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Treating panic

Psychological treatments are preferable to drug treatments

Almost all doctors encounter panic in their patients and have little difficulty in recognising it. Indeed, they agree on diagnosing panic more often than they agree on diagnosing any other psychiatric symptom[1]: extreme apprehension, together with severe autonomic symptoms such as sweating, dizziness, palpitations, and "jelly legs" constitutes panic. Expressing panic is physiologically demanding and cannot be maintained for long. Panics are therefore episodic and commonly occur as single attacks or in volleys. Since Klein pointed to the importance of spontaneous panic as a psychiatric symptom[2,3] panic disorder has been elevated to a diagnosis in the American psychiatric classification.[4] It is also included in the draft version of the 10th revision of the *International Classification of Diseases*.[5] Panic is thus differentiated from generalised anxiety but may occur with phobic symptoms, particularly agoraphobia.

Treating panic is one of the commonest emergencies in psychiatric practice. Panic attacks are extraordinarily unpleasant, and morbidity arises not just from the distress experienced during the attack but also from concern about having another one. As with many psychiatric disorders there is argument over the relative merits of drug and psychological treatments. Drugs are easier to give and begin to work quickly. A panic attack reaches its peak, however, within a few minutes, and no treatment (except possibly an intravenous injection) is effective this quickly. Panic attacks rarely have a prodrome, and spontaneity is one of their hallmarks. The most convincing evidence of effective treatment of panic with drugs is a series of studies with the tricyclic antidepressant imipramine.[2,6-9] Antidepressants prevent attacks, often completely—an observation that led Klein to postulate that antidepressants "block" panic attacks specifically. Similar efficacy has been shown for monoamine oxidase inhibitors, particularly phenelzine.[7,10]

The efficacy of antidepressants was an important reason for formulating panic disorder as a separate diagnostic category. This carried the implication that conventional sedative drugs such as the benzodiazepines were less effective in panic than in generalised anxiety, but this has never been adequately established.[11,12] Now one of the benzodiazepines, alprazolam, has been promoted specifically for treating panic, and a recent series of reports seems to support its efficacy.[13-16] In a cross national study alprazolam was significantly better than placebo after four weeks in patients with defined panic disorder. But this should not be taken as a recommendation for use because even short term use of benzodiazepines may promote pharmacological dependence.[17,18] Furthermore, patients who have been previously treated with benzodiazepines may show a spurious response to a new prescription of benzodiazepines: all that is happening is that the new drug is preventing the withdrawal reaction that arises after stopping the original benzodiazepine. This gain is often shortlived as withdrawal symptoms re-emerge after the new benzodiazepine is withdrawn. This was apparent in the studies of alprazolam: a third of the patients had withdrawal symptoms after reducing and stopping treatment, and by this time the active drug was less effective than placebo.[16] Any benefits that benzodiazepines confer in panic are more than outweighed by the risks of dependence. Although other drugs such as β blockers sometimes have a place in the treatment of anxiety,[19] they are not normally effective in panic.[20]

Psychological treatments have also been shown to be effective, but they have been less thoroughly researched than drug treatment. Most widely used have been strategies based on cognitive and behavioural psychotherapy,[21-24] such as respiratory control and anxiety management training and exposure treatment in patients with phobias. These procedures reduce the frequency of panic attacks, and if early symptoms are noticed a train of manoeuvres may prevent the attack developing. A feeling of helplessness is almost universal during a panic attack, and once sufferers feel that they have some control over the symptoms an important battle has been won.

These techniques need staff with specialist training, and usually the staff are not available to the average general practitioner who sees patients with panic most often. But there is increasing evidence that direct contact with these staff is unimportant in ensuring the success of treatment. Self help procedures are as effective as behaviour therapy for phobias[25] and for both panic and generalised anxiety.[26] As psychological procedures do not carry the same handicap as drug treatment they should be preferred if treatment is to continue for any time.

The message for doctors faced with patients with panic is simple: use tranquillisers sparingly and introduce patients to psychological treatments whenever possible. If these fail then consider treatment with antidepressants, but prepare the patient for a delay in response.

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The rise in private hospital care

Unpredictable implications

Data on the treatment of patients by the private sector in Britain are not routinely available. Knowledge about this activity comes from research surveys, and two of these, covering England and Wales in 1981 and 1986, by Nicholl *et al*, are published today (p 239 and p 243). Excluding psychiatric and maternity care, the authors estimate that the private sector accounted for about 7% of all inpatient admissions in 1986 and that admissions in the private sector had increased by 57% from 1981. Termination of pregnancy was the single commonest reason for admission, accounting for 28% of admissions in 1981 and 19% in 1986. The case mix was otherwise similar for the two years and consisted mainly of elective operations.

Most admissions were for conditions for which there are waiting lists in the NHS. Considering all elective operations, the authors estimate that 17% of inpatients and 11% of day cases in England and Wales were treated in the private sector in 1986; a fifth of all inguinal hernia repairs and over a quarter of all hip replacements were undertaken privately. Compared with the NHS the private sector treated proportionately fewer children and patients aged 65 years and over. There was wide geographical variation in the proportion of elective surgical conditions treated in the private sector—from 6% in the Northern region to a third in two of the Thames regions. Thus, although the private sector has grown considerably, it still provides treatment for only a limited range of conditions and a limited group of people in limited areas.

Could the independent sector increase substantially its contribution to health care in Britain? Nicholl *et al* question the scope for expansion into expensive high technology medicine, and it seems unlikely that the private sector would be able or willing to take on the comprehensive, open ended commitments of the NHS. None the less, with determination, financing, and incentive the private sector could, no doubt, expand its range of activities and grow further.

One constraint is the availability of professional staff. Important factors include past and present planning of medical school intake and medical career structures[1-3] and the substantial reduction in the next few years in school leavers.[4] Further short term expansion of the private sector will probably be possible only if professional staff can be attracted away from the NHS. In the longer term, national investment in training health professionals could be increased, and the option exists of recruiting labour from overseas markets. An increase in private sector activity might diminish the monopoly power of the NHS as an employee, and competitive pressure might result in an increase in salaries and improvements in working hours in health care.

It is important that private care is available for those services that are not available through, or not provided on a suitable time scale by, the NHS. What are the advantages and disadvantages of private sector care? Reports on the subject are burgeoning,[5-11] but much remains speculative. An increase in private sector care would probably erode the principle of providing health care according to need rather than ability to pay. This apart, much would depend on three key interrelated issues. The first is whether private provision will continue to be seen by the government as a means of adding to rather than substituting for NHS funding. Expenditure on health care in England and Wales is recognised to be low relative to that in other industrialised countries.[12] An increase in private expenditure, in addition to sustained and expanded funding for the NHS, might increase total expenditure on health care by reducing the power of government to cash limit it. The second issue is whether an increase in private care would by default adversely affect the NHS—for example, by depleting it of skilled staff or making doctors more difficult to contact for NHS emergencies. The third issue is whether the NHS would be expected and enabled to compete with the private sector with regard to those issues that influence people most in seeking private care—short waiting times, convenience, choice, privacy, comforts, and amenities—or whether the NHS would eventually become a second class service.

The question of whether economies in health care provision without sacrifice of quality might come from an expanded private sector is difficult. Detailed information on costing in the NHS and on comparisons of cost effectiveness between the private and public sectors is lacking. There are also notorious difficulties in measuring health care inputs and outcomes in ways that allow conclusions about different sectors giving value for money. Few doubt, however, the BMA's conclusion that the NHS "represents outstandingly good value."[11] Nicholl *et al* show that when individual conditions were compared day case care was, if anything, less