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# HIGH ANXIETY

The most widely used tranquilizer in America is more addictive than Valium-and is often less effective than nondrug treatments for anxiety.

The woman we'll call Rachel G.-now age 31-had experienced attacks of anxiety since she was child. But those occasional incidents did not prevent her from marrying and taking a responsible job at East Coast biotechnology company. Then, in late 1990 and early 1991, her life took a stressful turn. There was turmoil at the lab where she worked, her mother fell seriously ill, her grandmother committed suicide, and her marriage deteriorated. In early April of 1991, after a confrontation with her boss, she had full-blown panic attack. "I broke into a cold sweat," she calls. My heart was palpitating. I wore I was having a heart attack. was scared that I was dying . . . I uldn't walk. I couldn't even move." The attacks went on for two days. Rachel G. went to a psychologist for help, and simultaneously asked her regular internist for a pill to ease her suffering. Her physician prescribed *Xanax* (alprazolam). That was no surprise. In 1990, *Xanax* had become the only drug ever approved by the U.S. Food and Drug Administration for the treatment of panic disorder-repeated, intense bouts of anxiety that can make life almost unbearable.

problem. After about three months on *Xanax*, she tried to cut her dose in half. Within 48 hours, she recalls, "I couldn't sleep. My heart was racing, and [was getting dizzy spells. Only going back up to an intermediate dose would suppress the withdrawal symptoms.

In February 1992, Rachel G. began having frightening thoughts of killing herself. She visited a psychiatrist who prescribed *Tofranil* (imipramine), an antidepressant that also works against panic. Today, she is doing well, still taking imipramine-and also *Xanax*. Though she feels the *Xanax* is no longer helping her, she can't bring herself to quit. "I know I should have to experience the withdrawal symptoms," she says, "and those are the exact symptoms that I went on it to escape from in the first place.

Rachel G.'s problem is far from unusual. *Xanax* is not only the most common treatment for panic attacks, but also the drug most often prescribed for run-of-the-mill anxiety-the kind that anyone might experience during a rough period in life. It is now the nation's largest-selling psychiatric drug; more than that, it is the fifth most frequently prescribed drug in the U.S.

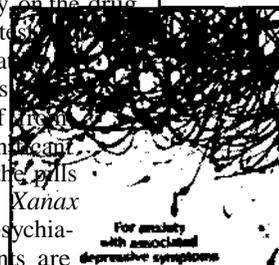
Even if you've never taken *Xanax*

significant. Anyone who takes *Xanax* for an extended period-even as little as a few weeks-risks developing a stubborn dependency on the drug.

*Xanax* is just the latest in a long line of tranquilizers that have promised to deliver psychiatry's holy grail: relief from anxiety with no significant side effects. And like the pills that came before it, *Xanax* has fallen short. As psychiatrists and their patients are discovering, *Xanax* does have some serious drawbacks-even more than the drugs it was supposed to improve on.

Like the sleeping pill *Halcion* (triazolam), its closest chemical relative, *Xanax* demonstrates that no pill can deliver peace of mind without a price. It also raises a troubling question: How did such a flawed drug become a pharmacological superstar?

The selling of *Xanax* has been fueled by a vigorous promotional campaign. The drug's manufacturer, the Upjohn Co., has made *Xanax* highly visible in the medical community by promoting it as a uniquely effective drug for panic disorder. But *Xanax* does not represent a remarkable treatment advance so much as a marketing coup. In fact, it is little different from other related tran-



**Anxious and blue? This ad suggests Xanax is especially useful for anxious people who are also depressed. While the FDA has this calm, many clinicians take issue with it.**



The more things change...  
 1967 CU report on Xanax's predecessor, Valium, reported that it didn't work much better than an inactive placebo in soothing the symptoms of anxiety.

ner or *NutroSweet*. The first drug in this category, *Librium* (chloridiazepoxide), came on the market in 1960: *Valium* (diazepam) came along three years later.

In 1979, a survey showed that 11 percent of Americans were taking antianxiety drugs, mostly benzodiazepines. The figure has dropped only slightly since then.

That was also the year the hazards of these drugs gained national attention through hearings held by Senator Edward Kennedy. As the hearings made clear, *Valium* and similar drugs caused two major problems: Physical dependency and sedation. People on benzodiazepines often found that they couldn't stop taking the drugs, and that they couldn't function well while they were on them. The drugs accumulated in the body; over time, they made the user more and more sluggish, drowsy, and forgetful.

Ironically, while the Kennedy hearings offered frightening testimony on *Valium*, they also set the stage for the arrival of its successor, *Xanax*. Introduced in 1981, *Xanax* was hailed as the first of a new chemical class

edge, *NutroSweet* expired in 1984, just as sales of *Xanax* were beginning to build. As generic competitors undercut *Valium's* sales, the drug's manufacturer promoted it less actively, and sales of *Valium* dropped further. Upjohn took advantage of the opportunity. By 1986, *Xanax* had overtaken *Valium* as the most widely prescribed benzodiazepine. By 1987, it reached fourth place on the national sales list of all prescription drugs. And in 1991, *Xanax* accounted for almost one-fifth of Upjohn's worldwide sales.

The trouble is, *Xanax* has now turned out to be more addictive than *Valium* itself.

### Sluckonla-

All benzodiazepines produce physical dependency if you take them long enough. Over time, it seems, the brain "learns to expect a certain level of the drug. If the drug is removed, the brain reacts with agitation, sleeplessness, and anxiety—the symptoms that led people to take the drug in the first place. Frequently, these symptoms are worse than the original ones, a phenomenon known

late the doses they take over. But they do have a true physical dependency, and their withdrawal symptoms make the benzodiazepines extremely difficult to kick.

A number of clinical studies have found that *Xanax* and other benzodiazepines that are eliminated rapidly from the body produce a quicker, more severe rebound effect than drugs like *Valium* that are eliminated more slowly. Some people who take *Xanax* three times a day, a standard schedule for panic disorder, find they even have symptoms a day after the drug wears off between one dose and the next.

In one major study, Dr. Rickels and his colleagues at the University of Pennsylvania found that anxious patients who had been on benzodiazepines for a year or more and tried to take them off their system had a 57 percent relapse rate. Fully 57 percent of the patients on *Xanax* and similar drugs could not stop taking them, but only 27 percent of the people on drugs like *Valium* were that physically dependent.

Other studies have produced similar results. A Yale study of pa-

## ALL-PURPOSE PRESCRIPTIONS

# WHO TAKES IT, AND WHY?

*Xanax* presents a paradox: It is a powerful psychiatric drug, but it is most often prescribed for people who have no psychiatric diagnosis at all. While many of those people may be suffering from a serious problem with anxiety that is never recorded on a diagnostic chart, others may simply be people who ask their doctors for some relief from stress.

We analyzed data from the 1990 National Ambulatory Medical Care Survey, a representative sample of doctor's visits conducted periodically by the U.S. Government. Our analysis shows that the drug is prescribed by a wide range of different kinds of doctors, for people with a wide range of conditions—a situation that increases the odds of misuse.

*Xanax* is usually prescribed by physicians in general practice. In the 1990 study, only 30 percent of *Xanax* prescriptions were written by psychiatrists, whereas nearly half were written by family, general, and internal medicine practitioners. (Various other specialists wrote the rest.)

Of all *Xanax* prescriptions, only 28 percent were written for people who were diagnosed with clinical anxiety or panic attacks.

Another 21 percent were for people diagnosed with depression, a condition for which the use of *Xanax* is still controversial. The rest were generally written for people who had no diagnosed psychiatric problem at all, although they did have a variety of medical diagnoses, the most frequent being high blood pressure. These statistics are similar to those obtained in another large national survey: IMS America, a private organization that monitors drug sales, found that only about one-fourth of all benzodiazepines prescribed in 1989 were given for anxiety-related conditions.

Many of those *Xanax* prescriptions may have been written appropriately for people suffering from short-term anxiety triggered by a medical problem. But the data, combined with the high sales volume of *Xanax*, suggest that the drug may often be prescribed as an all-purpose stress reliever. The FDA-approved package insert (which can be requested from the pharmacist) states specifically that *Xanax* should not be given simply to help people deal with the stress of everyday life, and that the drug should be given only as a short-term treatment for clear symptoms of anxiety or as a treatment for full-blown anxiety or panic disorders.



only 30 percent of the doctors interviewed said they had prescribed benzodiazepines to their patients. Similarly, a survey of long-term users in Toronto's Addictive Research Foundation found that two-thirds of them had tried to stop using the drug and failed. The experience of individual doctors underscores the problem. In 1988, researchers at the Johns Hopkins School of Medicine interviewed 100 American physicians who specialize in helping people withdraw from the benzodiazepines. Asked which drugs were especially difficult for patients to

quit, 84 percent of the doctors specifically mentioned *Xanax*, while 29 percent cited *Valium*. Even under the best of circumstances, clinicians have found that, to get people off *Xanax*, they must reduce the dose in tiny steps—a process that often takes months.

### 'Eraser' for the mind?

The fact that so many people try so hard to quit *Xanax*—as difficult as it is to do—shows that it is not an overly pleasant drug to take. One man we spoke with, a 41-year-old medical writer in San Francisco, started taking *Xanax* to deal with bouts of anxiety that made her feel "I was going headlong toward the frightening and dangerous unknown." After taking *Xanax* for 14 months, she decided to stop because, as she puts it, "It made me too stupid. I just couldn't function professionally. People would say things to me, and I'd be in a sort of fog and wouldn't be able to respond appropriately." (She ultimately succeeded in quitting, but had to go through a very difficult withdrawal process—nonetheless, she was taking a low dose, and her psychiatrist told her it would not cause dependency.)

A 1990 report by the American Psychiatric Association backs up this man's experience. It found that benzodiazepines tend to impair memory; a person on one of these drugs may have difficulty retaining information.

Clinicians report the same problem. "One patient of mine, a physi-

cian, said, "Benzodiazepines cause memory lapses, especially in the elderly," says Dr. Stuart Yudofsky, chairman of the Department of Psychiatry at Baylor College of Medicine in Houston.

Yudofsky also refers to evidence that the drugs impair coordination. And in his own experience, he says, "patients who have used benzodiazepines for years have often suffered falls and head injuries."

*Xanax* can also have the paradoxical effect of causing rage and hostility rather than tranquility. While this

is relatively rare, it's another reason for caution in using a drug that many people will be all but unable to quit.

Despite the risks, benzodiazepines have one clear use: They can be helpful for people in crisis who need short-term anxiety relief. "They're appropriate for what are called adjustment reactions," says Dr. Peter Tyrer, a professor of psychiatry at St. Mary's Hospital Medical School in London and a longtime benzodiazepine researcher. "For example, if someone has been in a car accident and is nervous afterward when he goes out into the street, he could take *Xanax* for a short time after that"

The problem, though, is that many people who start taking tranquilizers for the short term end up staying on them over the long haul. "For anxiety, in general, these medications tend to be used much too long and in too high doses," says Dr. Yudofsky. "People get put on a drug, the reason for taking it passes, but they're maintained on it week after week, year after year. That's misuse." Even Upjohn, in its own labeling for *Xanax*, cautions that the drug has never been established as effective for use over more than four months.

### Pushing the panic button

The people most at risk for becoming dependent on *Xanax* are those

with panic attacks, it's not at all clear how much they were really helped.

A panic attack is intense anxiety in a concentrated dose. Victims with a severe case may suffer several full-scale attacks a day, during which their hearts race and they hyperventilate, sweat, tremble, and feel a profound sense of terror. According to the largest, most thorough survey of psychiatric problems, conducted in the 1980s by the National Institute of Mental Health (NIMH), between 4 and 7 percent of Americans have panic attacks that are frequent enough to be considered a panic disorder. The majority of people with panic disorder also have a condition, agoraphobia—a term now used to describe a fear of ordinary activities, such as driving a car or shopping at the supermarket, that can leave the sufferer housebound.

By the early 1980s, researchers had begun to recognize that at least some types of benzodiazepines, in addition to easing ordinary anxiety, could also stop panic attacks. Upjohn proceeded to spend lavishly on studies to see whether *Xanax* could be used to treat panic disorder, and enlisted highly respected consultants in the effort. "The most senior psychiatrists in the world were . . . flooded with offers of consultancies [from Upjohn]," recalls Dr. Isaac Marks, a professor of experimental psychopharmacology at the University of London's Institute of Psychiatry.

In fact the research could just as well have been done with another benzodiazepine—one called lorazepam (*Ativan*)—that is also cleared from the body quickly, and has also been shown to stop panic attacks. But this drug has not been under patent protection for years—and since it has not had the profit potential that *Xanax* has, it has not been aggressively tested and promoted. Today, a bottle of 100 one-milligram *Xanax* tablets costs \$72.55, according to the Red Book, a standard drug price guide. The same amount of generic lorazepam in a therapeutically equivalent dose costs as little as \$3.75.

People with panic disorder, because they are prescribed high doses of the drug for an extended period of time to deal with their chronic panic attacks. Since they suffer from severe or dis-

**Street abuse  
Drug abusers  
traffic in *Xanax*  
because of an  
unusual property  
When combined  
with methadone,  
*Xanax* produces  
'high' much like  
heroin, the drug  
methadone is  
meant to replace**

Upjohn's major study on panic  
was  
a two-phase  
project called  
the Cross-  
National  
Panic Study.  
Phase One,  
conducted in  
the U.S.,  
Canada, and  
Australia,  
involved  
more than  
500

Though *Xanax* is the best-selling psychiatric drug in the U.S., it's not the most notorious. Vying for that distinction are *Prozac*, a drug for depression, and *HalcUm*, a benzodiazepine sold as a sleeping pill.

Both *Halcion* and *Prozac* have been reported to induce irrational behavior, including outbursts of murderous violence and suicide attempts. (*Halcion* was even blamed by some observers for President Bush's illness on his trip to Japan.) Lawsuits have been brought against their manufacturers, seeking damages for cases of suicide and assault committed by people taking the drugs. The accusations against both drugs prompted the U.S. Food and Drug Administration to ask expert committees to look at them more closely. Here's an update.

## Prozac (fluoxetine)

Introduced in 1987 by the Eli Lilly Co., *Prozac* rocketed up the pharmaceutical best-seller list on the strength of Lilly's strenuous promotional efforts, its evident effectiveness against mild depression, and its relative absence of side effects. Overlooked in the initial enthusiasm for the drug, however, was the lack of evidence that *Prozac* worked well against major depression, a prolonged, serious psychiatric disorder that puts victims at high risk of suicide.

*Prozac's* honeymoon ended in 1991, when a psychiatrist published a study on six chronically depressed patients who developed obsessive, violent thoughts after starting on the drug. The psychiatrist did emphasize that these six patients had unusually severe cases of depression; they had not responded to any other treatments, and five had had suicidal thoughts, though less severe ones, before they ever took *Prozac*.

But those distinctions disappeared in the uproar that followed.

The FDA review panel, convened late in 1991, concluded that people taking *Prozac* did not seem to have any more suicidal or violent thoughts than patients on other antidepressants (though the panel recommended further monitoring of the drug, just in case). In the panel's view, the suicidal thinking some patients experienced was caused by the depression itself, not the drug.

Psychiatrists point out that patients can react paradoxically to almost any powerful drug, including *Prozac*, and therefore should be monitored closely—especially early in

treatment, when they're getting used to the new drug. Meanwhile, *Prozac* remains the nation's best-selling antidepressant.

## Halclan (triazolam)

Though marketed as a sleeping pill, not an anti-anxiety drug, *Haldon* is actually *Xanax's* close chemical cousin. Like *Xanax*, *Halcion* is a benzodiazepine that's eliminated from the body very rapidly, meaning you can take it to get to sleep at night without being drowsy the next day. *Halcion* entered the market by 1987, the year of its popularity was the 18th largest-selling prescription drug and the largest-selling sleeping pill in the U.S.

The disadvantages of *Halcion* eventually made themselves known. People who used it for any length of time found that, when they tried to stop, they experienced rebound insomnia worse than the original. There were also reports that *Halcion* seemed to make some people hostile or paranoid. The FDA was worried, and analyzed the thousands of voluntary reports of adverse reactions to *Halcion* the agency had received from doctors. *Halcion* indeed was linked to more hostility reactions than any other sleeping pill, relative to the numbers prescribed.

Another troublesome side effect also emerged: Some people who took even small doses experienced a bizarre reaction called anterograde amnesia. The day after they took *Haldon* to get to sleep they were up and about, apparently functioning normally. But later, they would have absolutely no memory of their actions. In 1991, *Halcion* was banned in the United Kingdom.

An FDA advisory committee decided, in May of 1992, to let *Halcion* stay on the U.S. market. But the panel agreed that the original recommended dose of 0.5 milligrams a day was too high, especially for elderly people; a lower dose of 0.25 milligrams was less likely to cause side effects (though it could also make the drug less effective). The committee also recommended strengthening the package insert's warnings on rebound insomnia and hostility reactions.

While the controversy over *Prozac* didn't seem to affect its upward sales trajectory, *Halcion's* sales have suffered. By 1991 it had fallen to 38th place. And last November, in a widely publicized case, a Dallas jury decided *Halcion* had been partly responsible for driving a man to murder—a decision that may damage the drug's reputation even more.



Europe, enrolled 1122 subjects to compare *Xanax* not only with placebo, but also with imipramine, an antidepressant from a different chemical class that also blocks panic attacks (even though it has not received formal FDA approval for this use). At the time, the two studies were among the largest ever done on psychiatric drugs.

Well before the results were published, Upjohn used the research to promote its drug. The company sponsored conferences and symposiums on drug treatment for panic and anxiety, and then invited its consultants to speak at them—a strategy now used by many large pharmaceutical companies (see *Pushing Drugs to Doctors*, COLEMAN REPEL, February 1992). Many of those meetings were then written up in Upjohn-sponsored supplements to scientific journals, sent to thousands of psychiatrists in the U.S. and abroad.

When the Phase One results were finally published, they made a big splash: Four articles on the study consumed the better part of the 1988 issue of the *Archives of General Psychiatry*, the most prestigious psychiatric journal in the U.S. By that time, however, the international psychiatric community had already been hearing about *Xanax* as a treatment for panic for several years. Upjohn publicity had made psychiatrists—and, later, general-practice physicians—more aware of *Xanax* than they were of other, similar drugs. Almost certainly was responsible for the rapid growth of *Xanax* as a drug for all sorts of anxiety problems, just panic disorder.

"The Cross-National Study was the best advertising ever done," says Rickels of the University of Pennsylvania. "Upjohn sold millions of doses of this drug before they even got it approved for panic."

## No panacea for panic

Since receiving FDA approval for panic disorder, Upjohn has been using data from Phase One of the Cross-National Study in ads for the drug—including ads in journals for general-practice physicians. These doctors are likely to be unfamiliar with the actual results of the study, and to take Upjohn's word for what it shows. But despite the ads' claims, the study produced highly ambiguous results.

... of Upjohn's ads for *Xanax*: results from this midpoint of study. But the... was much less... by the study... look at the pe... o stayed in th... for the full eigh... shows a... ble picture:... d of the stud... was no signi... difference in th... ge number... attacks--(}f... oning in wor... and social life-- en the people... ad been taking... and those who... taking placebos.



WIL::Li

In addition, the Phase One study clearly showed how severe the "rebound" effect of *Xanax* withdrawal was at the two study locations in a, 109 patients who had completed the eight weeks of treatment (observed as the dose of the real or placebo) was tapered down a month's time. The *Xanax* group had averaged only 1.7 panic attacks a week--and the placebo group, 2.1 attacks a week--at the end of the eight-week treatment. But just two weeks after they stopped medication entirely, patients in the *Xanax* group were back up to 2.5 attacks a week--slightly worse than they had been at the beginning of the study. By contrast, two weeks after the patients on placebo stopped their drug, they averaged only 1.8 panic attacks a week. These findings are complicated by the Phase One study's greatest flaw: only 10 percent of the people on the real drug, and half of those on placebo, dropped out between the fourth and eighth week. At the time they left the study, the dropouts from the *Xanax* group had more symptoms than people taking placebo--a fact which would suggest the drug was more effective. But many people on placebo may have been suffering from withdrawal symptoms, since they had been taking benzdines just before they entered the study. There's also no way to tell whether they would have felt better at the end of the eight-week study if

... worked as well as the end of the eight weeks, 78 percent of people taking *Xanax* were panic-free, compared with 81 percent of those on imipramine and 75 percent of the people on placebo--virtually identical numbers.

Upjohn researchers and their supporters believe *Xanax* came out the clear winner in the studies. They point out that it acts much more quickly than imipramine and is easier to take. Imipramine is one of a class of antidepressants that can cause a range of unpleasant side effects, including sedation, dry mouth, severe constipation, blurred vision, weight gain, and impotence.

But other psychiatrists focus on the fact that people taking placebos did nearly as well as those on *Xanax*: by the end of the study--and avoided the rebound effect that plagued people on the real drug. That suggests that for many people, the mere act of visiting a doctor might have been reassuring enough to produce a measurable decrease in symptoms. It also suggests that nondrug treatment could help many other panic sufferers learn how to control their symptoms.

The same may be true for people who have more generalized anxiety--a form of chronic, excessive worrying, combined with physical and emotional symptoms, that affects about 4 percent of Americans, according to NIMH estimates. *Xanax*: itself, surprisingly, has never been tested as a long-term treatment for such chronic anxiety disorders. But Dr. David Barlow, a clinical psychologist who directs the Center for Stress and Anxiety Disorders at the State University of New York at Albany, points out that the benzodiazepines in general have not proved effective for treating these problems--except to offer temporary relief of symptoms.

Barlow reviewed two decades' worth of studies that used benzodiazepines to treat chronic anxiety. He observed that patients in the "uncontrolled" groups for these studies--that

... waxes and wanes over time, and that drugs may have little effect after their initial benefit

## Recommendations

If anxiety is an inevitable part of the human condition, then the wish for a magic potion to banish anxiety is probably a timeless human desire. In our own time, drug companies have marketed one tranquilizer after another, each one supposedly safer and more effective than the one before. But tranquilizers--in particular, the benzodiazepines--are still powerful, potentially dangerous drugs, subject to abuse and misuse.

Given the hazards and their widespread use, we should know surprisingly little about the risks and benefits of long-term benzodiazepine use--and too little in particular about *Xanax*, now the leader of the pack.

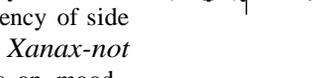
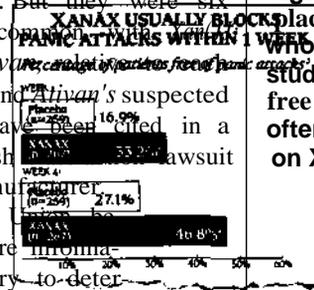
No one knows how many people are physically dependent on *Xanax* and how they may be affected by it. But there are some warning signs. A recent FDA analysis of reports of adverse reactions to drugs, which physicians send to the agency voluntarily, showed a number of cases in which the drug seemed to cause bouts of rage and hostility. Those side effects were rare, and were much less common with *Xanax* than with *Halcion*. But they were six times more common with *Xanax* than with *Ativan*. And *Ativan's* suspected side effects have been cited in a pending British lawsuit against its manufacturer.

Consumers believe that more information is necessary to determine the frequency of side effects from *Xanax*--not only its effects on mood, but its potential for impairing memory and causing other cognitive problems. Careful surveillance of the drug's clinical use could do much to resolve these questions.

In the meantime, if you or a loved one has a serious problem with anxiety, you need to understand your options clearly.

If you're not nonnally an anxious person, you should know that

As time goes by, a 1991 study ran the control below showing that nearly half of *Xanax* patients were panic-free after four weeks of treatment, versus just one in four people on placebo. What the ad didn't show: By the end of the placebo week, 80% of *Xanax* patients who finished the study were panic-free almost as often as patients on *Xanax* were.



person, but  
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and other lifestyle changes can also help keep anxiety in check.

It can also be useful, and appropriate, to take *Xanax* or another benzodiazepine to cope with acute stress—as long as you take the drug carefully. If your doctor prescribes one of these drugs, take it at the lowest dose possible and for the shortest time possible. Remember that even a few weeks of daily *Xanax* use can lead to dependency.

If you're suffering from panic disorder, agoraphobia, or chronic anxiety, you have a serious problem that requires professional evaluation and treatment by a psychiatrist or psychologist. It's not clear, however,

and nondrug therapy generally try the nondrug approaches first.

Whatever your problem is, you should avoid *Xanax* and its chemical cousins if you have any history of alcohol abuse or previous problems with other benzodiazepines. Those factors in your personal history make it more likely that you will become dependent on the drug. Alternative forms of drug therapy may be less risky. Antidepressants like imipramine can block panic attacks as effectively as *Xanax* can. For people with chronic anxiety who do not have panic attacks, a drug called *BuSpar* (buspirone) can frequently

you are to withdraw from it. When taking the medication, use extreme caution when driving, since these drugs can impair coordination. Do not exceed the prescribed dose, and do not drink alcohol while on the medication. (The interaction can be disastrous.) At the least, it can worsen the symptoms of speech, poor coordination, dizziness, and mental slowness that can stem from use of benzodiazepines. Inform your doctor immediately of any unexpected side effects, such as feelings of rage or agitation. If you seriously consider trying some form of psychotherapy to gain insight into your problem.

## SHORT-TERM PSYCHOTHERAPY

# RELIEF WITHOUT DRUGS

People with serious anxiety—including those with panic attacks—don't need to choose between a life on tranquilizers and a life under severe stress. The past decade has seen the development of a new type of nondrug treatment called cognitive-behavioral therapy. While it doesn't give the immediate relief of a drug like *Xanax*, it does produce results quickly—and may be the most helpful approach over the long term.

Cognitive-behavioral therapists believe that many people, perhaps even most, have panic symptoms at one time or another—a stressful situation, for example, may trigger a racing heartbeat or rapid breathing. These symptoms usually pass quickly, and most people never give them a second thought. But a few people overreact intensely when they experience panic symptoms; they misinterpret them as symptoms of impending insanity or death.

"They tend to catastrophize their symptoms," explains Dr. Robert Liberman, who treats panic-attack patients at the UCIA Neuropsychiatric Institute. "Anyone might feel dizzy getting suddenly out of a chair. A person vulnerable to panic might exaggerate that feeling, leading to sustained feelings of panic."

Cognitive-behavioral therapy works by teaching panic victims a new way of thinking about their physical symptoms. "The therapies consciously induce panic sensations—spinning patients on a chair to get dizzy, or having them run up and down stairs to get out of breath," Liberman says. Even when their heart is pounding, and they're short of breath and dizzy, they learn that nothing terrible happens and that these sensations naturally subside."

This technique and variations on it have been studied at numerous centers, with consistent results: After an average of a dozen weekly sessions, patients have few or no panic symptoms. More important, they maintain their improvement for a year or more.

Dr. David Barlow and his colleagues at the Center for Stress and Anxiety Disorders in Albany conducted one such study, comparing cognitive-behavioral therapy with *Xanax* and placebo over 15 weeks. The *Xanax* and behavior-therapy groups experienced

roughly equivalent declines in general anxiety. But two weeks after the study ended, 57 percent of the behavior-therapy patients were completely free of panic attacks, while half of those in the *Xanax* group were still having attacks, even though almost all were on the drug. In 1991, cognitive-behavioral therapy was endorsed by an expert panel convened by the National Institute of Health to evaluate treatments for panic disorder.

Short-term therapy for depression had similarly positive results in a study conducted over the past decade by the National Institute of Mental Health. For people with mild to moderate depression, both cognitive therapy and a form of short-term treatment called interpersonal psychotherapy worked as well as drug treatment (in this case, imipramine). For patients with severe depression, drug treatment worked slightly better than either kind of therapy.

Despite the evident advantages of cognitive-behavioral therapy, it is still less accessible to most people than drug treatment. Relatively few psychologists and psychiatrists are trained in this form of therapy. Most health-insurance plans reimburse poorly for psychotherapy. And without the kind of expensive publicity that the drug companies can put behind their products, nondrug approaches have received less attention than they deserve.

Not everyone is a good candidate for cognitive-behavioral therapy. "You have to have someone who is highly motivated, and some people having prolonged and frequent panic attacks are not able to endure the pain," says Dr. John Pecknold, a McNeister University psychiatrist who participated in Upjohn's *Xanax* study.

Nevertheless, CU's medical consultants believe psychiatrists should encourage their patients to more frequently consider this kind of short-term therapy as a treatment for anxiety and other psychological problems. These focused, effective methods entail less risk and offer better long-term results than drug therapy generally produces. They may also have the potential to be highly cost-effective. One recent study, for example, found even a single therapy session helped many people with panic attacks to overcome the problem.