation. When this was clearly not forthcoming I exploded verbally. I saw terror in Matty's face.

Shortly after this she was on the telephone repeatedly trying to get her mother. I asked what she wanted and she replied:

"Mum said that she was coming over with my things." She looked concerned, and her eyes were reddened. She continued, in a slightly panicky tone: "I'm getting asthma and I want her to bring my puffer."

After helping (unsuccessfully) to contact her mother, I took her out

onto the verandah by herself for a short while. I sat her beside me and doubled her surreptitiously. This caused me to ask her if I had scared her. "No" she said, "It doesn't matter." and she smiled sheepishly. By that stage the other two nine year olds were out there too. I was interested in getting her adrenaline pumping. She cried a little about her mother not being available. I then asked her if she could scream as loud as I did before. She shook her head and smiled through red eyes.

"Weren't you scared of me?" I asked again.

"No I thought you looked funny." She started gesticulating with her arms emulating me in a theatrical way. "You looked as though you were conducting an orchestra!" Magically the other two children got in on the act and emulated me in the same way, amid some hilarity from all three at my expense. As much as I was her double, they were her mirrors. I believed that she did register amusement and not fear when I screamed. Nonetheless, her face said "terror" all over it, at the time. I simply deduced that her inner boundary was underdeveloped to the point that she was unable to register the necessary experience of fear, let alone stimulate an adrenal response.

Nonetheless, she was warming up to some action. I was encouraged and asked her if she could add the noise that the conductor had made. She opened her mouth and vaguely squeaked. I mirrored her. I asked the other two if they could scream as loud as I had (model). They certainly did. My ears rang and the neighbours looked up to see what I was doing to the children. Encouraged by this, Matty filled her lungs and produced a sizeable noise. This came to full volume with a little more mirroring from us all. The wheezing vanished immediately. There was lots of comment about what a good scream. She was proud of her ability to terminate her own bout of asthma.

In that interaction she experienced the full cycle. I nurtured by assisting her on the telephone without question and I doubled her. I also mirrored her. The other two mirrored, encouraged and coached her. She screamed (adrenaline mediated activity) and the other two again mirrored her magnificent efforts. Re-approachment came in the attention of the neighbours and the celebratory congratulations of all present.

Case Study

J, a colleague, recalls his last bout of asthma. He was being chased around their house by an older, larger, stronger Polynesian girl. She was angry and she was after him. He was running and he was wheezing and she was catching up. He was thinking "I'm going to have to scream. If I'm going to get out of this one, I'm going to have to scream." He screamed and that was his last attack of asthma.

For J, pure force of circumstance was sufficient an auxiliary to stimulate adrenal activity.

Case Study

A, a skiing companion, was climbing up to the mountain hut at night with his daughter and her friend. The night was cold but not stormy. The friend began wheezing. She started panicking because she had not brought her puffer. He stood in front of her and offered her reassurance. He recalled me raving on about mirroring. He did just this. As he stood in front of her he emulated her breathing with a deep feeling of empathy and connection with her

and continued to reassure her. The wheezing settled and they continued the climb up to the hut.

Annette Rose (1990) reported on the effectiveness of spontaneous drawing in achieving expression in children and resolution of the wheezing

Being present, in this way, in the moment, is sometimes effective. In the two cases where positive reassurance and mirroring were utilised, the child was outside their usual social system. This, of course, is rarely the case. Lasting change and psychodramatic principled interaction with the asthmatic child involves training and experiential education of the parents. I found the primary health care setting to be an excellent venue for this because:

- It is a setting in which a trusting client/ staff relationship exists, in which such teaching can take place.
- The frequency of visits of people to their doctor offers the opportunity for "snippet" education.
- Treatment options for asthma can be offered.
- Progress can be checked and encouragement can be offered.
- Training courses and personal development group work can be provided.

For those who didn't respond to this "first aid" treatment I refer again to Bill Roe's work of 1984. He used the hospital admission, and giving the parents the opportunity to go home for a rest, to change the social circumstance and provide essential nurturing free of the fatigue and panic from which they had come. To have this sort of backing in a future study would be an appropriate ingredient in assessing the effectiveness and appropriateness of the primary health care approach.

PROCEDURE – PART 7

The Resolution of Chronic Asthma

Chronic asthma, associated with a lifetime of drug treatment, poses a greater challenge than treating the acute intermittent untreated asthmatic. The client's circumstance is the outcome of life decision added to life decision, having been made with inadequate and skewed personal boundaries. They are surrounded by people and a society who are adapted to their behaviour and are immersed in the drug treatment paradigm. These mount layer upon layer, like the skins of an onion. Considerable resources are required, including psychodrama in groups, and patience. The journey for the client is scary, requiring courage and commitment from all concerned and with no guarantees of success in terms of cure. Unlike the new born baby that Moreno refers to who cannot re-enter the womb and is reliant on the auxiliary activity of the parents and others, the asthmatic can re-enter the womb of drug therapy and the interactional barriers within which they live. The trust relationship between client, therapist and the team is of utmost importance if the "rebirth" is to take place. The case study that follows exemplifies all this. What amazes me is not that all people don't latch on to this paradigm and go for it, but that anyone has the perspicacity to find their way through the enormity of their journey to the point of breathing freely of their own volition. Meg did.

Case study

History

At the age of three Meg and her siblings were separated from their parents and from one another. Their home was considered inadequate by social welfare. Meg found herself in a foster home with a family of older blood sons of the foster parents. This family lived on a farm. She and the other foster children were expected to work on the farm. The blood children were exempt from such duties.

Within a year she found herself in the barn with the blood sons. There she was gang raped.

At the age of five she was caught pinching food from the pantry. As a punishment she was left in the pig pen for four days with a sow and her piglets. She recalls sucking from the pig's nipples for her own sustenance.

She continued to be raped, worked on the farm and beaten, until the age of 11. It was then that she complained to the foster mother about being raped. To protect her children, the foster mother manufactured a story such that Meg was imprisoned in the Burwood Remand Home.

One morning, early in her stay there, she commented to the girl next to her about the cold and lumpy porridge. This was overheard by a warden. Her face was pushed into the porridge and she was placed in a 4ft x 4ft solitary cell with only bread and water for 4 days in order to stop her "insolence".

At the age of 14 she was transferred to Sunnyside mental institution.

She married at 16. Her husband was physically abusive. Later in her first pregnancy she was kicked and belted by him. She came into premature labour and delivered in the hallway where she had been beaten up. She divorced from this man.

After this she met the first love of her life. He was an American professor. He was studying geology. One day, the snow cat in which they were travelling dropped down a crevasse where he and his two companions remained for three days. One of the occupants, a climbing acquaintance of mine, ended up with severe frost bite of both legs but he recovered. Another lost his legs with frostbite, only to die later as host and guide on the Erebus flight. Meg's fiancée did not survive. She was pregnant to him.

Meg married and she brought up a large family of both her own and foster children. She vowed and declared that hers and her foster children were going to get the love that she never did.

She developed asthma at the age of 4. The first wheezing she remembers clearly. It happened when she had diphtheria. These are her comments:

"I wheezed and with this the doctor took more attention of me"

"It never left my subconscious because of the attention that I always got. Because, you know, that is the only attention or love that I ever got. It was quite clearly the ally and the help to get me the love and the attention that I needed."

"It (the asthma) was useful to stop the boys raping me."

"In Sunnyside I was responding to the treatment that I got as a human being. I got lots of attention when I was asthmatic."

"If I had not had asthma, would I have survived? In fact it was my saviour."

"It became a part of me like my arm or my eyesight."

Her other security was a blue velvet dress which she got when she was aged 4. When one of the Burwood wardens realised the

importance of it to her, it was permanently confiscated. It was later effectively returned to her in surplus reality in a psychodrama.

Building Resources

Meg met me when I was a physician in Thames Hospital. I do not remember her and I don't think that she was under my care. For her, there was a tele response. She declared to herself that it was with me that she was going to get well.

When I left Thames Hospital and began my practice in Sealey House, she joined the practice as a patient. She attended the first of the regular Thursday night groups that were to continue uninterrupted for 10 years. Within the practice, clientele developed their roles as auxiliaries, both in psychodrama sessions and in the functioning of their daily lives. The practice had one or two full-time volunteer auxiliaries. Meg became one of these. She joined the psychodrama training programme for which I had organised trainers to come down from Auckland. She also attended week-long training sessions.

When she registered with the practice, she was severely and chronically asthmatic. For this she was taking maximum medication including a dangerously high dosage of oral steroids. She was also arthritic and walked with the assistance of a stick. She had chronic back and hip pain. For this she was taking regular Temgesic (a potent quick and long-acting narcotic now restricted because of its addictive capacity) and she was attending the Pain Clinic.

Her personal development was fuelled by her own grim determination to hang in, her belief in herself, myself and the psychodramatic process. I will report here a few of the many dramas that she did. I believe these are crucial ones. I will also report on other aspects of her developmental process.

Resource Building Psychodramas

Her early dramas reflected overwhelmingly the role of the resigned spirit. In one, her husband sat in front of TV in the role of the Great White Chief. At the rattle of the empty cup on the saucer she would adopt the role of the Servient Squaw. Frenetically the cup would be refilled and returned to Sitting Bull whose eyes remained firmly fixed on the TV. This was conducted as a simple role training session with mirroring and modelling. She became aware of her passive role and developed a degree of self assertion. Her husband was a willing and trusting member of the team dedicated to her growth and resolution. He provided sufficient resistance to change at home to be auxiliary to the development of assertive abilities, but he was aware not to overpower her.

Together with the awareness of giving away her own space and autonomy came the realisation that she needed to develop the role of the Congruent Expresser. Even though she had the availability of the groups she was, for a long time, unable to utilise these for practising congruent expression. She feared damaging or losing the friends and trusts that she had made. Such was her upbringing, and to bite her lip was so ingrained, that it was to take years for her to have the option to let go in full indignation. Nonetheless she would go down to a favourite auxiliary, a macrocarpa tree at the end of her farm. This was far from any risk of being seen or overheard. She would give the tree a negative identity in her life, then proceed to scream at it.

In her second year of

involvement, Rex Hunton directed her in a training group. In this group she confronted her rapists, the blood sons of the foster parents. Her final statement to these people was to say "just go away, you naughty boys, and never do that again". Together with a pat on the back side. This was the best she could do in expressing herself at that time. It was clearly incomplete, but it was a beginning.

While working in the practice and in our weekly team development group, Meg became more aware of her roles containing passivity and her clandestine manipulative behaviour. She was able to do this because of the unconditional support that she experienced. During this time she was exposed to a regular and ongoing cycle of ***nurture, double, mirror and re-approachment****.*

Two years after the drama with Rex, she was protagonist in another drama. This drama was directed by Evan Sherrard and supervised by Max Clayton. In this drama she enacted the pig pen scene referred to in the history section. In surplus reality, much to our accumulated joy, she pushed the foster mother into the pig pen. In this drama she did not access the full depth of her feelings. Nonetheless the drama was a triumph. The role of the Congruent Expresser was better developed than in the rape drama.

Resolutionary Psychodrama

A year after this, however, she was attending a group that I was directing in the band hall in Thames. Her relationship with the group was firmly established. She was experiencing the unconditional love that I had for her. This was her home turf now. I, too, was well prepared and warmed to function as her director.

Warmup:

During the group warmup Meg began wheezing more severely that usual. She said that she would like to go outside for a while and get a breath of fresh air. In fact she did not declare this. She asked me ***if*** *she could go. She emulated a school child requesting to go to the toilet in class time. I responded in a way that would clear the transference by saying.*

"It is up to you what you do." To which she replied:

"I feel as though I am being confined in a small space and I need to get out"

Interview and Contracting:

I explained to her that she was welcome to go but we could, with her agreement and that of the group, explore this feeling. She agreed and this is what happened:

Action:

We concretised the small space using auxiliaries to form four walls. This turned out to be the solitary cell that she was incarcerated in Burwood Remand Home. On investigating how she came to get there we set up scene one:

The dining room at the remand home. Present were many girls sitting around a long institutional table having a breakfast of porridge. Meg was over heard whispering:

"Who would want to eat this cold lumpy stuff!"

The warden who overheard this, grabbed her hair and pushed her face into the plate. The plate was represented by a small red cushion She was then led in this grasp to the head warden's office who said:

"We'll teach you to appreciate the food around here! Four days solitary

confinement, bread and water only!!"

The group warmup was high. I had checked that Meg's connection with them was strong and available before beginning the drama. Meg was deeply regressed into the role of the 11 year old. Her emergency response for obtaining humanitarian attention, her asthma, was operating stronger that ever. She was blue with asthma. I was considering whether we should terminate the drama and administer bronchodilator drugs lest she perish.

I chose to move into surplus reality:

Director: "Are you going to let this woman throw you into solitary confinement?"

At this moment I slipped the red pillow that represented the plate of porridge into her hand. The group members responded hollering at the tops of their voices..

"Don't let her Meg!!!"

The connection happened. The build up of all the work that she had done in previous dramas. The patience of the macrocarpa tree.

She paused. She eyed the auxiliary who was playing the role of the chief warden. A group member, smelling catharsis, was removing the auxiliary's spectacles. The warden was being played by a male who was 6ft 2", in contrast to Meg's 5ft 2". The regressed 11 year old became infused with adult resources.

She took an enormous breath. Please understand that it takes about 30 seconds for blood to circulate around the body. It took this time for her to turn from blue to bright scarlet. ***What we were witnessing, I believe, was the turning on of the body's adrenal system*** *and we were about to see it in action.*

Adopting the uncompromised role of the ***Congruent Expresser*** *she screamed:*

"HELL NO"

She proceeded to overpower the auxiliary. The auxiliary work was perfect in expanding her response. In succeeding she said:

"Try some of your own porridge!" *as she rubbed the red cushion in the auxiliary's face.*

What followed was a flow of congruently expressed statements about what the warden was not aware of, and what she was doing to a little girl.

Sharing:

The sharing was rich and served as a warmup to another resolutionary drama of a sexual abuse victim.

Follow up:

Meg had achieved and was practising in psychodrama the role of the Congruent Expresser. What would happen to her in the world outside?

She became totally wheeze free. She stopped all her drugs over a period of time. Since then (over 8 years ago now) she has had only two attacks of asthma.

One occurred when she was on her first post-operative day after a major knee operation. She felt unable to express herself adequately in the Seventh Day Adventist Hospital. In this religious institution, in a small cell of her own, a junior nurse had banged the operated knee with a bed pan. The surgeon, a friend of mine, was about to call for anti-asthmatic medication when Meg asked him to close the door and pull the curtains.

"You're a friend of Peter's. You'll understand." Having set the scene for the role of the Congruent Expresser to appear. She let fly. The surgeon was somewhat bewildered, but he was also impressed with the outcome of a lady breathing freely and looking greatly relieved.

The other occasion was similar in that she was again confined in an institutional cell, another hospital room. This time she had broken her ankle and felt that she had lost control of her life. Again she was able to recognise the situation and warm herself to assertive roles, engineering early discharge for herself.

Evidence of developing personal boundaries:

Shortly after the resolutionary drama she changed her relationship with us in the team. She became a part-time auxiliary and developed her own counselling and support service for young people. She developed relationships with other services in the town and gained employment with them. I interpret this as her demonstrating her ability to usher us to a position of lesser importance in her social atom, invite others in, yet keep loving and business contact with us. She has kept in close touch as she works step by step on her social atom repair.

Case Study

More recently I presented this work at a psychodrama conference. After a 2-hour presentation of the theory in which action was utilised to demonstrate personal boundaries, an asthmatic group member came to a point of extreme emotional warmup. He did this when he gained an awareness that he had been devoid of personal boundaries as long as he can remember. I requested him to look at other group members and, as he became aware of their congruent expression of love and caring, his catharsis deepened. I asked if it was the newness of the experience that lay behind his catharsis, and on agreeing his catharsis again deepened. A group member offered to put an arm around him which he accepted and then entered a ***nurturing*** *pose akin to that of a baby. This evolved into an opening up of the two until they sat side by side. The auxiliary* ***doubled.*** *He warmed up to a childhood scene in the car with his Father smoking and ignoring his needs for clean air, especially as he was wheezing at the time.*

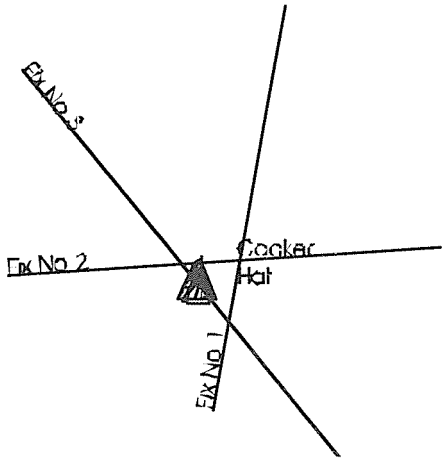
On maximising the expression of his rage the auxiliary ***mirrored****. I asked him to look at the mirror to see if what he perceived represented how he felt. He went through several cycles of rage and mirror until he was satisfied. His catharsis settled and, as he returned to be nurtured by the Auxiliary, comments of appreciation* ***(re-approachment)*** *were spontaneously expressed by other group members. Following both direct and reflective sharing (the latter at his request) he completed the group, wheeze free, and has remained wheeze free for the ensuing 6 months.*

ANALYSIS OF THEORY, EVIDENCE AND RESULTS

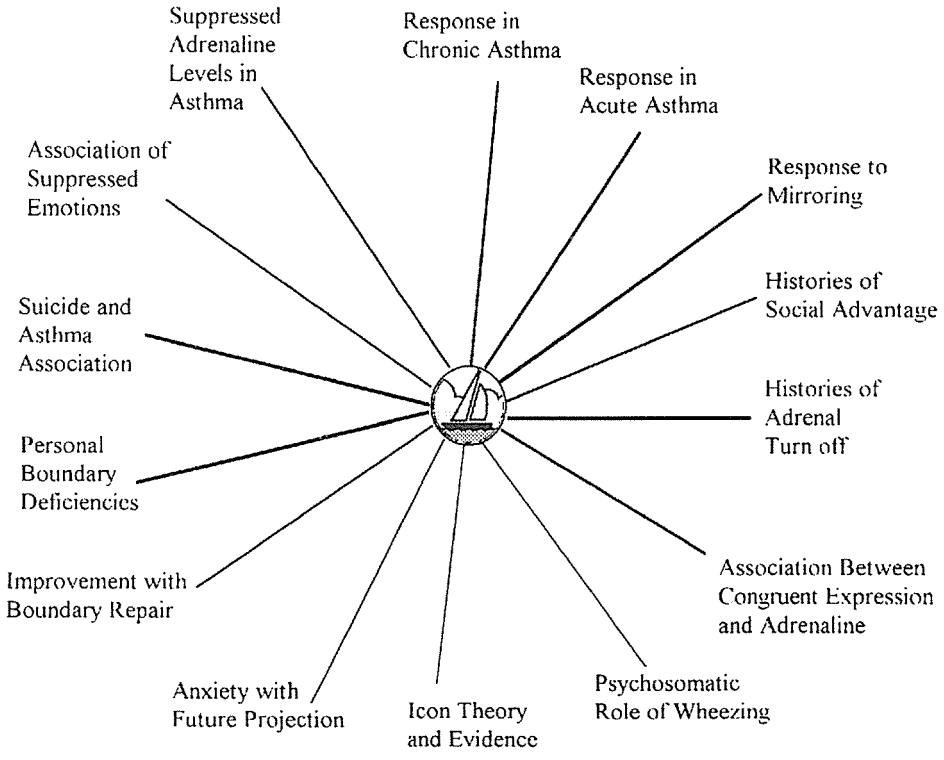
Validation of this study using standard statistical method, such as the double-blind cross-over trial, is clearly inappropriate. I have thus adopted two principles as guidelines on this journey of discovery:

- **Karl Popper's principle** that a theory can only be disproven, not proven. So far I have come across no evidence that refutes the personal boundaries/ psychodramatic paradigm.
- **Principles of nautical navigation**. In navigation a fix (compass bearing) from one land mark is only useful for plotting one's position on a chart when it is crossed by another. The "cocked hat" that comes from a

third fix gives a measure of accuracy. The higher the number of fixes the greater the accuracy. The "coin sign" states that five of the same with no misfits gains statistical significance.



This annotated nautical illustration gives an indication of how many factors support the proposed hypothesis. The number of factors exceed five for and none against making this a plausible theory worthy of further investigation and application.



CONCLUSION

In this study the purpose has been to establish what role psychodrama plays in the understanding and treatment of asthma. In so doing I have taken medical knowledge, my own clinical experience, the work of Moreno and his successors and developed and tested a theory.

I have proposed two personal boundaries which are maintained by the roles of:

- The Anxious Negotiator
- The Threatened Self Defender (Lion)
- The Fascinated Attracter
- The Welcoming Lover

In this proposal I point out that recognition, which is a basic human need, is unobtainable without these roles and a person without these will become depressed. I discuss the role of the psychodramatic mirror in providing recognition and paving the way to catharsis of integration.

I then suggest and provide anecdotal evidence, that these roles are basic to social atom development and are biomedically mediated by the hormones Adrenaline and Hydrocortisone. Analogues of these hormones are the mainstay of anti-asthma medication. I show that it is counterproductive to administer these substances as drugs when the individual is requiring auxiliaries in his/her life that will facilitate the natural production of these hormones which are basic to the spontaneity required to establish a functional social system.

I then proposed that wheezing is a psychosomatic role designed to protect the air sack within the lung. I presented anecdotal evidence which demonstates how skewed recognition is achieved by attendants diagnosing this psychosomatic role as asthma and then responding with attention, caring and often, panic. The asthma thus obtains a purpose of achieving personal recognition and is adopted as a psychosocial role. This is second-rate recognition, for the true self remains ignored. It also carries the restriction of the disease. Depression, however, eases until someone effectively treats the asthma (or threatens to do so!), then it returns, sometimes in suicidal degree. I propose and demonstrate that allergic asthma could be the psychosocial role of wheezing which has become linked to an apparently unrelated stimulus through conditioned response association.

I then provide further anecdotal evidence showing how auxiliary behaviour towards the asthmatic, in terms of mirroring and formal psychodrama, leads to personal boundary creation, social atom repair and an appropriate disappearance of the asthma. The ability to wheeze remains but the need disappears. I maintain that this is developing out of asthma which is in keeping with a psychodramatic paradigm rather than the treatment paradigm which has (as the literature so clearly indicates) failed biomedical devotees.

Included is a description of the cycle: Nurture, Double, Mirror, Re-approachment and back to Mirror. Through the nurturing of normal adrenal function, if this were a regular parenting custom, we might grow in an asthma-free society, wheezing only to keep our lungs clean rather than desperately needing to be noticed.

I thus conclude that psychodrama adds essential contributions to the understanding of asthma. Psychodramatic principles are basic to facilitating the process of developing out of the illness, as opposed to the physiological function of wheezing which is

protecting the alveoli in the lungs.

W Roe (1984) fulfilled the initial contribution of withholding drug treatment and altering the social circumstance by permitting the parents to go and have a rest. This thesis provides the other ingredient which involves teaching psychodramatic principles to the parents of asthmatic children. It also provides an action and insight process through which adults can resolve their previously unexplained dilemma of asthma.

IMPLICATIONS

- **For Students and Readers who are Psychodramatists**

This thesis expands the horizons of psychodrama beyond the world of psychotherapy into the world of physical illness and holistic health. It creates a link between asthma, depression and other dysfunctional states. The role of the mirror, the double and formal psychodrama become part of basic health care, such that students of psychodrama have a place in primary and secondary health care teams dealing with asthma, depression and other related conditions.

- **For Medical Colleagues**

We must hesitate and consider the wider implications and the evidence in the literature before prescribing hormone analogues for asthma. With the information contained in this thesis, the physician and GP are both in a position to facilitate the patient to make an informed decision regarding their treatment regime, rather than being placed on a prescribed asthma plan, which lacks the scientific backing of the knowledge of the untreated condition.

We should also look at the wider social environment and gear our practices towards being able to address the social issues that might well lead to diminution and/or resolution of asthma. Psychodrama becomes a basic element of primary health care training and service provision.

- **For Patients**

Firstly to know that if you are on anti-asthmatic medication, do not precipitously stop it, especially without supervision. This could prove fatal.

If you or your child has not started anti-asthmatic medication, there is an argument for not taking medication. Furthermore, there is the knowledge that it is possible to develop out of asthma and that the content of this work may provide a structured approach.

- **For Parenting Education**

A controlled trial is indicated in which the education and role training of parents in the cycle of nurture, double, mirror and re-approachment, and the understanding and implementation of personal boundary development, is assessed with respect to the incidence of asthma, suicide and other dysfunctional conditions.

- **For Research**

That it is well overdue to perform a study of the natural history of asthma. No treatment of any condition has any validity without this knowledge. Once such a study is done then a rational approach to researching the appropriate forms of therapeutic interaction can be designed.

Researching this approach would require properly set up, integrated primary health care units such as was prototyped in my practice at Sealey House in Thames.

- **Funding Bodies**

Those bodies funding the health of the public are now in a position to review the $33,000,000 that is spent annually (on drug therapy alone) for every million of a country's population (NZ figures 1994). Might not a portion of this be wisely spent on assessing the efficacy of this treatment and comparing that with interventions based on the psychodramatic principle of the auxiliary and social atom repair and development, in the hope that not only might the asthma morbidity and mortality improve but so too might the value of family life?

- **Asthma Societies**

Rather than promoting a one-strategy "party line" approach to the management of the asthmatic, it could well be more beneficial to adopt alternative approaches to such a perplexing problem.

I am of the opinion that there is now a need to gather together the health professionals who deal with asthma in an atmosphere of non-competitiveness. The purpose: to present our work and our views and to assimilate, as fully as we can, the views of others. >From that point it could well be possible to evolve the steps that need to be taken to do what is correct and appropriate to research and rationalise the approach to this condition.

REFERENCES

Aldrich T B, "A Preliminary Report on the Active Principle of the Suprarenal Gland", AM J Physiol,(1901), V, pp 475-461.

Beasley, Richard, Kathryn Smith, Neil Pearce, Julian Crane, Carl Burgess and Christine Culling, "Trends in asthma mortality in New Zealand, 1908-1986", The Medical Journal of Australia, (1990), June 4, Vol. l, p 521.

Booth R J, Asbridge K R, "Teleological Coherence and Harmony of Purpose: A Way of Looking at the Relationship Between Psyche and the Immune System", Teleological Coherence-Advances, (1992), October, pp 1-19.

Braun B G, " Psychophysiological Phenomena in Multiple Personality Disorder and Hypnosis", Am J Clin Hypnosis, (1983), 26, pp 124-137.

Clark N M, Gotsch A, Rosenstock I R, Review Article: "Patient, Professional and Public Education on Behavioural Aspects of Asthma: A review of strategies for change and needed research", J Asthma, (1993), 30(4), pp 241-256.

Clarke Paul S, Gibson Juliet R, "Asthma Hyperventilation and Emotion", Aust. Fam. Physician, (1980), Vol 8, Oct, pp 715-719.

Clarkson P, "A Multiplicity of Psychotherapeutic Relationships", Brit. J. Psychotherapy, (1990), 7,2, pp 148-163.

Lerher PM, Isenberg S, and Hochron SM, "Asthma and Emotion: A Review", J. Asthma, (1993) 30 (1), pp 5-21.

McQueen E G, "The Prevalence of Asthma", NZMJ, (1995), October 27th, (108), p 443.

Moreno J L, "Who Shall Survive?, Foundations of Sociometry, Group Psychotherapy and Sociodrama", Beacon House, (1953), pp 336- 337.

Parkinson P I. (1) "The Asthma Mortality Epidemic", (1995), NZMJ, June 14th, (108), pp 233-

234.

Parkinson P I, (2) "Physiological Wheezing", (1995), NZMJ, 22nd Sept. (108), p 392.

Puthenpadath L, " Looking Glasses", NZAP Newsletter, (1995), Sept, pp 17-20.

Roe W, "Science in the Practice of Medicine: Its Limitations and Dangers as Exemplified by a Study of the Natural History of Acute Bronchial Asthma in Children", Perspectives in Biology and Medicine, (1984), 27(3), pp 386-400.

Rose Annette, "Life Drawings", Women's Script, (1990), Spring, pp 14-16.

Taggart P, Parkinson P, and Carruthers M, "Cardiac Responses to Thermal, Physical and Emotional stress", BMJ , (1972) ,3, pp 71-76.

Wind P, Carson R C, Brown M J, Barnes P J: "Circulating Catecholamines in Acute Asthma", BMJ, (1985), Jan 26, 290, pp 267-269.

BIBLIOGRAPHY

Bandler R, and Grinder J, Frogs Into Princes, Publ. Utah: Real People Press (1979).

Clayton G M, Directing Psychodrama, A Training Companion, Caulfield, Victoria: ICA Press, (1991).

Chappell J, The Black Void, Psychodrama Thesis, Australia and New Zealand Psychodrama Association, Melbourne: ANZPA Press, (1990).

Moreno J L, Who Shall Survive? Foundations of Sociometry, Group Psychotherapy and Sociodrama, Beacon, New York: Beacon House, (1953).

APPENDIX 1

Suicide depression and asthma go hand in hand

Rosie's story is the first of three where I picked up the idea that removal of the asthma, or the offer to do so, is perceived more as a threat than a promise or an offer. At certain crucial times, one ill-considered comment appeared to be enough to take the person close to death. I talked about this with Rex Hunton. He too had noticed the same thing. That is, to offer a cure for asthma brought on deep depression and suicidal attempts.

In Nelson, where Bill Roe (1984) did his study, there were asthmatic deaths in children. They were not in hospital when they died. All were receiving medications at the time of their death. Before he died, Bill left me with this astounding bit of information. He said ...

"I interviewed the parents of each of these children and each one of these kids left a will. The will was usually verbal and to friends and family. Like –You can have my bike etc".

This prior knowledge of their own deaths and its apparently calm acceptance is part of the jigsaw puzzle of the genesis of asthma. It must be taken into account, along with the information that both Rex and I have accrued.

Making friends

An important shift was beginning to happen. It took dynamite-like upheavals to shift me. But following those I began to move from the Dedicated Curer, to the appreciator of my client and a valuer of the space between us.

Case Study

I became a little aware of this in my relationship with an asthmatic person who attended the nurses' clinic. Nonetheless, the skills of creating a trusting therapeutic relationship eluded me.

I liked her and the feeling was reciprocated. The doctor/patient relationship was sound. Into this was being built a level of the I/thou relationship (Clarkson 1990). I saw her frequently in the clinic. The energy that I felt towards her I channelled into listening and encouraging her to take sufficient time to care for herself. This is where our relationship hit a brick wall.

"Wait until you are well before you go back to work" was my instruction with my feet firmly planted in the role of the Didactic Adviser.

The next time I saw her I was keen to know how she got on.

Client: "I only needed a day off".(Self defensive placater)

Doctor: "And were you well?" (Friendly Spanish Inquisition)

Client: "Oh, I was eager to go to work."(Nimble Crab)

As it turned out, from questioning her and from spontaneous comments from her workmates and boss, that she was not well and really only just able to get through the day.

Client: "I'm scared that they will think that I'm just taking time off." (Self Deprecating Placater)

I suggested that I talk to them.(Non-insightful Helper)

Client "No, don't do that."(Threatened Subordinate)

By this time something in the space between us was getting quite tense. I felt I was breaking some unspoken rules. Nonetheless, I was filled with missionary zeal and said (lets face it, she repeated this behaviour several times and I was getting frustrated):

"How can I care for you if you don't care for yourself ? It's like trying to fill a bath without a plug in it!" (You fit my pattern or I'll kill you role.)

That did it. She never returned to the nurses' clinic. I assume she sought her medical advice elsewhere. Unless of course, what I said did the trick. I may never know.

When I began my general practice in Thames, I spent a month or so repeating this pattern. Patients were taking their notes and leaving. It took a fairly hostile receptionist, who was worried about the practice closing, to stop me in my tracks. The role of the Enthusiastic Journeyman needed tempering with a little common sense. Nonetheless, it was the Journeyman that was causing me to break new ground.

It took time but I was beginning to learn how to be friends with my patient without colluding in their pathological process. I was beginning to become aware of their deeper and hidden agenda.

APPENDIX 2

Additional case studies verifying the development of the role the Expedient Inactivist

Case Study

Grant is very clear about why he learned to turn off his outrage. His mother actually caught him with the axe raised ready to have it descend on his father's head. Sort of, literally, "Burying the hatchet".

Grant was not exposed to much in the way of listening. One day I was treated to the tale of his childhood when he felt rotten with the flu. Mum did not want to know

about his illness. Dad said "to hell with you, you are going to school."

At school the class was taken to the Whitianga Wharf and told to swim across to Ferry Landing.

"If your parents think you are fit enough to go to school then you're fit enough to swim" said his teacher. This is a swim of several hundred metres across the harbour mouth where a strong current flows. Grant did not feel up to it. The teacher disagreed and threw him bodily into the water. The water was muddy and Grant dived deep and swam. He went as long as his lungs would allow him, back, beneath the wharf. The plan had worked so far. He could see the concerned teacher's backside as he looked into the murky waters for the vanished Grant.

Grant climbed up the ladder at the back of the wharf and approached, from behind. Grant concentrated the full effort of his adrenal gland on the tip of his toe. The man was briefly levitated over the edge of the wharf as Grant's toe embedded itself in the teacher's buttock, who took his own dip in the swirling waters of the rising tide.

When they caught up with Grant he was caned by the teacher, thumped by his Dad and expelled from the school.

Even though his adrenally-motivated creative genius produced a crafty, retaliatory role it got him into deep water and didn't look after his interests. This was an isolated incident, but on further questioning there were many other times which ensured that it was wiser for him to tone down his anger, and his response, to the infuriating things that confronted him day by day.

Many asthmatics that I have talked with have learned from watching their parents' behaviour that there is no place for anger. For example:

" Dad arrives home drunk, gets upset by mum when she says 'You always arrive home drunk!' Dad gets angry and proceeds to beat mum up. "As a child I learned that there is no place for anger in this world."

On asking "have you ever seen an argument have a useful outcome?" the answer is usually "no, that just doesn't exist".

Childhood rape and incest, with disbelief from the other parent, was also common.

APPENDIX 3

Maori Spiritual Healing

Maoridom has a traditional holistic system of healing which I understand in this way:

There are a number of factors that, when combined in a state of balance, give rise to the life force, which is called the **Mauri**. This force encompasses the principles of existence, being, energy force and indestructibility. The factors involved are:

Te Taha:	*Matters pertaining to:*
• **Whakapapa**:	Ancestry
• **Wairua**:	The Spirit
• **Hinengaro**:	The Emotions
• **Tinana**:	The Body
• **Whenua**:	The Land
• **Whanau**:	The Family

The balance of these, once achieved, is entitled **Tapu,** and it is from this sacred balance that the **Mauri** emerges.

When a creative union occurs between two who have achieved **Tapu** the union of each one's **Mauri** is seen as the coming together of the earth and the sky. The subsequent explosion of creative energy is referred to as the **Ihi**. The magnificence of this moment creates

a feeling of awesomeness to the beholder and this experience is the **Wehi**.

The inability to achieve **Tapu** leads to illness and dysfunction.

For this knowledge I am indebted to Ms Betty Williams of Huora Te Awhina, Manaia, and her elders. I take personal responsibility for any inaccuracies or embellishments.