with electroconvulsive therapy. The reader was left wondering why this lady with a delusion that her food was being poisoned was not diagnosed as chronic paranoid schizophrenia.

Surely it would be wiser to apply the terms atypical anorexia nervosa or anorexia nervosa-like to such cases (Arya, *Journal*, February 1991, **158**, 285–286) until more is known about their (psycho-) pathogenesis.

BRIAN O'SHEA

Newcastle Hospital
Greystones
Co. Wicklow, Republic of Ireland

Reference

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Chronic fatigue syndrome

SIR: I read with interest the article by Hickie *et al* (*Journal*, April 1990, **156**, 534–540) about the chronic fatigue syndrome (CFS). It inspires a few reflections concerning the criteria and the study, and concerning the existence of the CFS itself.

Their criteria are of two orders: psychological and immuno-infectious. It risks associating two different types of patients: some with post-infectious syndrome and some with psychological problems. Fatigue is one of the most common symptoms in medicine (Adams, 1980; Bugard, 1989). Patients with 'fatigue', 'concentration/memory impairment' and occasional 'lymphadenopathy' may have diagnosis of CFS. What is the frequency of lymphadenopathy in the general population? What do we know about relations between fatigue, depression and immunological deficit? Is not chronic fatigue usual in infectious diseases and after?

What is the interest of a control group "selected from the in-patient and out-patient psychiatric services"? Why not from medical units? Do the authors suppose that the difference between the group of patients with CFS and the control group is necessarily non-psychiatric?

The authors find 29 cases of depression among 48 patients with CFS but they say CFS is different from depression and near medical pathology. Is CFS a medical equivalent of depression (Rodin & Voshart, 1986)? We might test this hypothesis by using antidepressant drugs in CFS or looking for the presence of the same biological disorders both in CFS and depression. The GHQ and Zung scores are elevated as with medical patients. Severe depressive disorders are rare in CFS. However, this quantitative result does not exclude the association of depression and CFS.

The authors make the interesting hypothesis of clinical similarities between CFS and depression. They show it to be false, but CFS could be culturally differentiated depression with overmedicalisation. The patients with CFS had the "conviction that they are physically ill" and "they held this belief and rejected psychological interpretations". According to Balint (1972), a medical rather than a psychological diagnosis is favoured, which could increase diagnosis of CFS and reduce those of depression or hysteria and other equivalent diagnoses in DSM–III–R (American Psychiatric Association, 1987). As stated by the authors, the patients with CFS have a "reluctance to accept psychological interpretations of their somatic symptoms" and have a high score on the denial subscale. Criteria for CFS must be more stringent (e.g. previous history of documented infectious illness, no depression, presence or not of psychiatric symptoms, etc).

Further studies are required to remove the confusion between CFS and depression. They should analyse the psychological context at the beginning of CFS and its psychological evolution. They will define whether fatigue is a result of, or only increased by, infectious disease, whether depression is cause or consequence, and whether CFS is a morbid entity or the somatic expression of a psychological disorder.

ERIC SERRA

Consultation-Liaison Psychiatry Unit
General Hospital
80100 Abbeville
France

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Family intervention

SIR: There is a point raised by McCreadie *et al* (*Journal*, January 1991, **158**, 110-113) which merits special emphasis. The authors noted the disappointing results of family intervention when compared with previous accounts (see, for example, Smith & Birchwood, *Journal*, May 1990, **156**, 654–660). The authors, in their discussions of this discrepancy,

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

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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