Brit. J. Psychiat. (1980), **137**, 494–496

Correspondence

IMMEDIATE PSYCHOLOGICAL HELP FOR SELF-HARMERS

DEAR SIR,

Some of those routinely assessing cases of deliberate self-harm may not be aware of useful psychotherapeutic approaches to such patients.

The act of self-harm can be seen as a communication with another person or people (Ramon, Bancroft and Skrimshire, 1975; and White, 1974). It demonstrates dependency or hostility, and usually combines the two. The act has manipulating or controlling elements. Usually, the individual seeks or is taken to professional help, when the doctor receives the communication contained in the act. An unsympathetic response by the doctor, clearly stated to the individual, might be appropriate. The individual then knows where he stands. He has been rejected. His problem and the responsibility for it remain his own. His ensuing anger with the doctor would also seem an appropriate and healthy response. An unsuccessful attempt to help by the inappropriate prescription of psychotropic drugs can be dangerous. The doctor's rejection is thereby disguised to look as if it were the opposite. The individual then finds it more difficult to give an open, angry response to the doctor, and might instead give a covert angry response of drug overdose.

If the doctor accepts, at face value, the individual's promise that he will never indulge in self-harm activity again, this implies that the act was something of which the doctor disapproved and was therefore an act of hostility to him. The individual, by his promise, tries to placate the doctor, rather than to examine his own behaviour. In the common example of self-poisoning following an argument, the doctor might challenge the individual who made such a promise by asking what alternative mode of dealing with his anger he proposes. Individuals often, then, make more positive suggestions. The doctor can then show that he finds these suggestions more acceptable and constructive than self-harm activity.

A variation of the promise never to do it again is a statement by the individual critical of his self-harm behaviour, such as feeling ashamed or saying it was a silly thing to have done. If the doctor, rather than simply being 'reassuring', can accept the individual's assessment that he has acted in a silly way he can then explore with him less silly ways in which he might have responded, and in which he might be expected to respond in future.

Murphy and Guze (1960) have written extensively on the general problem of the manipulative patient. A particularly difficult type is the young individual, frequently a woman, emotionally unstable but not mentally ill, who refuses to enter a psychiatric ward, and yet tells the doctor in forceful terms that she is going to kill herself. The sort of challenge by the patient is designed to make the doctor feel helpless and guilty. In this manipulation the individual has tried to pass responsibility for her behaviour to the doctor. The challenging response of the doctor might be to point out that she does not seem to wish to kill herself, but rather to have the doctor try to persuade her not to do so. With a response, she may be able openly to take back responsibility for her own actions.

These are some examples of an approach to immediate psychological help of self-harmers who do not require psychiatric admission. They are intended to be illustrative rather than exhaustive.

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OXYPERTINE FOR DEMENTIA

DEAR SIR,

In view of the recent interest in oxypertine (Freeman and Seni, *Journal*, May 1980, **136**, 522) I would like to report my clinical experience using this drug for disturbed patients with dementia.

Episodes of disturbed behaviour where hostility, aggression and overactivity are prominent features can cause considerable difficulty in the management of demented patients and are frequently the reason for an old person becoming a psychogeriatric

problem. The use of phenothiazines quite often does not make for easier management because of the side-effects encountered with their use.

With oxypertine in doses of 60–100 mg per day, I have found that good control can be obtained in most cases whilst avoiding the side-effects commonly encountered with phenothiazines. This may well be due to the different mode of action of oxypertine compared with the phenothiazines (Van Praag and Korf, 1975). Oxypertine does not block reception sites of catacholamines but depletes presynaptic stores of those transmitters and within a certain dose range, has a predilection for nor-adrenaline (NA) stores having little influence on dopamine or serotonin. It could be argued that the behaviour disturbances of fear, flight and flight type met with in dementia could be due to an imbalance of neurotransmitter substances, in that NA systems became more prominent. If this were so then this could explain the apparent differences in results when using oxypertine as against the phenothiazines.

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THE ABUSE OF ANTI-CHOLINERGIC DRUGS IN ADOLESCENTS

Dear Sir,

Mental disturbances resulting from the use of anti-cholinergic drugs are widely recognized and well documented (1). Their potential for abuse, however, is still not widely appreciated. In 1967 Stephens (2) reported the misuse of benzhexol among adolescents, and there have been more recent reports describing abuse of anti-Parkinson drugs, taken for their exciting and euphoriant properties (3). Rubenstein (4) has described a case in which extrapyramidal symptoms were feigned in order to obtain such medication.

I would like to report further the case of a 19-year-old male who was referred to psychiatric out-patients because of his explosive outbursts and threatened self-harm. He had been prescribed a depot flupenthixol injection by his general practitioner, presumably for its anxiolytic and anti-depressant properties. He was also given a supply of benzhexol (5 mg) tablets, which he found induced euphoria and excitement. He returned to his GP for more tablets and took five or six at a time. On one occasion he reported developing a painless, swollen abdomen which only subsided after several hours. A friend to whom he introduced the drug also obtained a supply by stealing a sheet from his general practitioner's prescription pad whilst he was out of the room. He also reported developing a swollen, painless abdomen on one occasion, together with similar psychological effects of excitement and euphoria.

The extent of abuse of anti-cholinergic drugs is still probably quite small, but I report these cases in order to draw attention to its existence. Their psychotropic effects may also account for the reluctance some patients have in discontinuing them. We are aware of the association of these drugs with the onset of tardive dyskinesia, and their effects on plasma levels of phenothiazines, and now the potential for abuse further strengthens the case for using them more cautiously. The possibility of abuse should also be borne in mind when, in a casualty department, an adolescent presents with a picture of pseudo-obstruction of the colon.

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THE DISABILITIES OF CHRONIC SCHIZOPHRENIA

Dear Sir,

We thank Dr Watt (*Journal*, July, 1980, **137**, 102) and Drs Cheng and Cristoveanu (*Journal*, August, 1980, **137**, 197) for their interest in our paper (*Journal*, April, 1980, **136**, 384–395). We hope that the following information will answer their queries. The various assessments were carried out as follows:

Cognitive testing (Withers and Hinton)—ECJ; Neurological—DGCO; Mental State (Karwiecka *et al*—ECJ and DGCO independently; Current Behavioural Schedule—ECJ and DGCO independently; all were tested on the same day.

The Current Behavioural Schedule is a means of recording nurses' descriptions of their patients' behaviour in a standardized way. The inter-rater