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 radioactive 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 radioactive 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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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 outpatient 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 outpatient department.

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In conclusion, though we have not carried out a controlled trial, our not inconsiderable clinical experience over five years confirms that brain polarization is extremely valuable in certain kinds of patient very difficult to handle by other means. This opinion is shared by the patients, their relatives and the nursing staff. As you recently pointed out (*Journal*, July, p. 119), 'No useful method of treatment was ever yet discovered in a strictly controlled trial, but such trials have their place when the exploratory work has been done.' We believe that Dr. Arfai and his colleagues took insufficient notice on the preliminary studies in planning their trial.

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RESULTS OF SYSTEMATIC DESENSITIZATION WITH PHOBIAS RE-EXAMINED

DEAR SIR,

N. McConaghy (*Journal*, July 1970, p. 89–92), suggests that in some reports of controlled studies of phobic subjects valuable therapeutic effects have been ignored because they did not reach statistical significance. It might be worth pointing out that statistics are sometimes useful in such studies inasmuch as they help the investigator distinguish between conclusions which may be correctly drawn from the results and those which may not. One advantage of the statistical treatment reported in the papers of Gelder, Marks, Cooper and others is that the reader can infer with confidence that the 'trend', to which McConaghy refers, for more subjects to show marked improvement with desensitization than with control procedures is nothing more than an interesting pointer to a future study designed specifically to test its importance. An appropriate null hypothesis might be that the trend reflects only chance factors and is not an effect of desensitization; published reports do not contradict this hypothesis.

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SHORTCOMINGS OF SCIENTIFIC PSYCHIATRY

DEAR SIR,

We regret that the brevity which we thought appropriate in reporting the negative results of our study of LSD treatment in alcoholism and neurosis (*Journal*, April 1970, **116**, 443–5), has given Dr. E. K. Ledermann (*Journal*, June 1970, **116**, 680) the impression that we had to be impersonal in striving for objectivity, since the facts were quite otherwise.

The therapist met each patient and described the purpose and method of the experiment in full before inviting his participation. Treatments were given in pleasant surroundings, each room being decorated with flowers and equipped with a phonograph and records. A nurse remained with the patient throughout each session, and the therapist made frequent visits to discuss his reactions to the drug. We are well aware of the possible complications of treatment with lysergide (Denson, 1969), and the therapist accepted personal responsibility for the safety of each patient during the session and the following week; contact was maintained by telephone and home visits.

The purpose of this study was to demonstrate what we and our colleagues had believed to be a therapeutic effect of LSD treatment (Smith 1959;, Jensen, 1962; Denson, 1966), and it was undertaken with much enthusiasm. Our negative findings have been a source of personal disappointment and we can readily understand the sentiments which motivated Dr. Ledermann's communication. If he and his associates at the Marlborough Day Hospital can succeed where we have failed we shall be delighted to acknowledge their achievement.

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