Brit. J. Psychiat. (1970), 117, 473–9

Correspondence

THE SEEBOHM REPORT

DEAR SIR,

Professor Querido has pointed out that mental illness can only be comprehended as a disequilibrium between the patient and his environment. It follows that psychiatric treatment can only be completed in the patient's environmental setting, and only there can mental health work continue to develop. These are the concepts which have governed the evolution of the mental health services of the last decade, services which have relied upon mutually dependent medical staff and highly specialized mental health social workers. Apart from research into clinical detail, it is difficult to foresee any major psychiatric advance which will not be concerned with the social sciences at least equally with clinical factors.

Were psychiatry not based in the hospitals by tradition and evolution it might well have developed as one of the major social services rather than as a primarily medical discipline. It is nonsensical to ignore its social element in the face of facts, history and logic. The effect of the Seebohm decision is to unify the social services, with undoubted benefit to the majority of staff and clients. But to have included the community mental health work without even discussion and still less decision of the future pattern of district psychiatric services, without consulting those responsible for these services, and without considering what effect the changes may have on the standard of care for the psychiatric patient living at home, is an incomprehensible negation of proper administration and government.

Dr. R. S. Ferguson's ungenerous letter (*Journal* July 1970, p. 126) suggests that he cannot in fact have studied the R.M.P.A. memorandum on the Seebohm Report. All that the Association has asked is that no irreversible changes in the present administrative structure should be implemented until the future pattern of the psychiatric services has been discussed, and the future of the medical services clarified. The arguments against the proposed change are powerful, but the need for changes, perhaps profound, is recognized and accepted. All of Dr. Ferguson's pejorative phrases—'resistance to changes', 'dominant, conservative ideology', 'linguistic nuances', 'institutional hierarchy'—can only reflect his own doctrinaire prejudice, since they cannot be inferred either from Dr. Pilkington's letter or from the Association's memoranda. I doubt if there is a psychiatrist in the country who is fully satisfied with the *status quo*, or would oppose searching multi-disciplinary discussions of future patterns of care.

Dr. Ferguson sees fit to support his view by quoting a journalistic misjudgement of a century ago. It would have been of far greater interest to hear just why he considers that the clinical and the environmental aspects of the care of mentally sick people should be placed without delay under different authorities, in preference to all alternative possibilities.

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TOXIC PSYCHOSIS CAUSED BY RADIO-ACTIVE IODINE

DEAR SIR,

'Radio-active iodine' treatment for hyperthyroidism first began to be widely used after World War II. Radio-active iodine was then released from atomic stock piles and made available for therapy. Slingerland, Lambery and Cassidy in 1958; K. Witton in 1959; Linguette, Swyngedauw and May in 1964; Kearns in 1967, have all published series which add up to many hundreds of cases treated by this method. The incidence of hypothyroidism without overt psychiatric or confusional psychotic occurrence has varied between 8 per cent and 14 per cent. Psychotic. episodes have been reported in only a handful of cases.

CASE REPORT

This patient became restless and unsettled and moved to a new address and so missed her follow-up appointment. She subsequently developed an acute toxic psychosis which simulated a schizophrenic illness. She was a woman aged 38 years, who had been widowed four years. Her mother had died a year before the onset of her hyperthyroidism. She had always been regarded as a fairly highly strung sensitive person. She had been treated with radio-active iodine at three to four monthly intervals and received her fourth and last treatment three months previously.

I was asked to see her because she had been agitated for 48 hours talking continuously about God and the

devil and the coming of the end of the world. She had not eaten because she believed her food was poisoned. However, when I saw her she was calm and detached. She showed me her Bible and told me she was sorting out her belongings to be prepared for the coming of the end of the world.

She was admitted into hospital under Section 25. At first she was restless and irritable, refused food, and would only talk with much persuasion. Apart from very moderate exophthalmos there were no abnormal physical findings. Temperature, pulse and blood pressure were normal. Blood cholesterol was found to be 410/100 ml. and protein-bound iodine 1.3 μg./100 ml. Full blood count, urine analysis and chest X-ray were normal. Blood calcium was not estimated.

Thyroxine 0.1 mg. was given three times a day, and the response was immediate and spectacular. The restlessness, irritability, suspiciousness and distressing feeling of impending doom all departed.

K. Witton in 1959 has described in detail a similar case, a 45 year-old married woman who had an acute transitory psychotic reaction following radio-active iodine treatment. This patient claimed to be receiving messages by television and to be annoyed by unpleasant odours emanating from the refrigerator. She went on to state that radio-active iodine had made her susceptible to mind control and that she would be used by Russia to obtain American secrets. Witton's initial diagnostic impression was, like mine, of an acute schizophrenic reaction.

The iatrogenic hypothyroidism came on rapidly as in the case I have reported, and the psychiatric complications were so overwhelming that at first she appeared to suffer from a schizophrenic illness. It is possible that with the increasing use of radio-active iodine, in the absence of a medical history, there may be more cases of toxic psychosis which might be mistaken for a schizophrenic illness until the overt somatic evidence of myxoedema should become apparent.

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References

Slingerland, D. W., Lambery, B. A., and Cassidy, C. E. (1958). 'First International Symposium on Radio-active Treatment of Toxic Goitre and of Heart Disease.' Liège.

Witton, K. (1959). *American Journal of Psychiatry.* Vol. 115, No. 8.

Linguette, M., Swyngedauw, J., and May, J. P. (1964). *Lille méd.*, 20, 10.

Kearns, John E., M.D. (1967). *Treatment of Hyper-thyroidism with Radio-active Iodine.* [20 year Review of 34 years specialization of treatment of hyper-thyroidism first by surgery and then for the last 19 years with radio-therapy covered over 1,000 patients. In only one case and that one treated with radio-active iodine was a toxic psychotic episode reported.] Charles C. Thomas, Springfield. Illinois, U.S.A.

POLARIZATION IN DEPRESSION

Dear Sir,

We were interested to read the article of Dr. Arfai and his colleagues (*Journal*, April, p. 433–4), describing a controlled trial of polarization of the brain in depression. While not querying their methodology, we feel that the selection of patients was such as to cast serious doubt on the validity of their conclusions.

Though claiming to have replicated the controlled trial of Costain *et al.* (1964), unlike these authors, they included only in-patients instead of a mixed in-patients/out-patients group. That the patients of these two studies differed is shown by the fact that whereas 17 of 19 of Dr. Arfai's patients were psychotic depressives responsive to ECT, agitated and suicidal patients were specifically excluded in the original investigation; it is also clear from the case histories of the preliminary study of Redfearn *et al.* (1964), that most of the patients responsive to the method were very chronic 'neurotic' depressives, unresponsive to ECT, with tension, phobic and hysterical symptoms. In the Blackpool and Fylde area we have tended to follow these indications, and we give the treatment to chronic neurotic or 'atypical' depressives with the above features, as well as anergia and somatic symptoms, in whom other anti-depressant treatments (including ECT) have failed or are contra-indicated.

In our out-patient departments, 24 patients are currently having positive polarization, and a total of 119 patients have received it since April, 1965. That we have used positive polarization over a period of five years, and are continuing to use it, reflects our satisfaction with it, even though some patients require prolonged courses (two or three times per week) in order to prevent relapse—one has had 290 applications to date. We have also used out-patient brain negative polarization on a small number of chronically hypomanic patients who refused to co-operate with other measures, their excitement and disturbed behaviour being controlled over long periods (Carney, 1969). Polarization is very acceptable to sufferers from affective illness, probably because it is simple to apply, is painless, and is given in a comfortably furnished rest room in the out-patient department.