

A MODEL FOR CONJOINT GROUP THERAPY FOR ASTHMATIC CHILDREN AND THEIR PARENTS

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INTRODUCTION

The purpose of this paper is to describe the development of a model for the treatment of the asthmatic child and of his parents in separate concurrent psychotherapy groups, and report on the initial success of this model at Cook County Hospital, Chicago, Illinois.¹

Bronchial asthma is a complex syndrome of the respiratory system that is considered to have a psychosomatic component. Although numerous precipitants have been identified, and numerous symptoms have been described, the relative contribution of physical and psychological factors is unknown. It is necessary, therefore, to study the effects of both pharmacological and psychological treatments.

PSYCHOLOGICAL INTERVENTIONS WITH ASTHMATICS

The importance of psychological variables in the incidence of asthma has been well documented (Luparello et al., 1968; Purcell et al., 1969; Weiss et al., 1970). A recent study (Hock et al., 1977) showed that psychological interventions provided in conjunction with medical management were beneficial to asthmatic boys when compared to patients who received medical management alone.

The patients in that study were 43 asthmatic males who were referred by the allergy staff to participate in research on the effects of combined psychological and medical treatment. The age range was 10 to 17 years of age, with a mean of 12.6. The patients were randomly assigned to one of

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three psychological treatment conditions or two control groups. They were treated in an outpatient clinic for eight weekly training sessions and observed again at one month post treatment to determine if the treatment effects still remained at that time. All of the patients continued to receive medical treatment throughout the program. The psychological treatments were relaxation training, (N=9), assertive training, (N=9), and combined relaxation plus assertive training, (N=10).

This study found that, 1) relaxation training significantly improved the asthmatic child's respiratory functioning and reduced the frequency of his asthmatic attacks, 2) combined relaxation plus assertive training was also effective in improving respiratory functioning and reducing asthmatic attacks, 3) assertive training by itself failed to improve respiratory functioning and showed a tendency to increase asthma attacks.

METHOD

The present program utilized the findings from the earlier research to develop a model that would use the best elements from that study and combine them with a parental treatment element in order to maximize their benefits. This rationale is based upon Lazarus' (1971) notion that effective psychological components should be added together in a multi-modal approach for maximum therapeutic effect. Such an approach requires that a number of treatments be combined to form the most effective composite treatment package. The goal of this program was to enhance the psychosocial functioning of the asthmatic child, and facilitate improved parent-child relationships in his home, in the expectation that this would raise the threshold for asthmatic symptomatology.

The model used a relaxation plus assertive training base since the previous research had shown a trend for assertive training to enhance the effects of relaxation training after therapy stopped (Hock et al., 1977).

There were 14 male asthmatics referred to this program because they exhibited distinct psychological problems, because they had been slow to show improvement in previous treatment, or because their parents had requested psychological help. Eleven of the 14 families referred continued to the completion of this program.

The next element added to the model was group psychotherapy for the children's parents. This was added to insure that the gains made by the children were reinforced at home, and to provide the parents with the opportunity to concurrently work on parental conflicts that could exacerbate their child's asthmatic condition. Family therapy had been considered for this program; however, too few fathers were available in our population to

make family treatment a viable alternative. Consequently, conjoint child groups and parent groups were selected for the treatment model.

Childrens Groups: Relaxation training and assertive exercises were combined in the same session. Free discussion was permitted when it facilitated affective expression, problem solving, or positive behavioral change. The initial phase of the group was highly structured. A modified form of relaxation was used that required about 30 minutes. Each child sat upright in a comfortable chair and was trained to alternately tense then relax large voluntary muscles, (e.g. hands, arms, feet, legs, face, chest, biceps, triceps, shoulders, and abdominals). After the major body groups were relaxed, guided imagery was used to create images of comfort and relaxation (e.g., resting on a beach, watching sailboats, and feeling breezes and sunshine). The guided imagery was intended to generalize relaxation from musculature to increasing areas of physiological activity, particularly respiration. Assertive exercises were regularly used whenever thought to be appropriate. Behavioral rehearsal of skills, like making eye contact, initiating conversations and meeting strangers, was used whenever these topics occurred during the meetings.

In the last portion of the sessions, structured games were employed to encourage trust and sharing. "What gripes me" is an example of these games wherein kids can freely complain about anything that comes to their mind. Another game called "Trust" directs the group to cooperatively lift one another. This exercise is designed to evoke feelings and discussions about trust. In another game, the boys drew names at random and gave one another positive feedback about what they liked about one another. The initial reaction to these games was to play them repeatedly.

During the middle phase of the groups, there was a transition to greater open-ended discussion. On some occasions the therapists utilized information from the "game" phase to initiate discussion. Free discussion was rarely spontaneous, and the children frequently resorted to previous games or exercises when they were uncomfortable. Interpersonal conflicts within the group were the first major topics to emerge. The boys were encouraged to examine their own roles within the group on these instances and express their own feelings and opinions to the group. The boys were urged to accept responsibility for their own behavior when these conflicts arose. They repeatedly explored their reactions to one another, their feelings of anger, and alternative methods of behaving when they become angry. This occurred, however, after months of meetings and testing the acceptability of expressing anger.

The final phase in the group involved termination. The phase was necessitated when funds for the program were depleted and the groups had to be

concluded. This aroused separation anxiety and temporarily increased asthmatic symptoms in some instances. Sadness was also present but less frequently expressed. Fortunately, there were several months available to work on these issues.

Eleven boys from a total of 14 referred by the allergy staff completed this program. All eleven participated for a minimum of nine months with those who began earliest participating for one year.

Parents Groups: Parallel therapy groups were conducted for one or both of the children's parents. These groups met at the same time as the children's group with a separate therapist. The groups were less structured than the boys' groups with open-ended discussion from the beginning. The focus was described as an opportunity to work on the behavioral aspects of their child's difficulties and discuss their own problems as well. The initial discussions centered around parental concerns with having an asthmatic child, taking medication, etc. Eventually, child management and attitudes about children became the topic of conversation. Finally, after several months, the discussions turned to the parents interpersonal and intrapersonal concerns and the conflicts the members felt in their own lives, marriages and relationships. At least one parent or surrogate parent from each of the eleven families participated regularly. This was generally the mother since only four fathers were seen during our entire program and none of the fathers came on a regular basis. Father absence or unavailability was a frequent observation with our asthmatic boys.

The parents' group was kept informed of the major direction of the children's group but specific content was not discussed in order to assure the children's confidentiality. Once the parents' group began to focus upon the problems of its own members, there was less interest in the content of the children's group.

Regular supervisory meetings were kept weekly with both the parent and child group therapists to clarify the issues being raised and maintain an understanding of the parallel development of the parent and child group treatment.

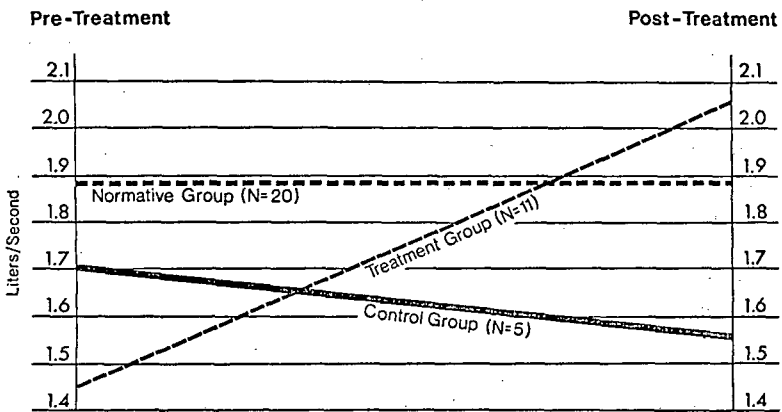
Dependent Measures: Pulmonary functioning was accepted as the primary criterion of improvement for this study. Cook County Hospital is a general medical hospital and the reduction in asthmatic symptomatology was the first goal of the therapy. An objective pulmonary index, Forced Expiratory Volume/First Second (FEV_1) was selected as the measure to monitor the child's respiration and allow for an evaluation of the course of his treatment. FEV_1 is a measure of the total amount of air a person can exhale in one second.

FINDINGS

An examination of the FEV₁ scores found that all eleven boys showed marked improvement in pulmonary functioning from a pre-score to the end of treatment. The mean FEV₁ for the treated patients was 1.479 liters per second with a S.D. of .664 prior to treatment. This score increased to 2.055 liters per second by the end of treatment for a .576 liter increase.

This program was set up from the beginning as a treatment program and not a formal experiment with a group comparison design.

Figure 1.
Conjoint Group Psychotherapy Treatment 1 year



However, data was available from five boys who could serve as control patients. Three of these five boys showed increased FEV₁ values while two showed decreases. Their mean FEV₁ score at pre-treatment was 1.701 liters per second with a S.D. of .352. At post treatment measurements this score was 1.543 liters per second for a net change of $-.16$ liters.

A paired *t* test shows that the change in the means of the treated patients is statistically significant ($t=4.58$, $df=10$, $p<.01$), while the *t* test for the control patients is not significant ($t=.96$, $df=4$, N.S.).

For comparative purposes the FEV₁ scores of 20 patients with non-respiratory diagnoses were obtained from the Pediatric Hospital. These children were patients who did not have asthma or any respiratory diagnoses and were of the same sex, age, and socio-economic status as our treated patients. (Their FEV₁ mean of 1.889 liters/second provides an FEV₁ norm against the treated patients are compared).

An examination of these data shows that the treated patients begin below the control patients initially, and are performing as well respiratorily as

the normative patients at the end of treatment, while the control patients make no improvement respiratorily during the duration of the treatment program. (See Figure 1)

CONCLUSIONS

A model for parallel group psychotherapy for asthmatic boys and their parents is proposed from conclusions based upon both research and clinical experience. The approach includes structured children's groups that combine formal relaxation training and assertive exercises with open-ended discussion emphasizing identification of feelings, expression of positive and negative feelings, and practice in self-assertion.

Parallel parental groups are established to reinforce gains made by the children, provide an opportunity to resolve parent-child conflicts, and reduce parental problems.

The initial application of this model in a one year program found that the respiratory function of eleven asthmatic male participants increased significantly by about $\frac{1}{2}$ liter of air per second while five medical control patients showed no significant changes in respiration during the same period of time.

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