Rostrum

Coping styles in asthma

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Dr Richard Farr had a distinguished career as a research scientist and clinician at the University of Chicago, University of Pittsburgh, Scripps Institute, and the National Jewish Medical and Research Center. He was president of the American Academy of Allergy, Asthma and Immunology from 1968 to 1969. In 1969, he became Chairman of the Department of Medicine at National Jewish, a position he held until 1978. He continued as an active laboratory investigator, as well as an attending physician on the clinical services, until his retirement in 1986. He died in January 1997. Dr Farr drew on his experiences treating patients with severe and refractory asthma combined with his keen insights and compassion for his fellow human beings in defining a series of coping styles that patients with asthma use to deal with their disease. The following article is from a transcription of a presentation of his famous "Coping Styles in Asthma" talk, which was given at the 7th Annual Meeting of the Association of Military Allergists, Fitzsimons Army Medical Center, Aurora, Colorado, September 14, 1978. As Dr Farr said in his introduction to that talk, "Some of these truths are going to last you the rest of your lives, whereas scientific facts are going to change."

Harold S. Nelson, MD

Some patients with asthma cope with their disease in ways that are deleterious to them. The coping styles used by these patients often were used by them before the onset of the asthma, but the asthma amplifies these styles, and the coping styles can amplify the asthma. There are striking similarities between these coping styles and those described in cancer victims. Like the latter, they may reflect denial, anger, bargaining, and depression. Recognition that patients are using these coping styles and appropriate intervention will prevent them from continuing to act in these self-destructive manners. (J Allergy Clin Immunol 1999;103:29-35.)

Key words: *Asthma, coping, denial, anger, depression, bargaining*

These are a group of observations with absolutely no scientific backing to them. Yet some of these complex symptoms and syndromes (Table I) are extremely important for physicians to recognize because once recognized, there are some positive things that can be done to help these patients. Scientific facts are going to change, but these truths will not change because human nature is not going to be changing all that much. Specifically, these are the ways that patients cope with their asthma and ways to identify what they are doing so that we can appreciate their condition and try to intervene in the hope that they won't continue to act this way and won't continue to hurt themselves and be self-destructive. Many of these coping styles appear to exist prior to the onset of the asthma, but the asthma amplifies these styles, and the coping styles can amplify the asthma. It is important to categorize these coping styles because some of them are dangerous to the patient and they interfere with their therapy compliance, and some of them are actually suicidal. Many of the patients don't recognize what they are doing to themselves. The obligation, once recognized, is to do something about them.

The first 3 syndromes occur in relatively healthy people. The first one is familiar—the "Stop and Go" syndrome. These are basically happy people. They've got asthma, they don't like having asthma, they go a mile a minute when they're feeling well, and they end up getting fatigued. Then their asthma exacerbates and they have to go to bed and take care of their asthma a little bit better, but when they get out of trouble, they get up and try to make up for lost time. They cycle from being relatively asymptomatic and running their heads off with unbelievable schedules to when they get tired, get sick, and have to go to bed. They are happy people who like to do the things they are doing, and by and large, they're fairly easy to control. You just sit down and talk to them about what they are doing and urge them to pace them-

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TABLE I. Coping styles in asthma

Syndromes
Relatively healthy people
1. Stop and go
2. Little Orphan Annie
3. Piggy bank
Truly vexatious to the soul
4. Tammany Hall
5. Nobel Laureate
6. Catch 22
7. Eeyore
8. Tiny Tim
Potentially dangerous
9. Humpty Dumpty
10. Perfect Patient
11. Hummingbird Tongue
Extremely dangerous
12. What can I do to be saved?
13. Hair shirt or I grind my own bread
14. Laugh, clown, laugh

TABLE II. Coping styles in asthma

Stage I: Denial
A. Stop and Go'er
B. Piggy Banker
C. Orphan Annie
D. Tammany Haller
E. Nobel Laureate
Stage II: Anger
"All asthmatics are angry."—A Denver Proverb
Stage III: Bargaining
A. Tammany Haller
B. Nobel Laureate
C. Humpty Dumpty
D. Perfect Patient
Stage IV: Depression
A. Piggy Banker
B. Hummingbird Tongue
C. Catch 22
D. Hair Shirt
E. "What can I do to be saved?"
F. Laugh, Clown, Laugh
Stage V: Acceptance

selves. Tell them to go ahead and enjoy, but live the Greek way: everything in moderation and nothing to extremes. Teach them to plan their day so that if they are going out Saturday night they don't plan on a Sunday morning brunch or a Saturday afternoon shopping tour. Teach them to pace themselves so they don't get themselves into a state of fatigue. Sometimes they don't realize what they are doing, and it helps enormously to ask them to keep a diary of their activities. When you see them the next visit, sometimes they will feel sheepish enough that they have forgotten the diary because they know how horrible it looks, or they'll bring it in and then they'll recognize how horrible it looks, with the numbers of things they have tried to pack into their week. Just talk to them about it and say "Why pay double, let's pace this thing out and you'll be all right."

The next syndrome is also relatively common, particularly among teenagers. It comes from the comic strip, "Little Orphan Annie," in which, as you recall, Orphan Annie starts off at home living comfortably with Daddy Warbucks, Punjab, the Asp, and Sandy. Everything is fine and they're having a happy time. Then Daddy Warbucks gets called out of town, and Orphan Annie and Sandy go off on their way. Week after week things get worse and worse and worse, and pretty soon they're in a valley someplace with a lion coming from the North and a tiger from the South and you don't know how they're ever going to get out of it. Then all of a sudden Daddy Warbucks, Punjab, and the Asp show up and bail them out of trouble. This keeps cycling on. Well, that's what a lot of teenagers and adults do. When they're in trouble, they will take their medications. They'll get to feeling well and say, "What do I need these medicines for?," and then they stop them and start getting themselves into trouble deeper and deeper. Then you end up being Daddy Warbucks, and the Fellow ends up being the Asp and Punjab, and you have to bail them out of trouble, but they keep cycling. Well, the thing to do here is to point out what they are doing. This is really noncompliance. Every time it is done say, "Hey, you're playing like Orphan Annie," and tell them the story. You just reinforce this every time you see them. Show them the chart, and somehow or other, it goes away in 99.9% of the cases.

The next syndrome is a little more complicated. This is the "Piggy Bank" syndrome. This is basically a "Stop and Go'er," except that they don't like what they're doing. It could be "I'm just the girl who can't say no" syndrome or the "suburban housewife" syndrome because they are driven to do too much stuff when they don't want to: "Will you bake 25 dozen cookies for the church bazaar?" Yes! "Will you take a Cub Scout Troop?" Yes! They allow themselves to accept too many responsibilities and you get the feeling they don't like it. The title comes from a sense that we are all born with about 98 emotional cents in our piggy bank. If somebody comes up to me and says, "Will you loan me 90 emotional cents?" and I say, "Sure, I'll loan you 90 cents," then I see something in life that I want that's even 10 or 15 emotional cents' worth, but I'm broke and I can't buy it. This automatically causes 2 things: You are angry at yourself for having overextended yourself, and you're also angry at the person to whom you willingly gave the 90 emotional cents. These people have got to be told that its alright to have fun and that everybody needs a doggie bonbon for themselves every day. If it's not every day, certainly every 2 days. You've got to have something out of life to take care of Number One before you go around taking care of Number Two, Three, Four, Five, and Fifty. This should be pointed out to the patient. Go after them pretty much like you do the "Stop and Go'er." Sometimes it requires a diary, but quite often it requires a prescription and on the prescription you should write—like

FIG 1. Cartoon of Dr Farr and the cartoon and literary characters that were the inspiration for his "coping styles."

you would for opium—the name, address, and "From 1 o'clock to 3 o'clock every afternoon is your time to do whatever you want. Knit, bowl, read, pick lint out of your navel, or whatever, but that's your time." Then they can take the prescription home and show it to these people. They can say, "Look, this is what my doctor says." Tell them it's all right if somebody calls and says, "Will you go to the movies with me tonight?" but they don't want to go to the movies. If they are tired, it's perfectly all right to say, "I'm sorry, I have other plans," even if they don't have other plans. It's not lying to them, the plan is to stay home tonight, take care of yourself, and get the doggy bonbon. They're a little tougher to handle than the "Stop and Go'er," but they can be handled in that way.

These 3 syndromes are the kind of garden variety cases that you see a dime a dozen of in the clinic, but then comes the next 5 syndromes. These are truly vexatious to the soul of physicians and nurses, and the key to these people is to not be angry with them. If you get angry enough, subconsciously you'll stay, "Alright you Son of a gun, I'll get rid of your asthma—50 mg Prednisone tid and hs" and subconsciously overprescribe. Furthermore, if you recognize the anger, sometimes it leads to ulcers on the part of the physician. I don't think, if you handle it right, there is any need to get angry with these people, no matter how vexatious they are.

Now the first of this group is the so-called "Tammany Hall" syndrome. These are folks who go to the top. They figure that if they go to the boss and scream loud enough, you'll pay more attention to their case and somehow or another they will get well faster. "I know my Senator, I know my rights." Usually it'll be over some kind of minor thing. They have the feeling that if you thought harder about their problem you could do something faster, quicker, and better. The first thing is to recognize that you're being medically blackmailed. Second is to go up and face these people head on and say, "Look, I realize this is a heck of a disease. I realize you're really hurting and in trouble, but I'm like a Volkswagen, don't honk because I can't go any faster, and if I spend all day working on your case, I couldn't do a thing better. I can't reduce your steroids any faster, and now let's you and I kind of work together." Again, don't get angry at them because none of us likes somebody going over his head and putting us on report, and that is in essence what they are doing. If you recognize the problem, then I believe that it'll diffuse the anger, and they will stop it. Then things go better coke after coke as far as your relationship with that patient.

Now here is the variant type, the so-called "Nobel Laureate" syndrome. These are people, frequently physicians or nurses or possibly successful businessmen, who first of all think they are brighter than you are, and chances are most of the time they're right. They usually are in some sort of profession, such as engineering, physics, or chemistry. They cannot understand how you can be so damn dumb and not be able to figure out how to fix their asthma. First, it is important that the entire staff treat them with dignity. They should be treated with "Yes, Sir, No Sir," and "Yes, Ma'am, No, Ma'am," and they should be treated with a lot of dignity, consulted freely with, and told precisely what's going to go on. They usually have read many books, such as *You Are What You Eat*, *Vitamin C*, *Uranium Mine*, and *Magic*

Cures. They are full of all this stuff, so you suggest to them perhaps some of the stuff that is written about asthma isn't all that hot, but you'll give them some reading material. Then what we usually do is go up and give them some of our papers to read. There is usually not much conflict between what we are doing and what we have given them to read, and that seems to help a little bit. For those who are not writing a lot of papers, look around and find some sensible semiscientific papers for them to read, then suggest that they come to you and ask questions about anything they are in doubt about. This seems to make them easier to handle.

The next is a kind of interesting group, the so-called "Catch-22" people. In essence, what they say is, "I'm sick with asthma because I can't take my asthma medicine because the medicines make me sick." They have it set so that they have a little asthma on the one hand, and they can't do anything else because they have this asthma. The prototype for this was a young physician who took his medical training in South America and was unable to pass his Federal Licensing Examination (FLEX). He had mild asthma, but he couldn't tolerate regular therapeutic doses of most medicines, and he couldn't study for the boards because of the asthma. You don't want to have to extract out of somebody a confession that "you're depressed." If you say you must have the blues about it, fine, accept the blues. The way to handle these people generally is to separate the 2 problems. Say, "I'd be pretty darned upset too if I was doing physical exams on the one hand and couldn't study for my boards on the other because I had your asthma."

Usually I use tricyclics to help them over the hump. We treat the 2 separate conditions separately. Usually, when they come back for a second visit, any resemblance to the asthma program that you had them on 2 weeks before will be purely coincidental. So then you have to go back and start off with pediatric doses and then work up. By that time, usually the tricyclic has caught on. Then you are direct with them and try to work out a program. In this case, it was a loan from his father, so he didn't have to do these physicals and he could go to the medical school for Grand Rounds. He is happily practicing medicine in the East at the moment, and not taking tricyclics, although he is taking very minor medication for his asthma. Sometimes these folks need some psychiatric help, and sometimes they don't.

Now another vexatious group is the "Eeyore," or the "heads you win, tails I lose," syndrome. This comes from the Pooh stories, as you recall. Eeyore is a little donkey to whom nothing's any good. He is a very negative guy. Nothing to eat but thistles, nothing to breathe but air, and his house is always the worst in the forest, the forest being Robin's nursery. They rebuild his house for him, and it still isn't good enough. Nothing is good for these people, and on the surface they appear to be really depressed people. But I believe they are of a subpopulation of people who just like to go around unhappy and miserable, so we treat them and they say "Alright, so my asthma is under control, but I've got to take pills 3 times a day," and "My asthma is gone, but what are you going to do about my big nose?" There is always something wrong. The way you treat these people, and they can be very vexatious, is just the way that Pooh, Kangor, Orr, and the other characters in Winnie the Pooh treated Eeyore. They loved him for what he was, and they tolerated him in fairly small doses. They realized that they were not going to get any thanks or appreciation. You just put out, and if something good happens back, that's fine. Now another fact about them is they're very amenable to having their lives structured. First, you find out what they like, "Well, I don't mind the movies too much." Then you say to them, sometimes with a prescription pad, "All right, I want you to go to a movie every Friday night." When they come back you say, "Well, how was the movie?" "Well, it was pretty good," they say, "BUT it was too long or too short, or I didn't like the lady in the lead role"; there is always something the matter with it. You just listen and structure their lives and get them out bowling and going to the movies and activate them a little better. What you are doing, in essence, is that you are giving them a better quality of life. They probably know it, but they won't admit it. Don't try to extract it from them. But actually, if you can get yourself around to enjoying their antics, pretty much like the Pooh characters enjoy Eeyore, then they won't be vexatious to you. Automatically, this vexation will go, and there will be no anger.

The next syndrome is the "Tiny Tim" syndrome, and that comes, of course, from Bob Crachet and his family. Their lives revolved completely around this crippled little boy. This doesn't have to happen in just pediatric cases, it can happen between husbands and wives when all they think about morning, noon, and bedtime is that asthma. Their whole life revolves around it. Where you make the diagnosis sometimes is that the asthma is under pretty good control, and it is not the patient who starts tearing up the program with noncompliance, it's the family of the patient. They say "Aren't we giving Johnny too much medicine?" or "Aren't you giving my husband too much medicine?" It comes from the other side; it comes not from the patient, but from the patient's family and associates. When you pick that up, the thing to do, and it works after you get some rapport with the patient, is to ask, "Hey, what would you guys do if Johnny didn't have asthma? What would you think about and do? What would your recreation be?" They will stop and look at you and quite often they will have a very flat face and wonder what in the world would they do. So the treatment, when you see them destroying a program, is to start getting them involved in outside activities to get their mind off the asthma business, such as golfing or reading, to give the family interests other than the asthma of the other family member.

The next 3 syndromes are potentially dangerous and should be recognized as such. The "Humpty Dumpty" syndrome comes from "All the king's horses and all the king's men couldn't put Humpty Dumpty together again." These are usually well-to-do people. They are people whose histories show that they have been to

Scripps, they've been to Mayo, and they've been to National Jewish Hospital. They've been to this place and that place, and they've even been down to Biloxi, Mississippi, but they keep looking for the magic cure. They cannot understand why the physician can't fix them because before that time, if the refrigerator broke, they'd just call up and not even bother getting it repaired, they'd just get a new one. If the car didn't work, they'd take it in once and if the mechanic could not get it so it was humming just like it ought to be, they would look around and say, "I'll take the blue one over there." These are well-to-do people for whom, up to now, their money has always been able to buy them what they wanted. The thing to do with these folks when you sit down with them is to say, "Look, I know you are hurting, you've been really first class people," and tell them what they are doing to themselves. The potential danger, you point out, is that they are likely to hear about the famous doctor in Mexico—this happens particularly at Scripps—who would treat asthma without cortisone. They would think he was a wonder worker, they would go down there, and they wouldn't get cortisone, but they will get about 50 mg of prednisone a day. Then they come back Cushingoid and hypokalemic. They are sitting ducks for quacks, uranium mine sitting, and things of that sort, and the only thing you can do for these people is sit down, talk to them, and show them what they are doing. There'll usually be a tearful session, but they recognize it and you have done them a favor by saying, "Look, the buck stops here, let's try to get you on the best possible program. If you do want to go to somebody else, please consult with us so we can help you pick out somebody that we think is a quality person and might have a better idea." That's the way you handle these folks.

The next syndrome that is potentially dangerous is the "Perfect Patient" syndrome. They are extremely pleasant people who are super cooperative and very compliant to their medical program. They usually have bad asthma. The diagnosis of these people is made by unrealistic goals; they want their asthma to be gone. They'll come and say "Doctor, I'll do anything you tell me; I'll be your guinea pig. If you've got experimental medicine, I don't care what the risks are involved; I'll take it." Well, these people have got to be cut off at the pass right now. They will be awfully flattering to you and they can suck you in a little bit that way. You've got to be sure to tell them you don't walk on water, that you cannot give them a certificate that says, "I do hereby promise that you will be rid of your asthma if you do what I tell you to do," because in the event that it doesn't work out that way, you are in for 1 of 2 things: extreme anger or extreme depression. For the patient's sake, stop this before it comes to where they either are very angry that "I did everything you asked me and I'm still sick" or they will be terribly depressed thinking that they have done everything possible and that nothing can be done for them.

The next syndrome is kind of an unusual one, but it is a pretty good one to remember. It is the "Hummingbird Tongue" syndrome. These are people who come in and say, "I get asthma 4 times a year," and you say, "How do you get asthma 4 times a year?" They reply, "Well, its usually when I get into peanuts" or, as with the prototype, shrimp. And "Why do you get into shrimp?" "Well, I dunno, I just get there." Well it turns out what these people are doing is using their asthma for particular reasons. The prototype of this one was a gal who went to receptions and cocktail parties with her husband. He was a "cocktail party Lothario" and used to be paying a lot of attention to the other ladies at the party. It bothered her so much that she would sally up, consciously or subconsciously, and get into some shrimp. She would be cold and blue on the cocktail party room floor, and that was the end of the hanky-panky. This happens, by the way, not infrequently, and these are people using their asthma. They know darn well how to precipitate an attack, and they use it to manipulate their environment. The treatment for these people, of course, is to point out they have better ways of dealing with the problem and that this is a terrible way to play it. They have a tongue and arms and legs, and they can handle this thing. In this case, it got into a little bit of marriage counseling, and everything turned out fine. These folks are not uncommon if you look for them. If you don't look for these people, you don't find these people and you can't help them. Therefore you should say to yourself "Do they or don't they have some aberrant behavior patterns that are really messing up the management of this particular case?"

Another syndrome that is quite common is the "What can I do to be saved?" syndrome. It is typified by somebody, with rhinitis frequently more than asthma, who has had very severe rhinitis for years and years and done nothing about it. All of a sudden, they come to you with this history and say "Doctor, I have got to get this rhinitis fixed." Well, that's a danger sign because it usually means that something else has gone wrong in their life and they figure that, "If I didn't have this rhinitis then things would be better." Start poking around in their business affairs and family affairs and try to find out what has gone wrong so that all of a sudden, after a 10 to 15 year history, they decided that they need to get this thing fixed. The reason to put these persons under the potentially dangerous group is that you've got to go after these folks pretty slowly. One of these patients, in my Chicago days, was a teacher with rhinitis. She couldn't teach because of her rhinitis. I marched in there one day and said, "Good news, you can go back to teaching now." She said, "That's fine." She got in her car in Chicago and drove to Denver, whereupon she shot herself. I'd fixed it so that she had what she felt was no alternative. Her nose was fixed, so presumably she would be back at teaching, although she wasn't ready to teach. So you gotta fuss around with these patients carefully when you see a "What can I do to be saved?" person.

Now for the extremely dangerous patients, the so-called "Hair Shirt" syndrome or "I grind my own bread." On the surface, they look kind of like the Eeyores, but what happens here is that you start treating them, and you get their asthma so that they can control it. At that point

they become very anxious and decompensate and can actually become psychotic. One of the more recent ones (not the prototype) was a lady who felt she was very sensitive to the preservatives in commercial bread. We went to great extremes to get some neat, normal wheat, and we made bread for her without any preservatives. Then we gave her the preservative-free bread versus bread with preservatives as a placebo. This was done with her knowledge. In the middle of the challenge, she became more and more anxious. Finally, she went down to the cafeteria and had 2 sweet rolls, a regular piece of white bread, a donut, everything you can imagine. She just went and had a commercial feast of preservatives in the middle of this double-blind study. Well, right there you knew you were dealing with something that was more than an Eeyore, because an Eeyore would go through with it; they are very compliant. So what you do first is to recognize the "hair shirt" person and then look around and find the least obnoxious symptom, as far as you are concerned, that they can have and give it to them. For example, in this case we said, "Yes, you probably are having a problem with commercial preservatives in bread, and we think it is fine that you make your own bread at home." You give them that and treat their asthma. These people are really tough to manage, but they rock along. They need psychiatric help but usually won't take it; they are just awfully sick people. But you recognize them and treat them pretty much like an Eeyore except that you leave them some misery and play that misery up and let them live with it so they don't hurt themselves. Otherwise, they can be suicidal or become psychotic.

The last of the syndromes is the "Laugh, Clown, Laugh" syndrome. These people are "Little Orphan Annies" who don't care. Generally speaking, they are older men and women who are very self destructive and very depressed. They know darn well what they are doing. They will tell you things like, "Doctor, don't spend your time with me, I am an old man (or old woman). Put your efforts into somebody young, I'm going to be OK," while all the time wheezing their heads off. They are really sick people, but they are rejecting therapy, and I rather suspect that some of them are just wishing they would be swept away and die. These people again are very difficult to handle when you see them. You can't get them to a psychiatrist, and they are very noncompliant. The best thing is to try to get some insight as to why they are so depressed. If you are lucky, you can then get them some psychiatric help, but the very least you can do is let them know you care. It is important to separate these people from an "Orphan Annie" and to know that you are dealing with a depressed person. Tricyclics, Elavil, and other drugs of this sort are sometimes helpful with these people.

There is a striking similarity between these asthmatic patients and the stages that Dr Elizabeth Kübler-Ross describes for her cancer victims in *Death and Dying*.[1] Dr Kübler-Ross points out that when people find out they have cancer, they go through 5 stages. First there is denial and isolation. This is when they go around to several doctors looking for confirmation that they do have cancer. They feel lonely. They say that don't have the disease and "It couldn't happen to me." Then they get into a stage of anger when they say, "Why me, oh Lord, why me?" At this point they get into the stage of bargaining. Kübler-Ross has only about 3½ pages in this little book of hers on bargaining, but the asthmatic patient is a super bargainer. The kinds of things the cancer patient bargains on are "Can't you keep me alive until June when my daughter gets married?" or "Can't you keep me going until September...?" when some other event is going to happen. They will bargain along like this. The fourth stage is, of course, depression, as in the "Perfect Patient" syndrome, or "I'll be the guinea pig" syndrome. One of the real worries that you have is that they can go from bargaining back to anger or forward to depression. The fifth stage that Kübler-Ross sees quite often is acceptance of the cancer; the opportunity to say good-bye to all their loved ones. When people do die, they are saying good-bye to a great deal of things: sons, family, mothers, and fathers.

"Stop and Go'ers" and "Orphan Annies" are deniers; "Tammany Hallers" are really deniers (Table II). They think you can get rid of the whole damn thing if you work hard enough at it. "Nobel Laureates" are big deniers. The anger may be passive-aggressive anger or it may be overt anger, but all asthmatic subjects are angry, and if you want, that's a Denver proverb. Why are they angry? Well, they've got a good reason to be. First of all, it is a wicked disease. You can talk about food drives, sex drives, this drive, and that drive, but there is no drive like the air drive, and the quickest way to cause somebody to panic is to shut off their air. You don't have to be a doctor, you don't have to be anything to figure out that you need so many breaths of air every minute or you are in trouble. You give them medicines. Theophylline and the β_2-agonists do make people jumpy and jittery, and sometimes you do have to calm them down with something like Valium or some other downers; these are sick-making medicines. The other thing that makes them angry is the aesthetics: hirsutism, fat, striae, and the marching hairline. One lady came up to me one time and said, "Doctor, I look like a gorilla," and you know, I had to kind of agree with her. The aesthetics of this thing bothers the females particularly; it's enough to make them angry. Realistically, the problems they have with osteoporosis, hypertension, those great salt-free diets they are put on, and that great potassium chloride they have to take every morning, noon, night, and bedtime is enough to make you a little mad at the world. Also, these patients are quite often not told the truth about their illness. Why aren't they told the truth? First of all, I have hardly ever met an asthmatic that hasn't been told it's all in his or her head. Wouldn't you like to have a broken leg and have somebody tell you that it was all in your head and then have x-rays show that you've got a spiral fracture of the tibia or something. This makes them very angry, and what's worse is they begin to believe it is all in their head.

Then you've got to dissuade them a little bit on this issue. Second, they are frequently told they have either emphysema or chronic obstructive pulmonary disease because we can't fix them. They may have elements of this, but they are frequently told that that is the whole thing and "I can't do anything for you." It is a frustrating illness for physicians as well. Third, they are not told about the steroid side effects before they begin. If you are going to start the patients on steroids, I think you have an obligation to sit down and tell that patient, "Look, I don't like these medicines any better than you do...," and then you start going through everything that could happen, including cataracts. It can be done kindly, but I want to know what is the benefit-to-risk ratio of the medications I am taking. Say, "Look, you are to the point where you've got to use them. We are going to try to use them on alternate days, a less dangerous schedule, but this could happen, even though I hope it doesn't." But what good is that? Well, I'll tell you what good it is. If the cataract comes, then you can go into the room and say, "Boy, I'm really sorry..." and mean it. "You threw the gutter ball and you got the cataracts. Thank God they can be fixed a little bit later, but sorry you've got it." I'm not talking about medico-legal affairs. I'm talking about the patient. You can relate better with the patient. If you want to see an angry patient, have somebody show up with cataracts who has not been told that steroids can induce a cataract. This way we're sad, she is sad, he is sad, I am sad, but at least you are sharing and commiserating as you would with a cancer victim—it's a sad thing. There's one other thing that they're not told the truth about and that's these coping styles, these syndromes. It's one thing to see somebody who is an "Orphan Annie," a "Tammany Hall," or something else and then go down in the lounge and talk to your friends and say, "Boy have I got a Hummingbird Tonguer down here," but it's another thing not to go up to the patient and in your own way to point out what's happening. Pretty soon you can get the problem across, have proper rapport with the patient, and say, "Hey, you're hummingbird tonguing again. That's what you did. That's what that was. You didn't take your medicines because you didn't want to go to Montreal to the meeting. You didn't take your medicines, didja?" When they admit that they didn't, say, "Alright, there are better ways not to go to Montreal. Just say, 'Honey, I don't want to go to Montreal. You go and I'll stay home.'" You can point these things out and you can actually get rapport with the patient using jargon of this sort.

And then there's bargaining. It's unbelievable what kind of bargains patients will make. The "Tammany Hall," "Nobel Laureate," "Humpty Dumpty," or "Perfect Patient" will all say, "Just get it so I can lift ten pounds," and you get them to lift ten pounds. Then they say, "Get me up to twenty pounds," and pretty soon they want to run in the Olympics. You get them on a good program, say 15 mg of prednisone every other day. "Get me off that 15 mg of prednisone!" They bargain on down and they won't leave well enough alone. The thing to do is to recognize when they are bargaining and do some bargaining with them if there's no damage to be done. On the other hand, if you see damage to be done as a result of the bargain, then you point out, "Hey, look, you're bargaining with me, and I won't bargain because you're setting yourself up for big troubles." Then usually, we can get through the bargain. Now remember Kübler-Ross's notion was to help people get through this thing and on to acceptance. When these people are bargaining with you, it helps to point it out and say, "Look, you've got a chronic illness and chances are that you are going to require medication for the foreseeable future. Look at your history, every time you stop your medicines you keep getting into trouble."

Depression is a "Hair Shirt," "Hummingbird Tongue," "What Can I Do to Be Saved," "Catch 22" reaction. What do you do with depression? First, you recognize it. Second, the greatest thing you can do for the depressive aspect is to extend hope to these patients. Before we had inhaled steroids, there was a subpopulation that was in real trouble, and some are fine inhaled-steroid responders. There are a lot of new medications that a lot of pharmaceutical companies are manufacturing. To tell the truth, all we have to do is to find some kind of a medication that will do the good work that steroids do without the side effects and we'll be in Fat City. There are 9 to 16 million Americans with asthma, and you don't have to beg pharmaceutical companies to work on a product that is potentially of benefit to 9 to 16 million Americans. You don't even have to lobby for it because it is economically feasible. You just think some of these things out, and also talk in the manner of Kübler-Ross. Read what she does and how she talks to these people about depression. Hopefully, what you're shooting for at the end is acceptance of the asthma. It's difficult to attain. You can do it, I think, more easily with rheumatic arthritis, for some reason, than you can with asthma. But first of all, your patients ought to be on an optimal medical program, and they should be well educated. Hope for the future is something that ought to be stressed as is hope for adaptation to the illness and treatment until this help that you're hoping for comes.

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REFERENCE

1. Kübler-Ross E. On Death and Dying. New York: Collier Books; 1970.