changes may occur independently of any neuroendocrine process i.e. from starvation although may still be an integral part of a psychiatric disorder. Furthermore it emphasises the importance of blood biochemistry in understanding the clinical picture and may strengthen the argument for routine biochemical investigations in psychiatric patients.

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PATTERNS OF CARE FOR THE DEMENTED

DEAR SIR,

The paper by Christie and Train (*Journal,* January 1984, **144,** 9–15) made several salient points about the provision of in-patient beds for the demented elderly. They also presented data showing that the provision of day care and/or "holiday" admissions prior to the final admission had no significant effect on the patients' ultimate length of stay in hospital. From this they concluded that "treatment, or what might more appropriately be described as support for patients and relatives is shown to have had no effect in reducing the duration of terminal hospitalisation".

While this may be so, it is not a logical conclusion on the basis of the data presented. Day care places and holiday admissions were not allocated on a random basis, and were thus presumably a reflection of perceived greater need. Most commonly the greater need would be that of the demented patient's relatives, rather than of the patient herself. Given that the more stressed and/or "help-seeking" relatives tend to be the recipients of this sort of assistance, one could view the fact that the "treated" patients do not require longer final hospitalisations as evidence that day care and holiday admissions are doing just what they ought to be doing i.e. providing sufficient support to enable stressed relatives to cope with a demented dependant at home for as long as their less stressed counterparts.

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DEXAMETHASONE SUPPRESSION TEST PREDICTS RESPONSE TO NOMIFENSINE OR AMITRIPTYLINE

DEAR SIR,

The dexamethasone suppression test (DST) has recently attracted considerable interest among biological psychiatrists. While its specificity for the diagnosis of endogenous or primary depression has not been confirmed fully it is conceivable that it could have application as a tool for the exploration of neurotransmitter dysfunctions in the limbic–hypothalamic system. A pathological (i.e. positive) DST might be secondary to either a decrease of noradrenergic activity (van Loon *et al,* 1971) or increased cholinergic activity within the central nervous system (Garver & Davis, 1979). Data on the involvement of serotonin on ACTH release are contradictory.

Using the DST as a peripheral indicator we investigated the possibility of a central noradrenergic–cholinergic imbalance in subgroups of depressed patients (Janowsky *et al,* 1972).

In 43 depressed inpatients the DST was performed. Subsequently, a group (n = 23) of DST positive and a group (n = 20) of DST negative depressives were treated for 28 days under double blind conditions with either nomifensine (150–300 mg/day), a noradrenaline (NA) potentiating drug, or amitriptyline (150–300 mg/day) a NA potentiating and potent anticholinergic compound.

DST positive depressives responded favourably to amitriptyline, but not to nomifensine. Conversely, DST negative depressives responded favourably to nomifensine but less well to amitriptyline. (Table).

TABLE

Clinical response in depressed patients with pathological (+) and normal (−) dexamethasone depression test (DST) treated with amitriptyline and nomifensine. Response is defined as decrease of Hamilton Depression Rating scale global score by 50 per cent within 28 days

	DST	Response	
		<50%	>50%
Amitriptyline (n = 20)	+ (n=10)	2 20%	8 80%
	— (n=10)	5 50%	5 50%
Nomifensine (n = 23)	+ (n=13)	8 62%	58 38%
	— (n=10)	3 30%	7 70%

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.