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 undervaluing of patients' social networks is repeated.

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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.

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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).