the fact that these numbers are too small to be meaningful.

Hornig & McNally have also extended our methods (Weissman *et al*, 1989) to simultaneously include six psychiatric disorders other than panic disorder, in addition to the three included in that original paper. This was done in an effort to control for the confounding effects of these comorbid disorders on the association between panic disorder and suicide attempts. Their Table 1 presents the results obtained by including in the model nine psychiatric disorders in addition to panic disorder and sociodemographic variables. The results of their analyses show that the effect of panic disorder on suicide attempts is not statistically significant under these circumstances. However, when we carry their analyses a step further and include social phobia (which appears to meet the same criteria as the other nine psychiatric disorders regarding its inclusion in the model as a potential confound; Schneier *et al*, 1992), we find that the association of panic disorder with suicide attempts is indeed significant ($P<0.0145$).

We agree with Hornig & McNally that comorbid conditions strongly influence the degree to which individuals with panic disorder are at risk for suicide attempts. We especially note that estimating the strength of this association will vary with the specific comorbid variables that are included in the model as we have demonstrated here. Therefore, the direct estimate of the risk of suicide in uncomplicated panic disorder is of the most interest. These arguments as well as supporting studies are summarised by Johnson *et al* (1992).

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Five group comparisons of treatments for anxiety disorders

SIR: Oehrberg *et al*'s (1995) comparison of the SSRI paroxetine and placebo in the treatment of panic disorder and agoraphobia reports an advantage for paroxetine treated patients. Patients in this study received standardised cognitive behaviour therapy along with their primary treatment (paroxetine or placebo). This design does not, however, permit a comparison of the efficacy and tolerability of paroxetine and placebo as is claimed. For paroxetine and placebo to be compared irrespective of cognitive behaviour therapy, one would have to assume an equivalent effect for the cognitive behaviour therapy for all patients in both drug groups. The design also ignores the possibility of differential drug by cognitive behaviour therapy interactions. The study design therefore only permits a comparison of paroxetine *plus* cognitive behaviour therapy with placebo *plus* cognitive behaviour therapy. A full comparison of paroxetine, placebo and cognitive behaviour therapy, would require a minimum of *five* treatment groups (Hollon & De Rubies, 1981), namely; paroxetine alone, placebo alone, cognitive behaviour therapy alone, paroxetine plus cognitive behaviour therapy, and placebo plus cognitive behaviour therapy.

Such five group comparisons of pharmacological and psychological treatments for anxiety disorders are rare, with one published study to date, comparing diazepam, placebo, and cognitive behaviour therapy alone and in combination in the treatment of generalised anxiety disorder (Power *et al*, 1990). We have recently completed a second five group study comparing the relative and combined efficacies of the SSRI fluvoxamine, placebo and cognitive behaviour therapy in the treatment of panic disorder and agoraphobia (Sharp *et al*, in press). The results of these more comprehensive studies suggest that the design used by Oehrberg *et al* is unreliable. This is particularly so for the placebo plus cognitive behaviour therapy group. In our studies this combination was more effective than the placebo alone treatment but less effective than the cognitive behaviour therapy alone condition, and is thus an inadequate representation of either placebo or cognitive behaviour therapy used alone. Such information could only be provided by a five group comparison which is the minimum standard design for such studies.

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Homicidal behaviour and mental disorders

SIR: The important study of Modestin & Ammann (1995) includes some misleading conclusions. The writers emphasise that "women with mental disorders . . . were no more likely than controls to have committed violent crimes". Their data shows that the female psychiatric in-patients committed six violent crimes whereas the controls committed none. Although the statistical test used by the authors did not indicate statistical significance, this may be a type 1 error. The authors also conclude that schizophrenia and affective disorders do not elevate the risk of violent behaviour, but alcoholism does. However, among men, the odds ratios for violent crimes was 3.1 for schizophrenia and 8.8 for affective disorders. The fact that 99% confidence intervals were very wide (lower ends below 0.6) was due to the small number of subjects, and therefore, the authors' conclusion on major mental disorders and the risk of violent behaviour is dubious. The authors' conclusion that "mental disorders . . . do not contribute to criminal behaviour" cannot be verified in a statistically significant way (with 99% CI) to be true or false in their relatively small sample.

We have analysed all forensic psychiatric examinations conducted on persons charged with a homicide during several years in Finland. Our results indicate that schizophrenia is associated with up to a 10-fold risk of committing a homicide among women (OR 10.8; 95% CI 5.5–21.3) and with about a 7-fold risk among men (OR 6.7; 95% CI 2.7–16.3). The odds ratio for alcoholism was about 16 (OR 16.0; 95% CI 11.3–22.6) among men and about 50 (OR 48.8; 95% CI 33.5–71.2) among women, when compared with the general population (Tiihonen *et al*, 1993; Eronen, 1995). The lower ends of 95% CI were clearly above 1.0 which indicates that the risk increase is significant at the 95% level. In a recent Finnish 3-year sample of homicide recidivists all offenders were type 2 alcoholics (85%) or schizophrenics (15%) (Tiihonen & Hakola, 1994) which also indicates that schizophrenia and the combination of alcoholism and personality disorders are the most important mental disorders causing homicidal behaviour.

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Seizure threshold in bilateral and unilateral ECT

SIR: Abrams *et al* (1973) reported shorter seizure durations with unilateral compared with bilateral ECT, and this has been confirmed by Weiner (1980). The general consensus of opinion is that bilateral ECT is associated with longer seizures compared with unilateral treatment. In addition, as seizure threshold increases, the seizure duration decreases and vice versa. However, the recent College video on ECT states that bilateral ECT is associated with an increased seizure threshold compared with unilateral treatment, and this is reiterated in the accompanying handbook. We would welcome clarification on this by the Special Committee on ECT as we are involved with the teaching of ECT to junior psychiatrists and regularly use both the video and handbook as a teaching aid.

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