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Association between sexual and substance abuse

SIR: Mullen *et al* (*BJP*, December 1993, **163**, 721–732) in a community study of women again find an association between sexual abuse and various forms of psychopathology including drug and alcohol abuse. Research in the US with young substance abusers showed that up to 75% gave a history of abuse (Rohsenow, 1988). There appears to be no comparable British research.

A small study on opiate addicts at a detoxification unit in London was performed to estimate the prevalence of a history of sexual abuse. Forty consecutive admissions were asked about sexual abuse during the routine medical interview. The sample consisted of 22 men and 18 women aged between 18 and 41.

Fifteen subjects (36%; 6 men and 9 women) had been victims of sexual abuse that involved genital contact of some sort. Two women had been severely and persistently abused by their fathers from the age of six. Three women had been raped in early adolescence (age 12–14) by acquaintances. Two women had had 'consensual' underage sexual intercourse with older men starting at age 12 and 14. There were two cases of genital fondling in childhood by male relatives. Among the men, three of the six described severe abuse involving violence occurring at age 12 or under. The other cases were genital fondling by older boys or men.

In Mullen *et al*'s recent survey of women 20% of the total sample report sexual abuse involving genital contact of some degree and 3% report actual intercourse. This compares with rates of 50% and 39% for the female opiate addicts studied.

These data suggest that a history of sexual abuse may be much more common among people with severe drug problems than among the general population. A larger study with an appropriate control group would be needed to clarify this. It also demonstrates that sexual abuse is a diverse phenomenon and is likely to have a complex relationship with substance abuse.

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Treatment of catatonia with intravenous biperidene

SIR: Stuporous catatonias are usually treated with high doses of potent neuroleptics or by electroconvulsive therapy. Treatment with neuroleptics may cause severe side-effects like the neuroleptic malignant syndrome, which may be similar to catatonic symptoms. Recently successful treatment of catatonic states with lorazepam was reported (Salam & Kilzieh, 1988), but the danger of respiratory depression limits the benefits of this therapeutic strategy.

Encouraged by reported observations (Winter & Grosse, 1979; Hirschberg, 1964), we treated two patients with catatonic stupor with intravenous (i.v.) biperidene. Prompt and impressive improvement of clinical symptoms was observed after single doses of 5–15 mg. Therefore, we studied the effect of biperidene in an open prospective study in 11 consecutive patients with catatonic stupor. All subjects were in-patients of a psychiatric hospital. They were treated with 5 mg biperidene i.v., given every 30 min up to 15 mg. Lack of response required crossing-over to 3 days 60 mg haloperidol per day and recrossing-over to biperidene subsequently. Exclusion criteria were organic mental disorders,

non-psychotic psychogenic disorders, and catatonic states without stupor such as catatonic excitement.

The mean age of the 11 patients was 38.6 years (range 22–63 years). Duration of illness was 11.7 years (range 0.4–23 years). Diseases were classified according to DSM-III-R criteria (American Psychiatric Association, 1987) as paranoid type of schizophrenia, chronic with acute exacerbation (295.34, $n=7$), subchronic with acute exacerbation (295.33, $n=1$), initial manifestation of schizophrenia (295.30, $n=2$) and schizoaffective disorder (295.70, $n=1$). The therapeutic effect was measured by means of a rating scale designed by the authors – score 4, extremely severe; score 1, no catatonic symptoms. Further details of this rating scale will be published elsewhere.

Ten patients with catatonic stupor improved within 60 min after i.v. biperidene (mean 17.7 min range 4–45 min). Doses of biperidene were 5 mg in eight patients and 10 mg in two patients. One patient did not improve within 90 min following 15 mg of biperidene and was therefore treated with a 3-day infusion of haloperidol (60 mg/day), without success. Following renewed biperidene injection catatonic stupor in these patients disappeared within 33 min.

We assume that the evident efficacy of biperidene on stuporous catatonic states is caused by its anticholinergic activity in the basal ganglia. Biperidene binds competitively with acetylcholine to cholinergic muscarinic receptors in the corpus striatum and hippocampus (Larson *et al*, 1991). Spontaneous, reactive or pharmacologically induced states of immobilisation and/or catalepsy in various animals can be removed by biperidene (Stille & Sayers, 1975).

Intravenous application of 5 to 15 mg biperidene improves the efficacy and safety of pharmacotherapy in catatonic states. Anticholinergic side-effects of biperidene have proved to be tolerable. No delirious states or anticholinergic side-effects were observed. However, these promising first results must be confirmed in a controlled study.

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Debt and deliberate self-harm

SIR: Hatcher (*BJP*, January 1994, **164**, 111–114) found it difficult to draw firm conclusions about the rate of debt in the study of deliberate self-poisoning population without a comparative control group. This problem has limited the majority of studies of deliberate self-harm (DSH). I conducted a pilot study to try to deal with this. The control population chosen was from a fracture clinic, the attenders at which, like the DSH population, have established current contact with the hospital service via the casualty department. They were given the same single-page questionnaire as the DSH patients. This consisted of 15 forced choice questions gathering demographic variables and information about employment, debt and psychiatric history. A Hospital Anxiety and Depression Scale (HADS) was incorporated.

To ensure similar sociodemographic characteristics the two groups were stratified into two age groups, two social class groups and by sex, giving equal numbers from both in each strata. This allowed 53 questionnaires from both DSH and control groups to be compared. Sixty-two per cent of each were male, 68% were less than 35 years old and 19% were from social class I, II or III.

One question was "Have you had significant worries with debt that you cannot repay?" Ninety-six per cent of the DSH group and 98% of the control group answered this. Thirty seven per cent of the DSH group replied "yes" compared with 13% of the control group. This is comparable with the 37% of self-poisoners in debt reported by Hatcher, as are the median ages of 26 years and 28 years respectively for the debt and non-debt groups. Both these groups had a median age of 31 years in the control group.

In the DSH group however there was no difference in proportion of those who reached 'caseness' for depression (Hamer *et al*, 1991) between the debt