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AUTHORS' REPLY: Some interesting points are raised by Driscoll & Thompson. Firstly, Levitt & Joffe (1988) actually suggested that the small numbers in their study groups might have led to a type I error (not type II error), a point which is difficult to grasp. However, our finding is similar to theirs in that we reported lower mean testosterone levels in the depressed group of men with melancholia ($n=11$) compared with the non-depressed control group ($n=10$). In the light of the thorough study by Rubin *et al* (1989), where blood sampling occurred at 30 minute intervals for 26 hours in 16 endogenously depressed men (according to Research Diagnostic Criteria) and 16 individually matched controls, and no significant differences in total testosterone were found, we hesitate to say that our results may reflect a type II error; more so since (as we stated) Rubin *et al* found testosterone levels to correlate positively with melancholia in the subgroup of six men with melancholia according to DSM-III criteria, and all of *our* patients were melancholic. Because of our small sample, we were particularly stringent in statistical analyses, and a test of significance showed $P=0.025$ for levels of salivary testosterone in the depressed men compared with non-depressed controls.

Secondly, in the depressed group itself we found significantly lower salivary testosterone levels to be associated with more severe depression. One possible cause (of several) suggested was hypercortisolaemia. Having examined the correlation between cortisol and testosterone, there is no support for this. The correlation between cortisol and testosterone was $r=0.042$ ($P=0.9$; $n=11$) before dexamethasone and $r=-0.11$ ($P=0.7$; $n=10$) after dexamethasone.

This finding therefore concurs with that of Yesavage *et al* (1985).

Thirdly, is there an age factor? We found no association of testosterone levels with age ($r=-0.26$, $P=0.4$; $n=11$), neither was there an association of depression, as measured by the Hamilton Rating Scale for Depression and the Montgomery and Åsberg Depression Rating Scale, with age ($r=0.08$, NS and $r=0.22$, NS).

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Attitudes to mental illness

SIR: I read with interest the two articles (Brockington *et al*, *Journal*, January 1993, **162**, 93–99; Hall *et al*, *Journal*, January 1993, **162**, 99–108) describing the survey of attitudes to mental illness in Malvern and Bromsgrove. Factor analysis indicated fear of the mentally ill as a main component, but in this case in fact almost 85% of the scores were positive “showing the absence of fear of the mentally ill among most people in the general community” (p. 95). This is a little surprising bearing in mind that a substantial proportion of the literature suggests that members of the ‘general public’, at least on occasion, view patients and former patients as unpredictable and dangerous. One might have therefore expected at least some ambivalence from subjects in this respect. In spite of the study’s sophistication, and its use of vignettes, it may be that an additional design could usefully have complemented their study; for example, the discourse analytic approach advocated by Potter & Wetherell (1987), Gilbert & Mulkey (1984), and others, in which subjects are freely encouraged to express their opinions in dialogue and