

	Hostel	Regional alcohol unit	Total
Mean (range) age (years)	42.9 (18-56)	41.5 (29-68)	42.2 (18-68)
Sex	25 M	23 M, 2 F	48 M, 2 F
No whose abode was:			
Sleeping rough	8	5	13
Night shelter	15	16	31
Hostel	2	4	6
Dependence score*	41	45	43
No with anxiety <sup>†</sup>	19	19	38
No with depression <sup>†</sup>	13	10	23
No with $\gamma$ -glutamyltransferase activity >40 IU/l <sup>†</sup>	12	8	20
No with mean cell volume >95 fl <sup>†</sup>	23	13	36
No who attended for assessment	17/25	14/25	31/50
No accepted for detoxification	14/17	11/14	25/31
Mean chlordiazepoxide dose (mg)	369	290	336
Total 5 day symptom score <sup>†</sup>	74	57	66
No who completed detoxification	11/22	8/22	19/44
No abstinent for one month	7/21 <sup>†</sup>	3/21 <sup>†</sup>	10/42
Time between referral and assessment (No of patients):			
<12 Hours	16	6	22
12-24 Hours	8	13	21
>24 Hours	1	6	7

\*As assessed by severity of alcohol dependence questionnaire.  
<sup>†</sup>One patient could not be traced.

poxide calculated. Detoxification was regarded as successful if the subject was abstinent one day after drug treatment was stopped and symptoms had subsided; the information for follow up at one month was obtained from contacts in the network of agencies concerned.

Altogether 95 subjects presented for detoxification during the time that the study was running. Thirty one of these were ineligible: 14 had been in the study previously; 12 excluded themselves by expressing a preference for where they were treated (one for the regional alcohol unit and 11 for the hostel); three had been abstinent for more than 24 hours; and two had been banned from the hostel. Fourteen others were not referred to the study. The remaining 50 subjects were randomised to either the regional alcohol unit or the hostel (25 to each). All of the 50 patients were heavily dependent on alcohol,<sup>2</sup> and a considerable proportion were clinically anxious or depressed.<sup>3</sup> More than half had macrocytosis; less than half had biochemical evidence of liver dysfunction<sup>4</sup> (table). There was no difference between the two groups in these measures.

The table shows the proportions of patients in the two groups who attended for assessment, completed detoxification, and were sober for one month. The apparent advantage in the group who attended the hostel was not significant. In both groups three subjects were not admitted: the hostel refused to admit one patient who was too young (age 18) and two others because it was full; the regional alcohol unit did not

admit three patients who were judged to be suffering insufficient withdrawal symptoms to warrant care as an inpatient. Three patients in each group failed to complete detoxification. Although both the mean total dose of chlordiazepoxide and the score for withdrawal symptoms were greater in the group treated in the hostel, the difference was not significant.

Significantly more patients had to wait over 12 hours for assessment at the regional alcohol unit than at the hostel ( $\chi^2$  with Yates's correction=6.57,  $p<0.02$ ) (table). There was no significant difference in the number who waited over 24 hours. When both groups were aggregated waiting over 12 hours did not have a significant effect on the likelihood of attendance or the subsequent completion of detoxification. Waiting over 24 hours before the appointment had a highly significant effect on attendance and detoxification: 31 out of 43 attended when the appointment was within 24 hours but none of seven when the appointment was later ( $\chi^2$  Yates's correction=10.40,  $p<0.01$ ). Nineteen of the 37 patients whose referral was appropriate and who were seen within 24 hours completed detoxification ( $\chi^2$  Yates's correction=4.41,  $p<0.05$ ).

Overall, 19 out of 44 patients completed detoxification and 10 out of the 42 who were traced remained abstinent for a month.

### Comment

This small study indicates that severely dependent drinkers can be detoxified as effectively in a hostel for the homeless as in a hospital; the hostel is generally preferred by this population and is cheaper. We found no indication that it is less safe. Patients are more likely to attend for and successfully complete detoxification if given an appointment for assessment within 24 hours of presenting. Giving appointments within 12 hours is not necessary.

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## Psychological distress after assaults and accidents

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Victims of trauma often have psychological problems as well as physical injuries.<sup>1,3</sup> The psychological sequelae may persist long after physical injuries have healed and can develop into psychiatric illness. Although fairly minor injury may produce serious psychological consequences<sup>4</sup> and uninjured witnesses of traumatic incidents may suffer psychological distress,<sup>5</sup> few studies have been attempted to identify which types of trauma cause the most serious sequelae. Such information is particularly important because of the limited time for counselling in general practice, accident and emergency departments, and orthopaedic

clinics and the limited resources of agencies such as Victim Support. We studied a series of patients who sustained injuries in assaults and accidents.

### Patients, methods, and results

Psychometric questionnaires were completed by 122 consecutive patients who were treated for jaw fractures at the Bristol Royal Infirmary and Dental Hospital during October 1987 to September 1988. The questionnaires assessed anxiety, depression, psychiatric symptoms, and personality trait (hospital anxiety and depression scale, Beck depression inventory, general health questionnaire, and Eysenck personality questionnaire) and were completed at outpatient appointments one week (within 24 hours) and three months (within two days) after injury. Seven patients were in hospital at one week and completed the questionnaires in their wards. Seventy patients had been assaulted (mean age 26; 52 men) and 52 had had

	Assault victims (n=70)		Accident victims (n=52)		Difference between two groups (p value)	
	Median score (95% confidence interval)	Prevalence of abnormality (%)	Median score (95% confidence interval)	Prevalence of abnormality (%)	At 1 week	At 3 months
Anxiety:						
1 Week	5 (3 to 6)	10	3 (1 to 7)	11	NS	0-004
3 Months	4 (2 to 6)	10	1 (0 to 4)	7		
Significance of change (p value)	NS		0-03			
Depression*:						
1 Week	4 (2 to 5)	10	3 (1 to 5)	15	NS	<0-001
3 Months	4 (3 to 5)	8	1 (0 to 2)	0		
Significance of change (p value)	NS		<0-001			
Depression†:						
1 Week	10 (3 to 14)	59	5 (2 to 22)	33	NS	NS
3 Months	5 (1 to 10)	29	0 (0 to 3)	17		
Significance of change (p value)	<0-01		0-03			
Psychiatric disorder‡:						
1 Week	6 (2 to 10)	60	4 (0 to 9)	48	NS	0-03
3 Months	3 (0 to 6)	40	0 (0 to 1)	19		
Significance of change (p value)	<0-04		<0-001			

\*Hospital anxiety and depression scale (score >10 represents abnormality).

†Beck depression inventory (score >8 represents abnormality).

‡General health questionnaire (score >4 represents abnormality).

road accidents (30; 45 men). Patterns of injury were similar except that only 3% of the assault group had Le Fort fractures compared with 10% of the accident group. Wilcoxon's matched pairs signed ranks test was used to compare results at one week and three months and the Mann-Whitney test to compare the assault and accident groups.

At one week, levels of anxiety and depression were similar in both groups (table), though the assault group had a higher level of psychiatric symptoms (mainly due to social maladjustment and preoccupation with physical symptoms). By three months, however, levels of anxiety, depression, and psychiatric symptoms were significantly lower in the accident group than in the assault group, in whom anxiety levels were unchanged. No significant differences were found in personality trait between groups, although assault victims showed more dissimulation at one week and were more emotional at three months. There were no differences between the scores of men and women either at one week or three months, though psychiatric symptoms were commoner in assaulted women than men at one week.

### Comment

Our results suggest that the short term psychological reaction is similar in victims of assault and accident. Half our patients were distressed one week after injury, perhaps because of temporary disfigurement, fear of permanent disfigurement or disability, and loss of self confidence. Social maladjustment and preoccupation with physical symptoms were commoner in the assault group, suggesting that a macho self image is particularly valued by young men. The more emotional personalities of the victims of assault at three months may reflect a long term loss of self confidence and suggest that

vulnerability in an assault was more difficult to deal with than vulnerability in an accident. Sustained psychological disturbance, which has been reported in studies of victims of violent crime,<sup>4</sup> may result from fear of further violence, lack of emotional support, or victims blaming themselves. The reasons for an accident can be externalised in terms of, for example, the state of the road, someone else's carelessness, or an act of God.

Personality traits did not differ between the groups, so that greater psychological distress among the assault victims cannot be accounted for by emotional disorder before the injury. The greater dissimulation observed in the victims of assault indicates more frequent attempts to appear in a more favourable light. Perhaps victims of accidents blamed themselves for what had happened less often and therefore did not feel the need to present themselves in a better light.

Our study suggests that psychological support is important for all victims of trauma during the first week and that longer term support is more important for victims of assault than of accidents. This might best be instituted and emphasised to relatives in accident and emergency departments and trauma wards and by general practitioners, but victims of assault may need more support from support agencies and appropriate mental health professionals as well as from their families, who will need to be properly informed about possible reactions after trauma.

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## ONE HUNDRED YEARS AGO

It is to be hoped that there is no foundation for the statement in American papers that the new sensation for American ladies is the use of strychnine lozenges as a pick-me-up. They are described as small doses of putty-coloured grey, each containing one-thirtieth of a grain. At any rate it is exceedingly desirable that the allegations that these lozenges are to be regarded as a safe tonic, with a bracing effect after fatigue, should not be accepted by English men or women as having a particle of truth. Strychnine is one of the most dangerous of poisons, and it has the peculiar property of being accumulative in effect. The thirtieth of a grain is a large medicinal dose, and in excess of the ordinary dose given under

the most careful medical supervision, and anyone who began the practice of using this most dangerous of poisons as a pick-me-up at all, would very soon find its ill-effects; and in anything like the dose mentioned these effects would probably lead to fatal accidents. The theatre and the sermon at church are described as places or occasions of *emui*, in which the strychnine bonbons are particularly grateful. But any who adopted the system might easily become the subject of a sensational domestic drama, and their place in the church before long would only be a passing prelude to doleful funeral service. (*British Medical Journal* 1890;ii:1322)