Summer 6-30-1960

Maternal Attitudes Associated with the Development of Bronchial Asthma in Children with Atopic Dermatitis

Fayek Latif Nakhla
University of Colorado Boulder

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MATERNAL ATTITUDES ASSOCIATED WITH THE DEVELOPMENT OF BRONCHIAL ASTHMA IN CHILDREN WITH ATOPIC DERMATITIS

by

Fayek Latif Nakhla

M. B., B. Ch., University of Cairo, 1956

A thesis submitted to the Faculty of the Graduate School of the University of Colorado in partial fulfillment of the requirements of the degree

Master of Science

Department of Psychiatry

1960
This Thesis for the M.S. degree by
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has been approved for the
Department of
Psychiatry
by

[Signatures]

Date June 30, 1960
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Maternal Attitudes Associated with the Development of Bronchial Asthma in Children with Atopic Dermatitis

Thesis directed by Associate Professor Brandt Steele

The point of departure of the study is the observation that over fifty per cent of cases of infantile eczema develop asthma in the majority of cases by four years of age. It would be of great clinical value to be able to more skillfully predict the development of asthma in cases of atopic dermatitis. It was hypothesized that the mother of the asthmatic child, as compared to the mother of the non-asthmatic child, would show significant differences in her relationship to the child on five specific variables, including dependency, autonomy, aggression, rejection and affection.

The subjects of the study are the mothers of ten children, all of whom have a history of infantile eczema. Five of the children developed bronchial asthma before the age of five years and the remaining five are non-asthmatic. Structured interviews with each mother comprised the basic data. These interviews were independently rated for each of the five variables by two judges. Inter-rater reliability was adequate. Mothers of the asthmatic children were found to be more rejecting than the mothers of the non-asthmatic children to a statistically significant degree.
No significant differences were found between the two groups on the other four variables. The results of this study support the theory of maternal rejection in asthma which has been reported by several observers. The author recommends that a team approach between pediatrician, allergist and psychiatrist can be of value in predicting and preventing the development of asthma in cases of atopic dermatitis.

This abstract of about 250 words is approved as to form and content. I recommend its publication.

Signed

[Signature]

Instructor in charge of dissertation
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INTRODUCTION AND REVIEW OF LITERATURE

Asthma continues to be, in spite of its widespread prevalence and its recognition since earliest times, a subject of medical controversy. The area of greatest dispute exists in its etiological concepts.

Hippocrates recognized the importance of the emotional factor in the precipitation of asthma. He advised the asthmatic to guard himself against anger. Van Helmont (1), in 1650, introduced the concept of nervous or spasmodic asthma. Thomas Willis (2), in 1685, stated, "Medicines wont to be given in hysterick passions are also proper in convulsive asthma." Floyer (3), in 1685, appears to be the first to attribute asthma to contraction of the bronchial musculature. Bree (4), in 1800, described the role of emotions in asthma. "The passions of the mind may excite a paroxysm (of asthma) or strengthen the predisposition to it." Henry Salter (5), in 1860, drew attention to the heredity factor. He also wrote that he considered "that asthma is essentially and with perhaps the exception of a single class of cases, exclusively a nervous disease, that the nervous system is the seat of pathological condition." Cruschman (6), in 1882, attributed an exudative diathesis as the cause of asthma.

It is obvious that the earlier observers emphasized the presence of an emotional factor in the etiology of asthma. Meltzer (7),
in 1910, postulated an allergic basis for asthma. With the advancement of knowledge in the field of allergy, the role of the allergic factors in the causation of asthma has been the dominant one.

E. Wittkower (8), in 1935, discusses the literature mainly from the viewpoint of the relation of allergic and psychic factors and of somato-therapy and psychotherapy. His conclusions about a concept of the psychogenesis of asthma are:

(1) An allergic genesis of asthma without neurotic component is certainly true in many asthma cases (example of the asthma epidemic with known exciting factor shown by Frugoni).

(2) A purely psychological conditioning without somatic predisposition is possible, in some cases even probable, but unproved.

(3) The large majority of asthma cases have a twofold causation: either that, with allergic predisposition, psychological factors actuate the latent disposition for the disease and make it apparent, or that asthma of an allergic origin is embodied in a neurotic superstructure by secondary psychological overlay.

In recent years, a number of theories have been put forward regarding the nature of the psychogenic factor in asthma. Even though it is generally accepted that emotional factors do play a part, their extent and exact role is still quite uncertain. French (10) points out that as most asthma patients are hypersensitive to certain asthmagenic substances which may be so widely distributed or so numerous, that

---

1 Dunbar (9) comments, "Anyone familiar with the literature on asthma, where the mechanism of imitation is so often stressed, would think immediately of the possibility of a 'psychic epidemic.'"
excluding the possibility of an allergen being the cause of an asthmatic attack may often be impossible.

The multiplicity of etiological factors in bronchial asthma and their complex relationship has been stressed by many recent investigators. D. A. Williams et al. (11) state:

There is, however, a general acceptance that there is no one etiological factor but that allergic, infective and psychological factors all play a part. The relative importance of these factors is, however, far from clear and may indeed vary from one district to another depending on climate and other factors.

Linford Rees (12) concludes that:

The etiology of asthma may be considered as a field in which a large number of interdependent causative factors, both in the organism, and in the environment, exist and interact. Allergic, infective, psychological, and endocrinological influences may be interdependent and have antagonistic, or additive, or even synergic actions. Again all these causative forces may be influenced by environmental stimuli which may be either non-specific in their precipitating influences, or specific, e.g. an allergen to which the organism is sensitive. In these interactions, neurohumoral influences may play an important role.

Nature of Emotional Factors in Bronchial Asthma

The first significant study attempting to investigate the specific nature of the emotional factors involved in bronchial asthma, is that of French and Alexander (10). These authors presented the theory that the main psychogenic problem in bronchial asthma is fear of estrangement from mother and inhibition of crying.
Dennis Leigh (13) points out how influential the Chicago study has been on subsequent American work. He states, however, that, "As a study in speculation it is admirable, but unfortunately few real facts emerge. Nonetheless, the central themes have appeared as accepted fact in later publications."

Prior to the work of French and Alexander, few investigators had attempted to unravel the possible specific mental mechanisms involved in the etiology of bronchial asthma. However, Wittkower (8) in 1935, in a review of the literature, wrote:

According to the analytic conception, asthma, as are all other neuroses, is based on an ego- and libido- conflict; as the ultimate cause, difficulties in detachment from the mother, and a protest against it, have been maintained in analytical quarters in the special case of asthma (Kronfeld).

French (10), referring to a paper by Federn (14) in 1913 about a case of bronchial asthma, wrote:

Asthma occurred for the first time after separation from the mother and seemed to be precipitated by the frustration of erotic or ambitious wishes. The asthma seemed to be associated with a particular mood in which the patient felt like an unhappy and abandoned child. Federn compares this mood to the attitude of a child who is impelled to seek help by shrieking and wailing.

Eduardo Weiss (15), in 1922, upon the basis of an analysis of an adult male asthmatic, concluded that the asthma attacks develop as a reaction to a fear of separation from the mother. He compared the asthma attack to "...the shrieking, helplessly sprawling, newborn child with blood-red swollen face..." He likened the asthma attack to
the anxiety experienced by the infant as a result of separation from
the mother at birth. Weiss' patient's life was characterized by a
very dependent relationship to his mother and mother-substitutes.
His fear of maternal rejection originated with his inability during
his childhood years to express his sexual impulses because of the
mother's extreme intolerance of any sexual interest on his part and
a prying curiosity into his affairs.

Rogerson, Hardcastle and Duguid (16), in 1935, published a
report of a study of the asthma-eczema-prurigo syndrome in children
and its relationship to emotions. It was found that certain personality
traits occurred with unusual frequency in the 23 children studied.
The characteristics described were marked over-anxiety, lack of
self-confidence, considerable latent aggressiveness and egocentricity.
It was also found that the parents were over-anxious and over-protective
(in seventeen out of 23 cases). This over-protection in a number of
instances resulted from the fact that the child was fundamentally
unwanted. The excessive concern was an attempt to overcome the
feelings of guilt produced by the real rejecting attitude toward the
child. They found the parental attitude pathological to such an extent,
and the resulting conflict over dependency on the mother so severe,
that these children could have been primarily referred for their
emotional problems.
In the earlier part of this study, Rogerson (17) observed that many cases of intractible asthma-eczema-prurigo improved or became free of symptoms while in a convalescent home, but relapsed when they returned to their own homes. This was attributed to psychological factors as no allergic basis was found.

In the treatment of these children, emphasis was placed on encouraging the child to separate himself from the mother's over-solicitous attitude and to take the initiative and responsibility for his own behavior. Facilitating a diminution of the child's anxiety when separated from his mother was also emphasized. Attempts were made to change the parents' over-protective attitude into a more permissive one. Treatment results were significant. In a series of 25 cases, ten became symptom-free and eight improved.

The most detailed psychological investigation of bronchial asthma is that of French, Alexander et al. (10). In this study, the material obtained from the analyses of sixteen adult patients and eleven children were evaluated to determine whether the emotional conflicts and personality structure in these patients showed any common features and to find if any correlation existed between these factors and the precipitation of asthmatic attacks.

They observed that the patients varied considerably both in their personality traits and in their presenting emotional difficulties. They noticed that an asthmatic attack would often occur in reaction to
the danger of separation from the mother or loss of her love. The situations which brought this on were either the possibility of actual separation from the mother, or more frequently a temptation situation in which forbidden impulses of which the mother disapproved threatened to break through and result in withdrawal of mother's love. The repressed impulses most frequently threatening the patient were sexual ones. Other unacceptable impulses were those hostile to the mother or urges of independence. French believes that throughout the lives of patients subject to psychogenic asthmatic attacks there seems to be a continuous undercurrent, more or less deeply repressed, of fear of estrangement from the mother. This might occur in an actual life situation, in a dream, or in relationship to the physician, a mother figure.

The patients utilized varied defense mechanisms to protect against the underlying conflict during the asthma-free periods. The variation in defense mechanisms accounted for the great variation in the superficial clinical picture presented by the patients. Most common were those attempting to seek reconciliation with the mother, such as confession of the unacceptable impulses. French repeatedly found that these patients would become blocked at the point where their unconscious wishes were leading them to make a confession. They would be afraid to confess and instead develop an asthmatic attack. Many of the patients were particularly "good" children,
attempting to assure themselves of mother's love. Others used various rationalizations which were acceptable to the parents. Still others used physical suffering as a means of gaining the parents' sympathy. Another group of defense mechanisms, in sharp contrast to the first, is the attempt to master a traumatic event by its active repetition. Through aggressive behavior a number of children sought reassurance that mother would not reject them. The third group of defenses were attempts on the part of the patient to withdraw from the temptation situation. This was done by an attempt to become independent of the mother or withdraw into a protection situation. The latter was exhibited in the unusually large proportion of symbolic intra-uterine fantasies in the patients' dreams.

It was noted that there seemed to be an intimate relationship between asthma and crying. They suggested that the asthma attack is an equivalent of a repressed and inhibited cry of anxiety or rage. It was of particular interest that during analysis, crying caused the cessation of the asthmatic attack.

French (10), discussing a case of bronchial asthma reported by Hansen (18) in 1930, stated:

A particularly thoroughly studied case of Hansen's parallels our own observations very closely and illustrates a point which we have found exceedingly important—the asthma patient's extreme sensitiveness to any danger of enstrangement from the parents and the precipitation of asthma attacks whenever the patient is unable to relieve this tension by the confession of the forbidden impulses.
Mohr, Gerard and Ross (10), in their summary of the psychoanalytic study of asthmatic children, found that the mothers of these children showed certain character traits and attitudes with remarkable uniformity. They were described as being highly narcissistic women who were ambitious for themselves and their children. They were not maternal women and had ambivalent or rejecting attitudes toward their children. Positive attitudes toward the child seemed to serve a narcissistic gratification.

Since the publication of French and Alexander's monograph (10) in which Margaret Gerard was a collaborator, she (19) has published additional data on another five asthmatic children treated psychoanalytically. All of them presented conflicts similar to those found in the Chicago Institute study. They all showed an exaggerated fear of separation from the mother. Marked maternal rejection was present in all cases from an early age. Because of the therapist's accepting attitude, the patients were able to become more independent and give up their infantile dependency needs. As a result of treatment, asthmatic attacks ceased in four of the children. The fifth child improved but had already developed secondary body changes evidenced in a barrel chest.

Miller and Baruch (20) investigated the incidence of maternal rejection in a group of 63 clinically allergic children, 37 of whom suffered from bronchial asthma, and a control group of 37 non-allergic
children. They found a highly significant statistical difference in that 98 per cent of the allergic children had rejecting mothers compared to 24 per cent in the non-allergy group.

Jessner et al. (21) studied a group of 28 asthmatic children and their mothers, and investigated the meaning of closeness and separation of the child from his mother. They found that the child had a striking need to be close to the mother. This was manifested in a number of ways both in outward behavior and fantasy. The strong wish for closeness and protection was also seen as dangerous and restricting to the child's independence and growth. The mother of the asthmatic child also often showed an unconscious wish to keep the child close in an infantile dependent attachment, yet rejected the child in other ways. They observed that some mothers on the surface reject their asthmatic children and appear to fit into the concept of rejection suggested by Miller and Baruch. They felt that this was only one aspect of a complex relationship.

The source of the mother's need to be close to the asthmatic child stemmed from unresolved childhood conflicts. Frequently the mother had an unsatisfactory relationship with her own mother and her conflict about dependency on a mother-substitute continued. Several of the mothers transferred their infantile attachment to a mother figure. "With the child they repeat the symbiotic relationship with the mother figure. The still active conflict between dependence
and independence, between closeness and distance, is transferred to him. They hold on to him and push him away at the same time."

John Coolidge (22) discusses three cases in which both the child and mother were asthmatic. They were part of a series of 52 asthmatic children studied at Massachusetts General Hospital. He found that all three mothers still had conflicts with their individuality and dependence on their own mothers. The mother unconsciously regarded the child as part of herself and had a powerful feeling of possessiveness toward the child. She attempted to handle her unresolved conflict around dependence through her relationship with her child by being both mother and child. In these three cases, the asthma, through identification, strengthened the bond between mother and child. The child responded likewise and its conflicts reflected those of the mother. The child partly wished to maintain this close and protected relationship with the mother but also longed for an independent way of life. The child, however, dared not deal with this conflict because of fear of the outcome of upsetting such a precarious equilibrium.

Coolidge found that the other children studied, who did not have asthmatic mothers, showed many similar characteristics to these three cases. The majority of the children had a clinging and controlling relationship to their mothers. Many had difficulty in dealing with their aggressive impulses. There was evident improvement in the child's asthma and emotional tension when it was separated from the mother.
In the three cases with asthmatic mothers, there was a greater identification between mother and child, and greater evidence of the child's repeating mother's basic conflicts.
STATEMENT OF PROBLEM

The point of departure of this study is the observation that over fifty per cent of cases of infantile eczema develop bronchial asthma. In the majority, the onset of asthma occurs by four years of age. Another common observation is the diminution in the severity of the eczema symptom with the development of the asthma.

Obviously a greater understanding of the factors involved in the shift of symptoms from eczema to asthma is of immense clinical significance. An increased skill in predicting the development of bronchial asthma in cases of eczema will enable such patients to receive proper protection. Allergists have stressed the importance of methods in their speciality of attempting to predict and prevent development of respiratory allergies in cases of infantile eczema. Due to the multiplicity and complex relationship of the etiological factors in asthma a multi-discipline approach to this problem is imperative. The psychosomatic literature has made only minimal contribution towards furthering the knowledge and understanding of this problem.

There is general agreement in the psychosomatic literature that the psychogenic factor in bronchial asthma involves a disturbed
relationship with the mother. Investigators have studied the nature of
the conflict with the mother and various characteristics of the mother-
child relationship have been described. An attempt will be made to
investigate whether a specific mother-child relationship plays a
significant role in the development of bronchial asthma in children
with atopic dermatitis. This approach is advocated by Melitta Sperling.
Her opening remark in discussing John Coolidge's paper (22) was:

To make the mother-child relationship the focal point of
investigation is a most promising approach in the study of the
dynamics of asthma, in particular, and of psychosomatic
disorders in general.

Allergy Concept of Eczema-Asthma Syndrome

In 1953, Ratner et al. (23) coined the term "dermal-respiratory
syndrome" which they defined as "a symptom complex in which both
dermal (urticaria, eczema) and respiratory (perennial rhinitis, hay
fever, asthma) manifestations of allergy occur in the same patient,
either synchronously or at different periods." This was by no means
a new observation since many earlier writers had reported this
phenomenon.

There is general agreement that eczema is a frequent
antecedent of asthma. Susan Dees (24) summarizes the reports of
several observers in Table I. She states that the most detailed
studies are those of Glaser, who found that 53 per cent of eczemas
progressed to asthma, and Ratner, who reports 59 per cent of patients
with eczema develop upper respiratory allergy and asthma.
<table>
<thead>
<tr>
<th>Authority</th>
<th>Source</th>
<th>Per cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaser</td>
<td>New York</td>
<td>53</td>
</tr>
<tr>
<td>Ratner</td>
<td>New York</td>
<td>59</td>
</tr>
<tr>
<td>Kraepelien</td>
<td>Sweden</td>
<td>66</td>
</tr>
<tr>
<td>Sheldon</td>
<td>Michigan</td>
<td>60</td>
</tr>
<tr>
<td>Tuft</td>
<td>J.N.H.A.C.,* Colorado</td>
<td>32</td>
</tr>
<tr>
<td>Deamer</td>
<td>California</td>
<td>30</td>
</tr>
<tr>
<td>Clein</td>
<td>Washington</td>
<td>33</td>
</tr>
</tbody>
</table>

*Jewish National Home for Asthmatic Children, Denver
Ratner et al. (23) in studying the age of onset of different allergic syndromes state that their findings confirm the generally accepted view that eczema in childhood always has its onset in the first year of life. Their findings in asthma are also in agreement with other investigators, that childhood asthma generally makes its appearance by the eighth or tenth year and in the bulk of cases it develops by four years of age.

Allergists have pointed out for many years the importance of not regarding eczema in infancy and childhood solely as a dermatological condition. They state that every eczema case should be viewed as a potential case of asthma or hay fever.

In the treatment of infantile eczema, the importance of prevention of respiratory allergy is stressed. There has been much emphasis on the need for adequate and appropriate treatment for inhalent sensitivity.

Psychosomatic Concepts of the Eczema-Asthma Syndrome

The role of emotional factors in allergic states has been most extensively studied in the condition of bronchial asthma. The evidence of emotional factors in eczema and other allergic conditions is still less definite. There is also insufficient evidence at the present time to formulate a direct connection between allergy and emotional conflict.
Leon Saul (25), in 1941, attempted to determine whether there is any direct relationship between emotions and allergy. He studied different conditions of an allergic nature in which emotional factors played a role. He suggested that the central emotional factor was a strong longing for love, basically for the mother's. Saul presented the hypothesis that when this longing is especially intensified and frustrated, or threatened with frustration, the allergic sensitivity is increased and the symptoms appear. It may also operate independently from allergens by producing similar symptoms.

Saul (26), in 1946, attempted to further investigate the role of the relationship to the mother in cases of allergy. He points out that preceding the "oral" form of attachment to the mother, the infant has a relationship to her via the skin during the intra-uterine period as well as for some time thereafter. At birth, too, respiration is established. The mother no longer respires for the infant, which must handle its oxygen supply independently. He elaborates on this form of attachment to the mother by saying that such a longing is expressed in wishes, fantasies and dreams of a desire for shelter.

Saul made the observation that the individual in whom the dermal and/or respiratory mechanism has some weakness, or is a point of fixation, or in whom the attachment to the mother predominantly takes these forms, appears to be predisposed to skin and respiratory allergies. He likens this to the role of the oral attachment to the
mother in gastro-intestinal disorders. He comments on the close association of asthma and skin allergy as follows:

Possibly this may be connected with the fact that the child's relation to the mother during the entire fetal period is predominantly via the skin contact, and the birth, the separation from the mother and exposure of the skin, coincides with and also stimulates the transition from fetal and neonatal respiration.

Austin Hyde, Jr. (27) attempts to explain the common observation of eczema occurring in infancy and asthma appearing in the second year of life, followed by diminution of the eczema. He suggests that the achievement of speech, by allowing the child an additional method of communicating its problems, may be the fundamental factor causing a shift of allergic symptoms from the skin to the respiratory system.

Hypothesis

In children with an allergic constitution, as manifested by history of atopic dermatitis, the mother-child relationship, as measured by five specific variables, is significantly different between children who develop bronchial asthma and those who fail to develop asthma by the fifth year of life. More specifically, it is hypothesized that, as compared with the mother of the non-asthmatic child, the mother of the asthmatic child will manifest:

1. More general babying or fostering dependency of the child.
2. Greater restriction of autonomy of the child.
3. Poorer toleration and restriction of aggressive behavior.
4. More rejection of the child.
5. Lesser affectionateness toward the child.
Subjects

The subjects of the study were the mothers of ten children who were patients at the Pediatric Allergy Out-Patient Clinic, Colorado General Hospital. Other common characteristics of these children included: (1) age range between five years and ten years; (2) Anglo-American culture; (3) non-psychotic or mentally defective; (4) had no other major physical ailment; (5) suffered from infantile eczema. The only selection criterion directly related to the mother was an ability to communicate in a reasonably meaningful manner in an interview. Socio-economic level was not considered a selection criterion. The majority, however, were in the middle socio-economic level.

Half the number of children had developed bronchial asthma prior to the age of five years and the remainder had not developed bronchial asthma. On that basis they were divided into two groups. There were in all five boys and five girls. The asthmatic group consisted of two girls and three boys and the non-asthmatic group consisted of three girls and two boys.

The children were selected from the patient card index of the Pediatric Allergy Out-Patient Clinic. Selection was done at random.
by going through the index alphabetically and choosing the patients who satisfied the necessary criteria until the required number was obtained.

Collection of Data

The author interviewed each mother for approximately one and one-half hours. A structured interview was designed and followed with only slight deviations which were necessary and appropriate for each individual case. Each interview was tape recorded. (See Appendix I for outline of structured interview).

The interview was structured with the objective of studying the mother-child relationship with particular emphasis on investigating the following five variables: Does the mother: (1) tend to baby the child and foster dependency in him; (2) restrict the autonomy of the child; (3) restrict the child's aggressive behavior; (4) reject the child; (5) show affectionateness to the child.

Two judges listened to a recording of each interview and rated the five variables being studied. The author was one of the judges in all ten cases. The other two judges were staff psychologists from the Division of Clinical Psychology, University of Colorado Medical Center.

Each variable is single-ended. It was scored as to presence or absence, and when present it was rated on a scale from one through five. Each variable was defined, and each judge was given detailed
instructions about scoring, and examples of grades 1, 3 and 5 of the scale of each variable. (See Appendix II).

Inter-judge reliability was measured by the Spearman Rank-Difference Correlation Coefficient. All of the correlation coefficients were above .85 with the exception of the correlation coefficient for the affection variable which was .55. All of these correlation coefficients were significant ($p < .05$).

Results

The Median Test was used in all statistical analyses. There were no significant statistical differences between the asthmatic and non-asthmatic group for the dependency, autonomy, aggression and affection variables.

The difference between the asthmatic and non-asthmatic groups for the rejection variable approached significance. Column I, Table II shows that for the asthmatic group there were four subjects whose rejection scores were above the median and one subject whose rejection score was below the median. Column II shows that for the non-asthmatic group, there was one subject whose rejection score was above the median and four subjects whose rejection scores were below the median. The application of the
Median Test to these results indicated the probability of a split as extreme or more extreme than the one observed is only ten in one hundred ($p \leq .10$).

**TABLE II**

**NUMBER OF SUBJECTS WITH REJECTION SCORES ABOVE AND BELOW THE MEDIAN**

<table>
<thead>
<tr>
<th></th>
<th>Asthmatic Group</th>
<th>Non-asthmatic Group</th>
</tr>
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<tbody>
<tr>
<td>Above Median</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Below Median</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>
The discussion will be limited to the concept of maternal rejection since it is the only variable in the study in which results approach significance. This is in line with the vast majority of the psychosomatic literature on the subject in which invariably there is discussion of the role of maternal rejection in the allergy patient. In many significant studies, which have had a strong influence on subsequent work, the theory of maternal rejection has been cited as the basic psychogenic factor in the allergy patient.

The first point to be discussed is that of definition, since this is a source of some confusion and difficulty in reviewing the literature. In this study, the rejecting mother is defined as one who shows a desire of separating herself and remaining indifferent to the child. Miller and Baruch (20) used David Levy's definition of the rejecting mother as "one whose behavior toward the child is such that she consciously or unconsciously has a desire to be free from the child and considers it a burden." They added a further criterion used
by Newell (28), namely that the rejection be expressed verbally by the mother. This definition is closely similar to the one used in this study. Donald H. Williams (29) in his investigation of the maternal rejection factor in atopic dermatitis states:

In this study the rejection did not take the form of overt neglect but was, rather, an accumulative effect of a continuing irritability toward the child expressing itself as frustrating, nagging and scolding, emotional explosions and "scenes", unreasonable discipline, insistence on petty regimenting detail, an attempt to overpower the child's will, a running battle each meal time over eating habits and, above all, a striking lack of demonstrative love expressed by the unfolding arms, the loving caress and the "soft word" that "turneth away wrath" (hostility).

This definition is obviously a very broad one which includes several maternal attitudes even though possibly secondary to one of rejection. The primary source of difficulty, however, arises not so much from differences in definition but from the lack of definition characteristic of the majority of other publications.

The second point of discussion is the question of the psychogenic role of maternal rejection in bronchial asthma and atopic dermatitis. There have been relatively few
studies investigating the mother-child relationship in atopic dermatitis. In 1951, Williams (29) stated that he confirmed the common observation of maternal rejection in his study of 53 children with atopic dermatitis. He also pointed out that management of the maternal rejection factor in his series led to more favorable therapeutic results than occurred in a control series in which this factor remained untreated. As mentioned above, Williams' concept of rejection is extremely broad. The methodology of his investigation is also difficult to evaluate.

In the same year, Spitz (30) listed infantile neurodermatitis among the psychogenic diseases of infancy and attributed it to maternal hostility concealed behind a facade of manifest anxiety. Rosenthal (31), in 1952, in a study of 25 infants with infantile eczema found that they received significantly less caressing and cuddling than a control group. He observed that the lack of caressing and cuddling of the child resulted most commonly from the mother's wish to free herself of the burden of caring for the child.

Marmor et al. (32) studied the mother-child relationship in 22 children with atopic neurodermatitis, five of whom also had a history of bronchial asthma. They observed that in the period just
preceding the onset of the eczema, the child was either rejected or neglected by the mother or else fortuitously separated from her in one hundred per cent of the cases. They stated that in thirteen of the 22 cases there was strong evidence of conscious or unconscious rejection of the child by the mother. In the remaining nine cases, the circumstances which involved neglect of or separation from the child could not be definitely correlated with maternal rejection, but seemed to be the result of unavoidable events. They concluded that their findings differ from those of other observers in that they did not find the usual high incidence of maternal rejection in these children.

Some workers (16, 20) have reported a high incidence of maternal rejection in the allergic individual without making specific mention of any particular allergy syndrome. Their allergy cases, however, were mainly made up of asthmatics. Other workers (10, 19, 21) have reported a high incidence of maternal rejection in the asthmatic individual.

The third point of discussion and the source of much controversy is whether maternal rejection is the primary maternal attitude or secondary to the mother's frustration and anger generated by failure of the mother-child relationship satisfying her needs. The studies of Rogerson et al. (16) and Miller and Baruch (20) strongly consider rejection as the mother's basic attitude toward the child.
Most other investigators, I believe, are impressed with the high incidence of maternal rejection in the mother-child relationship but not as the primary maternal attitude. French and Alexander et al. (10) describe an unusually close but ambivalent relationship between the asthmatic child and his mother with a continuous fear of rejection or loss of mother's love. Margaret Gerard (19) reporting on the analyses of five asthmatic children stated that they all showed conflicts similar to those found in the Chicago Institute study and that marked maternal rejection was present in all cases since an early age. Jessner et al. (21) seem to reverse the theory of maternal rejection by stressing that the mother's basic need or attitude is to be close to the child. Coolidge (22) also described the mother of the asthmatic child as unconsciously regarding the child as part of herself and having a powerful feeling of possessiveness toward the child. Abramson (33) opposes the theory of maternal rejection and states that the disturbance in the parent-child relationship is rather that of mutual engulfment (introjection). He emphasizes that this concept of incorporation or engulfment is different from that of over-protection and cannot be considered a compensation device for unconscious rejection. He states that parental rejection may occur when the parent becomes enraged at the failure to form the character of the allergic child in a pattern based upon the parents' own narcissistic needs.
The results of this study support the theory of maternal rejection in asthma which has been reported by several workers. The literature investigating the possible role of maternal rejection in atopic dermatitis is very limited. The results of this study do not point in the direction of a high incidence of maternal rejection in atopic dermatitis reported by some observers. This is in agreement with the conclusions of Marmor et al. (32). No comparison of the results of this study with those of Williams (29) and Rosenthal (31) will be attempted because of the different criteria used to define maternal rejection.

Some of the forms of maternal handling and attitudes toward the child will be mentioned to describe the rejecting and non-rejecting mothers in this study. The rejecting mothers characteristically showed frequent hostile handling of the child and attempts to distance themselves from him. Two of the children were unwanted. In one case, the marriage had been "forced" by the pregnancy with the child. Another child was the youngest of five children in a family with marked financial stresses and a father physically disabled and unable to work. In a third case, the mother's feeling about the pregnancy was, "We really did not want a child that soon." The same mother, when asked why she had not breast fed, said, "The idea is repulsive to me. It is animal-like to breast feed."
All the rejecting mothers showed definite attempts at distancing themselves from the child and expressed certain feelings of indifference about the child. One mother mentioned how she went to work immediately following her child's birth and continued to work for two and one-half years so that they could save some money. She recognized that this had been detrimental to the child, who developed asthma at ten months of age and was frequently sick during that period. The child also had behavior problems. Another mother, when asked if she had time to play with her seven year old daughter, said, "Do you mean if I get down on the floor and play house with her or something? I don't do that. If she were the only child, I would have had to do it." Four of the rejecting mothers used the term "ignore" to describe their handling of behavior problems, such as temper tantrums or excessive crying. Another mother described how she had always made her child take long naps until he was five years old "to get him away from me." Another common feature was the mother being irritated by the child and nagging him. The mothers made statements like "I get irritated by being around him all the time" or "I nag her too much and pick on her."
They also tended to be critical of the child. One mother described how she responds to the child telling her that he does not love her by saying, "I don't love you, too." Another mother, when asked what she does when her child is involved in an argument with neighborhood children, said, "I never interfere. You can not believe anything kids in the block say, including Dave." The rejecting mothers were also more severely punitive. One mother used a stick to beat the child "so that I can hit him harder and not get hurt myself." Another mother locked her child in a small hallway for one-half to one hour at a time. Another slaps her child in the mouth and shakes her "till she can not get her breath."

The mothers with lower rejection scores made many more positive remarks about the child, and stated that they enjoyed being around the child. The mothers made remarks like, "He's a lovable guy" or I would not trade him for anything." One mother, when asked which age period she enjoyed most in her child, said, "Oh, I like them from birth on. There is something to enjoy in every age." The mothers frequently expressed enjoyment in playing or doing things with the child. Another mother said, "We and the children enjoy doing a lot of things together because we have no close neighbors."
The above discussion certainly points to the need for further study of the concept of maternal rejection in allergy and more specifically in asthma. Maternal rejection appears to be a part or an outcome of a more complex situation. It is suggested that investigation of the factors contributing to the mother's rejection of the child would further our ability to evaluate and understand this attitude. This would undoubtedly involve studying the mother-child relationship in the setting of the family complex. This brings up another important point, namely the father-child relationship. This relationship certainly plays a significant role in determining the influences and meaningfulness of the mother-child relationship.

There are obvious limitations in this study. The population was too small. The two groups were not as well equated as to age and sex as is desirable. In a future study with a larger population and more adequate controls a statistical technique could be utilized which would be more sensitive to variation in the pattern of the scores.

A study such as the present one, though not in itself predictive, is useful for exploratory work as testing hypotheses, defining variables and other preliminary work. A definitive predictive investigation would entail an extensive longitudinal study with positive and negative predictions.
It is also becoming more and more apparent that no one specialized approach can investigate the complex problem of the etiology of asthma in an adequate and comprehensive manner. The need to integrate recent contributions from different fields is very necessary. It should certainly be possible that a team approach between pediatrician, allergist and psychiatrist working in an atmosphere of cooperation and mutual enlightenment can be of value in predicting and preventing the development of asthma in cases of atopic dermatitis.
SUMMARY

(1) The subjects of the study are the mothers of ten children, all of whom have a history of infantile eczema. Five of the children developed bronchial asthma before the age of five years and the remaining five are non-asthmatic.

(2) It was hypothesized that the mother of the asthmatic child, as compared to the mother of the non-asthmatic child, would show significant differences in her relationship to the child on five specific variables, including dependency, autonomy, aggression, rejection and affection.

(3) Structured interviews with each mother comprised the basic data. These interviews were independently rated for each of the five variables by two judges. Inter-rater reliability was adequate.

(4) Mothers of the asthmatic children were found to be more rejecting than mothers of the non-asthmatic children to a degree approaching statistical significance. No significant differences were found between the two groups on the other four variables.
REFERENCES


BIBLIOGRAPHY


APPENDIX I

INTERVIEW OUTLINE

Introduction

As you may have noticed there is a recording machine. I will be recording this interview to make sure that I get an accurate record of the things you tell me.

As I mentioned in our telephone conversation, I am interested in getting to know a bit more about children with allergic difficulties, more in terms of what the child is like, generally, at home with his family, at school, etc. Now, I don't know anything about X (child's name) except his age and that he had eczema (and asthma). I will be asking you several specific questions about X and about how you both get along.

(1) First, I'd like to get a picture of the family. Number of children and their ages. Ages of mother and father.


(3) Inquire where mother grew up. Her formal education. If she works or has worked. Also where father grew up and his schooling.
(4) Family health. Generally and specifically about allergic conditions. Were mother or father familiar with eczema and/or asthma prior to child's illness.

(5) Is there anything else about the family which you feel is important and that I should know about?

(The above background information took about ten to fifteen minutes of the interview).

The Pregnancy

(6) Was it a planned pregnancy?

(7) How did you feel when you first realized you were pregnant?

(8) How did the pregnancy go?

The Child's Infancy

(9) Now, would you think back when X was a little baby. What was it like then?

(10) Did you have time to spend with X as a baby besides the time that was necessary for feeding him, changing him and regular care like that? (If yes) Tell me about what you did in this time. How much did you cuddle him, talk to him and that sort of thing?

(11) All babies cry, of course. How did you react to that?

(Attitude about picking him up, crying in the middle of the night, etc.)
(12) Would you tell me something about how his feeding went when he was a baby? (Breast or bottle fed, feeding difficulties, weaning).

(13) Do you think that babies are fun to take care of when they're very little or do you think they are more interesting when they are older?

(14) How much did your husband do in connection with taking care of X. (Changing diapers, feeding, bathing).

Health of Child

(15) Would you tell me some about X's eczema (and asthma) and his general health. (Will attempt to bring out relationship between mother's attitude about X's health problems and the five variables being studied).

General Babying or Fostering of Dependency

(16) How much attention does X seem to want from you?

(17) Do you ever find yourself helping X with things you feel he could really do by himself?

(18) Do you sometimes feel that X is not as strong or can take the usual everyday difficulties as other children his age?

(19) Have you ever felt that X is growing up too fast in any way?

(19 a) How did you feel about his starting school?

(19 b) Have things been easier or pleasanter for you in any way since he has been in school?
Poor Toleration and Restriction of Aggressive Behavior

(20) Would you tell me how X and his (siblings) get along together?

(20 a) How do you feel about it when they quarrel?

(20 b) How bad does it have to get before you do something about it?

(21) How does X get along with neighbor children and other playmates?

(22) How about when X is playing with one of the other children in the neighborhood and there is a quarrel or fight. How do you handle this?

(23) Some people feel it's very important for a child to learn not to fight with other children and other people feel there are times when the child has to learn to fight. How do you feel about this?

(23 a) Have you ever encouraged X to fight back?

(24) Sometimes a child will get angry at his parents and hit them or shout angry things at them. How much of this sort of thing do you think parents ought to allow a child? How do you handle it when X acts in this way? Give me an example.

(25) How do you handle it if X is disobedient or has a temper tantrum?
Restriction of Autonomy of the Child

(26) I'd like to get some idea of the sort of rules you have for X. What are some of them?

(26 a) How about making noise in the house. How much of that do you allow?

(26 b) How far is X allowed to go by himself?

(27) Do you usually keep track of exactly where X is and what he is doing most of the time or do you let him watch out for himself quite a bit?

(28) Does X get an allowance? (If not) Do you think you will give X an allowance? Is he in any way advised or restricted as to how to spend his allowance?

(29) Does X choose the clothes, toys, or other items you buy for him?

(30) How does X act when he has deliberately done something he knows you don't want him to do when your back is turned?

(31) What do you do about his denying something you're pretty sure he has done?

(32) I'd like to know what your thoughts are about a couple of things.

(32 a) A child should never keep a secret from his mother.

(32 b) A child has a right to his own point of view and ought to be allowed to express it.
Mother's Rejection and Affectionateness to the Child

(33) I'm wondering if you could tell me more about how you and X get along.

(33a) What sort of things do you enjoy in X?

(33b) In what ways do you get on each other's nerves?

(33c) Do you show your affection toward each other quite a bit, or are you fairly reserved people, you and X? Can you give me examples of how you show your affection.

(34) Before X started kindergarten, did you teach him anything like reading words, writing, drawing or things like that?

(35) Do you have any time to play with X for your own pleasure?

(36) I'd like to know something about how you go about correcting X and getting him to behave in the way you want him to.

(36a) Do you ever deprive X of something he wants as a means of discipline?

(36b) Do you tell him that you won't love him as a way of disciplining him?

(37) Do you have any system for rewarding him for good behavior?

(38) Some parents praise their children quite a bit when they're good and others think that you ought to take good behavior for granted and there's no point in praising a child for it. How do you feel about this?
Closing the Interview

This brings us pretty much to the end of the interview. There are just a couple more thing I'd like to discuss.

(39) (Ask about any specific variable not adequately covered).

(40) How do you feel about being a mother? (Burden, limitations, would rather work, etc.)

(41) Is there anything else about X or about how you two get along which you would like to tell me.
APPENDIX II

VARIABLES

I. General Babying or Fostering of Dependency

**Definition:** It is the mother's tendency to help the child through the ordinary difficulties of everyday life. This is a general variable including motor, mental, emotional and social behavior.

**Scoring:** The frequency and degree of babying should both be considered. Indicate presence or absence of this variable. If present, rate on a scale from one through five.

**Examples:** Grade 1: Mother usually helps the child when needed. However, mother shows undue concern about whether child can get by alone. Grade 3: Mother usually helps child more than needed; seldom lets him struggle unsuccessfully. Grade 5: Mother continually helps child even when child is fully capable and willing.

II. Restriction of Autonomy of the Child

**Definition:** Autonomy includes the child's desires to be free, to resist coercion and restriction. It involves the desire to avoid or quit activities prescribed by domineering authorities and to be independent and free to act according to one's impulses.
This variable is most commonly fused with aggression, which should be dealt with separately (in Variable III).

**Scoring:** Rate the mother's limitations on the child's own initiative which will interfere with the child's freedom to act according to his impulses. Note that "limitation" is defined broadly, including direct and indirect, positive and negative, verbal and non-verbal, mandatory and optional. The frequency and degree of mother's limitation of child's autonomy should both be considered. Indicate presence or absence of this variable. If present, rate on a scale from one through five.

**Examples:** Grade 1: Any restriction of child's freedom to choose, decide, originate or reject beyond reasonable interpretation of child's welfare. Grade 3: Child restricted in many of his decisions and choices by mother's values and desires. Grade 5: Child restricted strictly. He makes no decisions about his activities.

**III. Poor Toleration and Restriction of Aggressive Behavior**

**Definition:** A child's aggressive behavior has the following desires and effects: (a) physical; to overcome opposition forcefully, to fight, to avenge an injury; (b) verbal; to belittle, ridicule, or depreciate an object; (c) feelings and emotions; irritation, anger, rage (temper tantrum), also revenge, jealousy, hatred.
**Scoring:** Rate the tolerance and restrictions set up or implied by the mother regarding aggressive behavior as standards to which the child is expected to conform. Are the requirements numerous and severe or few and mild? In meeting these standards, would the child be highly circumscribed in his aggressive behavior, or would he still have a large measure of freedom? Disregard whether requirements are sharply codified or merely implied in the discipline policy. Consider the standards expected regardless of how well they are enforced. The frequency and degree of mother's restriction of child's aggressiveness should both be considered. Indicate presence or absence of this variable. If present, rate on a scale from one through five.

**Examples:** Grade 1: Mother's standards for child's aggressive behavior are slightly restrictive beyond reasonable interpretation of either the child's welfare or appropriate family convenience. Grade 3: Restrictions are unnecessarily abundant with little concern for child's needs as an end. Grade 5: Mother strongly disapproves of and immediately attempts to suppress any form of aggressive behavior.

### IV. Rejection of Child

**Definition:** The rejecting mother shows a desire of separating herself and remaining indifferent to the child. Rejection is a
pervasive attitude of withholding love. It may involve a sense of contingency, e.g. "I love you if," or an attitude of resentment and disappointment.

**Scoring:** Consider all evidence in mother's attitude which in any way may impinge upon the child as rejection, however subtle, vague, or indirect. Indicate presence or absence of this variable. If present, rate on a scale from one through five.

**Examples:** Grade 1: Mother shows tendency to reject the child even though she takes acceptance for granted. Grade 3: Mother's predominant tendency is to avoid, repulse or exclude the child, but without open rejection. Grade 5: Child openly resented and rejected by the mother. He is made to feel unwanted.

V. **Mother's Affectionateness to Child**

**Definition:** Affectionateness is a pervasive quality. It involves love, demonstrativeness of affection and warmth.

**Scoring:** Rate the mother's expression of affection to the child personally. Rate the attitude shown to the child, rather than the deeper one which affects the child only indirectly as through care, solicitude, or degree of devotion to the child's welfare. Rate the presence or absence of this variable. If present, rate on a scale from one through five.
Examples: Grade 1: Mother is temperate, attached, kind and forgiving. Grade 3: Mother is affectionate, warm, loving and expressive. Grade 5: Mother is passionate, consuming, intense and ardent.
**APPENDIX III**

**TABLE III**

**SCORES FOR VARIABLES IN ASTHMATIC AND NON-ASTHMATIC GROUPS**

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