These data suggest:

1. Noradrenergic hypofunction in DST negative patients, who seem clinically to be more often mild to moderate, or—according to certain classification systems—neurotic, or minor depressions. This group may profit from selective noradrenergic antidepressants such as nomifensine, desipramine (Amsterdam *et al*, 1983) or other non-cholinolytic NA-enhancing compounds.

2. A noradrenergic hypo- plus a cholinergic hyperfunction in DST positive patients who seem to represent largely the more 'endogenous' type of depression. This subgroup may well respond to NA potentiating plus cholinolytic antidepressants as amitriptyline, doxepine etc.

A correlation between cortisol and MHPG excretion has been found in depressed patients (Rosenbaum *et al*, 1983). Combining the presented findings with the MHPG prediction data (Beckmann and Goodwin, 1975) it appears that DST negative/low MHPG depressives respond to NA potentiating drugs and that DST positive/high MHPG depressives respond more favourably to NA potentiating plus anticholinergic antidepressants.

These data support the concept of a biochemical heterogeneity of depression and offer a suggestion for a more specific antidepressive drug therapy.

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## PSYCHOTHERAPY AND INSTANT DISLIKE

DEAR SIR,

The excellent, down to earth, sensible article on "Contraindications and Dangers of Psychotherapy" by Sidney Crown (*Journal*, November 1983, **143**, 436–441) is marred by one glaringly disputable statement. He states that 'Everyone knows that people either like or dislike others almost at sight; from a psychodynamic point of view it seems likely that both conscious and unconscious factors are involved. There is something irreducible and unanalysable in the patient-therapist interaction just as there is with friendship'. Dr Crown should observe more closely the behaviour of people. It is often very easy to itemise some of the reasons for instant like or dislike even before any speech takes place, when observing (1) eye contact or lack of it; (2) beauty or ugliness; (3) height; (4) similarity or dissimilarity of class as evidenced by dress; (5) colour of skin; (6) colour and style of hair or lack of it; (7) age; (8) grace of posture or lack of it; (9) visible display of interests of the person for example of jewelry or style of dress. All this non-verbal information and behaviour can of course immediately tap unconscious transferences. Once verbal interchange has taken place even at a very superficial level even more information is available between people from (a) accent; (b) tone of voice; (c) evident interest from the object. Need one continue? I strongly disagree that there is "something irreducible and unanalysable in the patient-therapist interaction just as there is with friendship". It is by the conscious act of reducing and itemising verbal and non-verbal behaviour that one gets nearer to analysing the unconscious likes and dislikes of people.

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## METHODOLOGY OF DRUG AND PLACEBO COMPARISONS

DEAR SIR,

Dr Millar (*Journal*, November 1983, **143**, 480–486) has performed a useful service in drawing attention to the difficulties involved in using patients as their own controls and we would like to respond to his paper both in general principles and in relation to our paper on benzhexol and memory which formed the basis for his criticism.

Taking principles first, it is perfectly true that despite randomisation of order, patients who have the placebo second may have their performance on the placebo affected by the preceding active preparation.