region (e.g. the left amygdalo-hippocampus). Dr Adams and I have therefore agreed to do this. If more than five additional studies are found, then I will give Clive Adams a bottle of Glendronnach malt whisky; if fewer than five, I get a bottle. We will let the journal editors know the outcome of our efforts with a view to updating readers.

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Qualitative research – a rejoinder

Sir: In a valuable editorial, Buston *et al* (1998) make the case for qualitative research in psychiatry, the approach they advocate being in essence that of the field-working sociologist or anthropologist. However, qualitative research is not restricted, as they assume, to the phenomena of perceived meaning. Charles Darwin's inquiries on the Galápagos Islands (his observations, for example, of the Islands' finches) were by any standards qualitative. Psychiatry, too, in common with other human sciences, suffers methodological awkwardnesses which the authors do not make explicit. One is especially pressing: it is unclear under what circumstances, if any, claims can rationally be made about interactions between variables within an individual's life on the strength of evidence about interactions between variables within samples or groups.

A descriptive or statistical analysis of the properties Darwin's 13 kinds of finch had in common would have represented their idiosyncracies – the detailed differences on which a momentous advance in biological theory was to depend – as noise within a classificatory system.

How, then, is psychiatry to be distinguished from journalism or false science? Our contention is that the answer lies in a heuristic 'logic'. This is 'conversational', and has the properties of an argument or debate. Within it, psychiatry grows, as particle physics grows, from rejoinders which take the form "Yes, but . . ."; from the challenge implicit in anomalies and exceptions to the currently agreed rule.

Where samples are necessary, these can of course be built up quite quickly by means of the detailed study of one patient at a time. There are advantages, too, in samples which are large enough to permit the development of new devices – the open-ended Relationship Episode Questionnaire (Hale & Hudson, 1992), for example – but small enough to allow each individual to be seen in the round. The preeminent advantage of small- to medium-sized samples is that they allow the two sorts of evidence – about interactions within samples and interactions within individuals – to answer one another back.

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Hale, R. & Hudson, L. (1992) The Tavistock Study of Young Doctors. *British Journal of Hospital Medicine*, **47**, 452–464.

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Active placebos in antidepressant trials

Sir: We would like to respond to some of the issues raised in Healy's (1998) commentary on our meta-analysis of antidepressant trials using active placebos (Moncrieff *et al*, 1998). In particular, we feel it is important to clarify that in randomised controlled trials intention-to-treat analysis is preferred for the estimation of effect because of the potential for bias inherent in analysis of 'completers' or 'compliers'. Random allocation is employed to obtain groups which do not differ systematically from each other. Drop-out and non-compliance cannot be assumed to be random processes and hence the groups remaining may differ in ways unrelated to the treatment effect. The protection against bias afforded by randomisation no longer holds. There is evidence which confirms that people who comply *per se* have a better prognosis than those who do not (Fuller *et al*, 1986; O'Sullivan *et al*, 1991). Any degree of unblinding may make people more likely to comply with one form of treatment than with another and hence introduce a source of bias.

We concur with Healy's scepticism of the concept of specific treatments for depression. We feel that our study, with its implication that treatment effects of antidepressants may be overestimated, is a further indication of the weakness of this approach. However, it may be very difficult to evaluate substances on the basis of the 'therapeutic principle' thesis advanced by Healy. Any substance with noticeable physiological effects may act as an active placebo by suggesting that the patient is on an active and, therefore, helpful substance. How this effect can be distinguished from physiological effects that are genuinely helpful to patients is difficult to say and may call for different forms of evaluation.

We would like to inform readers that this review was conducted under the auspices of the Cochrane Collaboration Depression, Anxiety and Neurosis group and that it will be available on the Cochrane Database of Systematic Reviews, where it will be periodically updated.

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O'Sullivan, G., Noshirvani, H., Marks, I., *et al* (1991) Six year follow up after exposure and clomipramine therapy for obsessive compulsive disorder. *Journal of Clinical Psychiatry*, **52**, 150–155.

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