and expressed suicidal thoughts. There were no biological features of depression. The initial diagnosis was of an unspecified personality disorder.

We helped him find bed and breakfast accommodation. However, three days later we learnt that he had been evicted. He returned to Out-patients again; on the first occasion he cut his wrists in the waiting area, but, perhaps surprisingly, did engage in treatment and later came to accept referral to the Day Hospital.

This was a young man who provoked feelings of hopelessness and futility in anyone who tried to help him; all previous interventions had been rejected or sabotaged by him. Presentation of his case to the group helped the social worker who had seen him to understand some of the reactions stemming from those feelings in herself and to recognise that this man could not deal with being alone all day even if he was given bed and breakfast accommodation. He was now offered additional psychological support that was more appropriate to his needs.

Comment

This multidisciplinary supervision group has encouraged a wide ranging approach going beyond the medical psychiatric diagnostic model. Although the patients have been traumatised, the interview allows an opportunity to intervene at a time of acute crisis when both the acuteness and the crisis are being denied by the patient. Within the group overall emphasis is given to understanding an individual's experiences of his or her situation within a broadly psychodynamic developmental model, rather than merely arriving at the correct psychiatric diagnosis and disposal.

At another level, the group has assisted in facilitating practical communication between members of the team allowing them to make maximum use of their different areas of expertise. The group has also functioned as a ward round, providing fuller coverage of the overdose service. As a result, our scarce resources have been shared and patients get maximum benefit from them. Breaking down inter-professional barriers has helped to prevent rivalries emerging between different staff members. The group has also contributed to the working relationship of the liaison service with medical and casualty staff who appreciate their patients being contained and not rejected.

Taking these patients seriously when they come into hospital has given us an opportunity to intervene at a time of crisis which might not otherwise be possible, however much in need of help a person may be. The group may help us to prevent the development of more serious problems in these vulnerable patients.

Acknowledgement

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Expert opinion

Alprazolam and panic disorder

In May 1988, the greater part of an issue of *Archives of General Psychiatry* was given over to reports of the results of a clinical trial of alprazolam for panic disorder. More recently, in March 1991, supplement no 365, of *Acta Psychiatrica Scandinavica* (APS) was devoted to a further trial of alprazolam for panic disorder. Few other psychotropic compounds have received such concentrated coverage. What, if anything, emerges from the studies reported?

Very little it would seem. Both sets of studies use a profusion of rating scales and statistical techniques. Both analyse in detail the trends in various sub-scales

of the scales that have been used. There are intention-to-treat analyses, completer analyses and point analyses. Despite this and despite many "significant" findings, little of true significance appears to emerge from these studies. Alprazolam and imipramine are both superior to placebo but this hardly remarkable. Alprazolam has a quicker onset of action than imipramine. Again, something that could have been predicted before either the US or cross-national collaborative panic studies began. At the end of the day, it is not clear that anything more has been demonstrated other than alprazolam produces a benzodiazepine type anxiolysis, whereas imipramine produces an anxiolysis of the type found with drugs active on the 5HT system. We still await good phenomenological distinctions between these two forms of anxiolysis.

Indeed, perhaps the most interesting finding of the APS reports resulted from an analysis of the characteristics of placebo responders. Individuals who responded well on placebo far from being the weak, dependent, suggestible persons who are sometimes seemingly conjured up by the notion of a placebo responder, had in actual fact greater strength of personality and coherence of egostructure than those who failed to show such a response. Unfortunately this interesting, indeed "significant", finding may not get the attention it deserves owing to its being buried among a mass of largely unrelated details in a supplement sponsored by a drug company.

What is perhaps equally interesting about the recent APS supplement is what it fails to mention. Following the series of articles in *Archives of General Psychiatry*, a cross-national collaborative letter was written to that Journal by Isaac Marks and several others (1989) criticising the interpretation put on the results. Their conclusion was that, contrary to the tenor of the papers published, given the results cited, alprazolam was of dubious benefit in panic disorder. This provoked a spirited response from Gerald Klerman and co-investigators on the US study of alprazolam. Nowhere in the APS supplement are the issues raised by Marks and others referred to.

A further omission are the recent reports of an efficacy of cognitive therapy for panic disorder. In contrast to the drug treatment of panic disorder, which at best achieves 60–70% response rates and which is liable to be accompanied by a relapse of the disorder on tapering of therapy, particularly in the case of benzodiazepine therapy, cognitive therapy, it would appear, achieves success rates approaching 90%. There have been several publications to this effect in recent years. The findings have been delivered at a number of conferences. Yet, no reference to them is made in this supplement. All references to the cognitive therapy of panic disorder date from 1985, which seems quite surprising.

The cognitive therapy findings are of importance for a reason other than their apparent superiority to either alprazolam or imipramine in the treatment of panic disorder. A stated aim of the US and cross-national collaborative studies of the efficacy of alprazolam in panic-disorder was to determine whether panic-disorder was a valid nosological entity distinct from agoraphobia and other anxiety states. There is little evidence from the reports of the research on alprazolam that bears on this issue and no evidence of any specificity of alprazolam to panic disorder. At present the best evidence for the validity of panic disorder as an independent nosological entity lies in the high rate of response to a specific set of cognitive interventions.

There is, perhaps, one further significant aspect to these studies on alprazolam and panic disorder. Despite a lack of evidence that alprazolam is particularly efficacious for panic-disorder or specific to it, recent advertisements for this compound in the American journals have made much of its being the only drug with a specific licence for use in panic-disorder. This licence was, of course, obtained on the back of the American and cross-national studies referred to above.

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