point out that the Nithsdale family treatments were given by "experienced practitioners, but who did not have special skills in family intervention in schizophrenia". This point is crucial if future reports along these lines are not to cast doubt on the established value of specialised family intervention.

Anyone who has worked in a team which specialises in family interventions with schizophrenia will be able to confirm that the work is both distinctive and sophisticated. They will also be able to confirm that it is not generally recognised, often even by knowledgeable and experienced colleagues, that successful family intervention requires specific training, preferably with a specialised team.

In this sense "The application of the results in a routine way to the work of the busy clinical team . . ." (Kuipers & Bebbington, 1988) is no trivial enterprise – not that these authors imply it should be.

JIM BIRCH

South Shields General Hospital
South Shields
NE34 0PL

References

KUIPERS, L. & BEBBINGTON, P. (1988) Expressed emotional research in schizophrenia: theoretical and clinical implications. *Psychological Medicine*, **18**, 893–909.

Uraemia and mania

SIR: I wish to comment on Thomas & Neale's case report (*Journal*, January 1991, **158**, 119–121). The authors describe a case of mania "secondary to advanced uraemia" caused by polycystic disease of the kidneys in a 62-year-old woman. I question that mania was secondary to advanced uraemia, for the following reason. Their case had chronic renal failure. Nine days after the beginning of haemodialysis she became manic. At that time urea had fallen. As mania appeared after haemodialysis, when urea was falling, it seems more likely to me that haemodialysis precipitated the episode in a predisposed individual.

I have recently described a patient with chronic renal failure who developed mania following abrupt nicotine withdrawal (Benazzi, 1989). Mania worsened when haemodialysis was started for the first time.

FRANCO BENAZZI

Psychiatry Service
Public Hospital "Morgagni"
47100 Forli
Italy

Reference

BENAZZI, F. (1989) Severe mania following abrupt nicotine withdrawal. *American Journal of Psychiatry*, **146**, 1641.

The social networks of long-term patients

SIR: The finding of the TAPS project (*Journal*, December 1990, **157**, 842–852) that long-stay patients' responses to the Social Network Schedule (SNS) corresponded with observational data is reassuring. We have been using different versions of the Goodmayes Network Analysis Questionnaire (GNAQ) which is similar to, and I understand influenced the development since the early 1980s of, the SNS. As with the SNS, about two-thirds of patients on long-stay wards have been able to respond and the average size of networks has been similar; but individual variation is wide with some very large, as well as very small, networks.

The general picture from two surveys is of networks containing a substantial number – but rarely all and frequently not a majority – of the residents on the same ward as the respondent, together with an important proportion of patients from other wards who were particularly likely to be seen as friends or confidants. Some contacts had clearly been maintained for, or revived after, very long periods, despite being undermined throughout the years by moves without consideration of networks. Relationships with staff both on and off the ward were very important but in contrast there were few contacts with people outside hospital apart from relatives. It is an irrecoverable loss that relationships between patients within mental hospitals, which must have been a major factor in ameliorating the institutional experience, were not systematically explored much earlier. As a result they were undervalued as the deinstitutionalisation movement developed and no account was taken of them in earlier studies of patients' attitudes to discharge (Abrahamson *et al*, 1989).

At Goodmayes Hospital it has proved both illuminating and useful to seek to maintain existing networks and re-establish old ones, as well as fostering new contacts, during preparation for resettlement. These remain important after discharge, since merely placing long-stay patients out of hospital does not ensure a wide range of contacts 'in the community'; former relationships are the main, and often the only, feature of hospital life to be missed. Our experience of group homes over the past 19 years supports the TAPS concern that despite their other benefits the small, relatively intense networks they foster may be unsuitable for some patients.

As suggested, social clubs may compensate, and an encouraging range of relationships has developed within and around an evening club established in 1987 in Newham, in conjunction with a group-orientated out-patients clinic which has itself expanded networks. Encouragement of social contacts

https://doi.org/10.1192/bjp.158.5.718b Published online by Cambridge University Press

across individual group homes and flats can also contribute. More basically, we have been impressed by the effect of adding to the range of medium-sized housing projects provided, which have been specifically designed to combine individual units and communal facilities. Their larger networks appear to be the more welcome because there are also greater opportunities to withdraw temporarily when needed: the difference in milieu seems to be to some extent analogous to that between extended and nuclear families. The first such project has been in operation since 1983 and recent schemes are catering very successfully for heterogeneous populations containing apparent isolates of the kind highlighted by the TAPS studies, including a number of profoundly deaf patients.

There has been a tendency to belittle arrangements that increase inter-patient contacts as promoting ghettos, but the evidence is that they encourage rather than inhibit the development of relationships in the wider community (Segal & Aviram, 1978) and it will be reprehensible if the institutional under-valuing of patients' social networks is repeated.

DAVID ABRAHAMSON

Goodmayes Hospital
Ilford
Essex IG3 8XJ

References

ABRAHAMSON, D., SWATTON, J. & WILLS, W. (1989) Do long-stay psychatric patients want to leave hospital? *Health Trends*, **21**, 16–21.

SEGAL, S. P. & AVIRAM, U. (1978). *The mentally ill in community based sheltered care*. New York: Wiley.

Incestuous abuse in psychiatric patients

SIR: We read with great interest the article about incest in normal weight bulimic women by Lacey (*Journal*, September 1990, **157**, 399–403). We have also carried out research work on the prevalence of child sexual abuse in in-patients with neurotic and psychosomatic disorders. We think that our findings (Kinzl & Biebl, 1991) confirm and supplement Lacey's results.

Very serious and long-lasting child sexual abuse was found in female psychiatric in-patients with different psychopathologies and mental disorders (20% of the total sample). Self-damaging behaviours of different kinds and a tendency to "acting-out" proved to be the main symptoms of sexually abused patients; nearly all those patients showed multi-impulsive personality disorders (Lacey & Evans, 1986). Few of the patients surveyed were able to talk about child sexual abuse early in therapy and the majority were able to talk about it only after a long time of therapy; some will never talk about it. Because of the strong feelings of guilt and frequently marked suppression of the incestuous experiences the prerequisites for the disclosure are a lot of empathy, "real sympathy" (Ferenczi, 1949), and a reassuring therapist–patient relationship, as well as the therapist's readiness to talk about it and to believe what the patients say.

JOHANN KINZL
WILFRIED BIEBL

Innsbruck
Austria

References

FERENCZI, S. (1949) Confusion of tongues between adults and the child. *International Journal of Psychoanalysis*, **30**, 225–230.

KINZL, J. & BIEBL, W. (1991) Girl sexual abuse: aspects of the genesis of psychiatric disorders and therapeutic implications. *Acta Psychiatrica Scandinavica* (in press).

LACEY, J. H. & EVANS, C. D. H. (1986) The impulsivist: a multi-impulsive personality disorder. *International Journal of Psychoanalysis*, **30**, 715–723.

Tolbutamide and fatal water intoxication

SIR: Peh *et al* (*Journal*, June 1990, **156**, 891–894) present an instructive case reminding us of the serious risks of unrecognised hyponatraemia in psychiatric patients ("psychogenic polydipsia"), but fail to note a possible significant contributing factor towards their reported patient's unfortunate demise.

The individual in question was first recognised to be hyponatraemic some time after being started on a regimen which included tolbutamide (500 mg t.d.s.). As with the related sulphonylurea chlorpropamide, tolbutamide has an antidiuretic action in normal adults and has been associated with dilutional hyponatraemia in several published case reports (Hagen & Frawley, 1970; Gossain *et al*, 1976; Darlow, 1977; Lichtenberg & Abraira, 1978; Kadowaki *et al*, 1983). In one of these cases, an individual receiving the same modest dose of tolbutamide (500 mg/day) presented with serious hyponatraemia, twice replicated on rechallenge (Lichtenberg & Abraira, 1978). Upjohn, the manufacturer of the Orinase brand of tolbutamide, has received reports of another nine cases (personal communication). A retrospective review of 108 patients treated with tolbutamide for an average of 6.6 years found five (4.6%) had a recorded serum sodium less than or equal to 134 mmol/l, including one (0.9%) with a value of less than or equal to 129 mmol/l, and a complication rate less than that of a comparison group receiving the more common offender, chlorpropamide, but greater than that of a group receiving glibenclamide (Kadowaki *et al*, 1983).

https://doi.org/10.1192/bjp.158.5.718b Published online by Cambridge University Press