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

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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

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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).

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Psychogenic polydipsia (an ill-advised term; the presumption of a psychogenic aetiology is far from established) has appropriately received attention as a poorly understood syndrome, but several agents are well established contributing factors in many cases, and deserve recognition. The use of nicotine, thiazide diuretics and carbamazepine are most commonly implicated, but we should not forget the occasional patient who may be treated with chlorpropamide, tolbutamide, clofibrate, cyclophosphamide or vincristine.

PRITESH J. SHAH
WILLIAM M. GREENBERG

Division of Psychiatry
Bergen Pines County Hospital
Paramus, New Jersey, USA, 07652

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Tardive oculogyric crisis and obsessional thoughts

SIR: Before the introduction of neuroleptics, the most common cause of oculogyric crises (OGC) was post-encephalitic Parkinsonism. In these patients, OGC was found to be commonly associated with a variety of transient mood and thought disturbances, including obsessional thinking (Stern, 1927). Although patients suffering from drug-induced OGC are known to secondarily become very anxious (Dorevitch, 1984), an association with obsessional thinking and compulsions has been reported in only one case (Leigh *et al*, 1987). The case described below is significant for two reasons: the patient had a late-onset and recurrent OGC while on neuroleptics, and the episodes of eye deviation were frequently associated with obsessional thoughts.

Case report. A 47-year-old woman was first treated for schizophrenic illness 20 years ago with trifluoperazine for six months with gradual and complete recovery of her delusions and auditory hallucinations. Obsessive–compulsive symptoms were not noted as part of her illness, nor were marked obsessional traits a feature of her pre-morbid personality. Following a relapse two years later, she was again treated with trifluoperazine for 2 months, and then maintained on depot fluphenazine decanoate until the present, with doses varying from 12.5 mg every four weeks to 25 mg per week.

About two months after starting fluphenazine decanoate, she developed recurrent episodes of OGC which failed to respond to benztropine (12 mg/day) and improved markedly with procyclidine (20 mg/day), on which she has been maintained ever since, with 2–3 episodes of OGC per week. The episodes occur most frequently in the afternoon but have no reported relationship to fatigue, psychological stress or day of injection.

The description of the OGC provided by the patient was fairly stereotyped. One episode was observed by the author when she agreed to stop her procyclidine for a day. No precipitant was obvious. She became anxious and markedly distressed, and her eyes deviated upward and slightly to the right; the frontalis and nuchal muscles contracted, with retroflexion of the neck. There was no strabismus or skew deviation and she could move her eyes in the upper field of vision. During the episode, she had repetitive and intrusive thoughts about her children: "Are they my children?" and "What would it be like without children?". These thoughts were unwanted, resisted unsuccessfully and were not elaborated into delusions. Twenty minutes after taking 5 mg procyclidine orally, the OGC ceased, and with it her repetitive thoughts. She reported having had obsessional thoughts during many, but not all, episodes of OGC. The main themes had been: counting repeatedly (e.g. numbers from 1 to 10, steps in her office, number of lights in the house, totals of purchases in the shop), romantic thoughts involving her with various men, and her children. No obsessions or compulsions were present unrelated to the OGC. If untreated, the OGC usually lasted for many hours, with the longest duration having been 14 hours. She was unable to abort the attacks. Additional relevant observations were the presence of tardive akathisia and mild tardive dyskinesia.

That this striking association between drug-induced OGC and obsessions has rarely been reported may be because it is seen only in the tardive OGC syndrome which itself is probably rare (Fitzgerald & Jankovic, 1989). This association permits speculation on the morphophysiological basis of the two disorders. For example, while dopamine has been the focus of attention in OGC, and serotonin in obsessions, our case suggests that the situation is likely to be far more complex.

PERMINDER SACHDEV

Neuropsychiatric Institute
The Prince Henry Hospital
Sydney
Australia

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