Antecedents of "Spontaneous" Panic Attacks

SIR: I would like to comment on "Prodromal Symptoms in Panic Disorder With Agoraphobia" by Giovanni A. Fava, M.D., and associates (1), in which it was suggested that many individuals with panic disorder/agoraphobia manifest long-standing avoidant patterns before the onset of their first panic attacks. In my practice I see a very large number of individuals with panic disorder and/or agoraphobia. My approach is largely cognitive and behavioral, but unlike the few other practitioners in the city who also see large numbers, I rely less, I believe, on clinical assistants and thus get to know firsthand some of the antecedents, which only gradually come to light.

Without any statistical analysis to back me up, I had already reached the strong conclusion that very often the original, apparently spontaneous panic attack is the culmination of years of avoidances based on various fears. Many of these avoidances have become very refined and subtle, appear natural to the individual (and even part of his or her "character"), and are often highly rationalized. It is only with both increasing exposure to phobic avoidances and some review of their previous behavior that these patients become aware that their avoidances are not natural or inevitable. The entire sequence, however, is not unconscious in the usual psychoanalytic meaning of that word. Rather, it seems that the avoidances have eventually painted the individual into a corner where further avoidances are no longer tenable or the life situation no longer allows them, and panic ensues.

It does not necessarily follow that such apparently spontaneous panic attacks should not be treated with tricyclics merely because the antecedents are detectable, but I would agree that such antecedents are far more common than initial histories indicate, and while some panics still appear "spontaneous," the more detailed the ongoing inquiry, the fewer appear spontaneous.

I thought the article by Dr. Fava and associates was an example of a highly useful and relevant clinical investigation.

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Addiction to Neuroleptics?

SIR: Like most psychiatrists, I have persisted until recently in telling people that neuroleptics are not "addictive." I had in mind a model of addiction that involves the compulsion to take substances that produce pleasure, euphoria, or sedation. I also had in mind a classic withdrawal syndrome with seizures or other signs of CNS hyperactivity.

As clinicians, many of us have become increasingly aware of the difficulty we encounter in helping patients relinquish these drugs, even when they are made aware of the dangers of long-term use, such as tardive dyskinesia. In addition, there have been reports in the literature of symptoms associated with attempts to discontinue neuroleptic drugs; these include nausea and vomiting, dyskinesias, and dysphoria, sometimes in the form of tardive psychosis (1–3).

Stedman's Medical Dictionary (22nd edition) defines addiction as "habituation to the use of a drug, the deprivation of which gives rise to symptoms of distress, abstinence or withdrawal symptoms, and an irresistible impulse to take the drug again." By this definition, it appears that neuroleptics may produce "withdrawal symptoms" sufficiently severe to compel the individual to continue ingesting the medication. Although the classic model of CNS hyperactivity is not required to fit the definition of addictive, we find this phenomenon in the form of dopamine hyperactivity, the presumed mechanism behind many of the withdrawal symptoms.

Perhaps we should acknowledge that the neuroleptics are potentially addictive and label them as such.

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Should "Depression" Be Dropped the Way "Neurosis" Was?

SIR: Paul Fink, M.D., in his role as President of the American Psychiatric Association, set the theme for this year as "Overcoming Stigma" (1). The upcoming years are also important as we plan the revisions of our nosologies for *DSM-IV* and *ICD-10*. I believe that these two goals are partly linked. With the introduction of *DSM-III*, the term "neurosis" was eliminated (since there was lack of consensus on the definition of the term), and manic-depressive illness became bipolar disorder. The effect of these changes has been to reduce in part the stigma attached to these disorders. Since that time, several public figures have announced that they have bipolar disorder, and the Arkansas appeals court has required a major insurer to reimburse for the disorder as they would for a medical illness. I see two basic reasons for following in the same direction and renaming major depressive disorder.

The first reason is the lack of clarity in the use of the term "depression." Depression is a subjective experience, which patients and others describe in various ways. Everyone experiences periods of depression, but only a few have the illness we call depression. Most of us have successfully treated patients for major depression who have not even complained of depression, particularly agitated or pseudodemented elderly patients and patients with somatization symptoms. On the other hand, the majority of patients presenting with depressive symptoms do not have major depressive illness. The use of a nonspecific symptom to name a presumably specific syndrome reduces the clarity and meaning of our diagnosis.

The second major reason for the renaming has to do with stigma. Since depression is such a ubiquitous emotion, the general public (our nonpsychiatric colleagues included) believes that people should be able to handle it on their own. This leads to individuals not seeking help or instead pursuing medical investigations of somatic manifestations of the dis-