practice cohort of patients who actually are on lithium.

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SIR: We agree with Schou (*Journal*, December 1986, **149**, 798–799) and Grof (above) that the findings we reported in *Psychological Medicine* last year (**16**, 521–530) do not by any means prove that prophylactic lithium therapy is ineffective, even in our own city. We ourselves emphasised that we could not exclude a number of possible explanations, including changing diagnostic criteria, for the threefold rise in the admission rate for mania that occurred between 1970 and 1981. On the other hand, we failed to find any evidence to support any of these alternative explanations. The samples of case notes we compared (40 from 1970–72 and 40 from 1979–81) yielded no hint either that diagnostic criteria had changed or that the threshold for admission had fallen between these two time periods. We are aware, of course, that diagnostic criteria for mania changed very dramatically in North America in the course of the 1970s. But Baldessarini's comments on the American scene cannot be extrapolated to Scotland. In many parts of the USA a diagnosis of mania was a rarity in the 1960s but this was never so in the UK. For example, in the comparison of admissions to mental hospitals in New York and London carried out by the US/UK Diagnostic Project in 1968 only 0.5% of the New York patients had a hospital diagnosis of mania compared with 6.9% of the London patients (Cooper *et al*, 1972). What is more, Eagles & Whalley (1985) found no significant increase in the first admission rate for mania to Scottish mental hospitals between 1969 and 1978 and it is difficult to see how any major change in Scottish criteria for a diagnosis of mania could have occurred without affecting that rate.

We do not pretend to understand why the admission rate for mania should have increased so much during a time period when the use of lithium was steadily increasing, but we are impressed by the evidence, which neither Schou nor Grof refers to, that lithium withdrawal, deliberate or inadvertent, may result in a temporarily *increased* risk of a manic episode. There are at least four reports in the literature of patients relapsing within a fortnight of their normal lithium tablets being replaced by placebo, and it is not far-fetched to suggest that patients may, for a variety of reasons, end up taking lithium intermittently more frequently under the conditions of ordinary clinical practice than in the context of a closely supervised clinical trial.

We published our findings not to deter others from putting their patients on prophylactic lithium but in the hope that they would provoke them to ask questions about mania and about lithium which they had not asked previously, and to design new studies to answer those questions. In the meantime we cannot do better than repeat the last sentence of our paper – "whatever the true explanation, there is no comfort in these findings for those, including ourselves, who have believed for the last 15 years that maintenance lithium provides an effective prophylactic treatment for at least a substantial minority of patients with recurrent affective disorders".

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Panic Attacks: New Approaches to an Old Problem

SIR: Gelder's paper (*Journal*, September 1986, **149**, 346–352) should not be given more weight than it claims, as a somewhat ephemeral expression of his picture of the subject and reflecting his well-known interest in behavioural psychotherapy. However, there is the danger that some readers might mistake it for a serious appraisal of the subject, placing new ideas in relation to a review of the old ones. In particular, since the paper begins and ends with approving references to Freud, some readers might not realise the almost total omission of everything that Freud thought important on the subject. There is a case for expunging his rather dotty theories of 1895 but it