other options. We compared the above effect size with the effect sizes for the three studies quoted above. These were 0.83 (95% CI 0.53–1.13), 1.36 (95% CI 0.90–1.80) and 0.38 (95% CI 0.14–0.61), respectively.

We then looked at the number needed to treat (NNT) based on the responders as per the Clinical Global Impression – Improvement (CGI–I) scores. The NNT for the study by Kasper *et al* (2005) is 7 (95% CI 4–20) and for the comparative studies, 4 (95% CI 3–6), 2 (95% CI 2–3) and 3 (95% CI 3–4), respectively. van der Linden *et al* (2000) reported a meta-analysis of the effectiveness of serotonin reuptake inhibitors (SSRIs) in the treatment of social anxiety disorder. They found a collective NNT of 4 (responders on CGI–I) and a mean effect size for all SSRIs of 1.0 (the SSRI/placebo difference at end-point on the LSAS). None of the ten SSRI studies in the meta-analysis included escitalopram.

It is tempting to suggest that the placebo response in the study of Kasper *et al* (2005) was high and distorts results. However, if randomisation is presumed to have been successful, an equivalent placebo effect would have occurred in the escitalopram group. The impressive *P* values reported by Kasper *et al* (2005) are likely to be because their study was overpowered and they used analysis of covariance (ANCOVA) which is known to have greater statistical power.

Based on our analysis, among the different SSRI medications escitalopram is less likely to be effective in the treatment of social anxiety disorder. We suggest that *P* values can mislead and should not be interpreted as measures of magnitude of effect.

Allgulander, C. (1999) Paroxetine in social anxiety disorder: a randomized placebo-controlled study. *Acta Psychiatrica Scandinavica*, **100**, 193–198.

Baldwin, D., Bobes, J., Stein, D. J., *et al* (1999) Paroxetine in social phobia/social anxiety disorder. Randomised, double-blind, placebo-controlled study. Paroxetine Study Group. *British Journal of Psychiatry*, **175**, 120–126.

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Stein, M. B., Liebowitz, M. R., Lydiard, R. B., *et al* (1998) Paroxetine treatment of generalised social phobia (social anxiety disorder) – a randomised controlled trial. *JAMA*, **26**, 707–713.

van der Linden, G. J., Stein, D. J. & van Balkom, A. J. (2000) The efficacy of the selective serotonin reuptake inhibitors for social anxiety disorder (social phobia): a meta-analysis of randomized controlled trials. *International Clinical Psychopharmacology* (suppl.), **2**, S15–S23.

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Authors' reply: We thank Drs Lele and Joglekar for drawing our attention to the absence of the 95% CIs for the primary efficacy end-point (treatment effect measured as the difference in the Liebowitz Social Anxiety Scale (LSAS) scores from baseline) in our article on the treatment of social anxiety disorder with escitalopram (Kasper *et al*, 2005). The treatment difference between escitalopram and placebo was 7.3 (95% CI 2.2–12.4) with a standardised effect size of 0.30 (95% CI 0.09–0.51).

When comparing the results of this trial with the literature we looked at the size of the effect of the active treatment, that is, the adjusted change from baseline in LSAS scores, not the standardised effect size. These values are 33.0 (Allgulander, 1999), 29.4 (Baldwin *et al*, 1999) and 30.5 (Stein *et al*, 1998), which are comparable to the 34.5 change in our study with escitalopram (Kasper *et al*, 2005). The main difference between these studies is the placebo response, which was largest in our study.

In interpreting differences in placebo response rate (and hence standardised effect sizes) it is important to recognise differences in study design. One of the paroxetine studies (Allgulander, 1999) was a small (n=92) single-centre trial with a 40% placebo withdrawal rate (compared with 18% for paroxetine) and patients were also required to have been treated for at least 2 weeks. These factors may be responsible for the small placebo effect with the last observation carried forward (LOCF) analysis. In the studies of Allgulander (1999) and Stein *et al* (1998) patients were not excluded if they had comorbid depression, which was the case in our study. Finally, in our escitalopram study the mean baseline LSAS scores in the placebo and treatment groups (95.5 and 96.3) were higher than in the paroxetine studies (70.4 and 78.5 in Allgulander, 1999; 78.0 and 83.5 in Stein *et al*, 1998; and 86.1 and 87.6 in Baldwin *et al*, 1999).

We would like to emphasise the appropriate powering of our study. ANCOVA is overpowered if the distribution is skewed but our data are fairly normally distributed. Allgulander (1999) state that their data were skewed and non-parametric tests were used.

In line with the results of our study additional recent data (Lader *et al*, 2004) confirm the efficacy of escitalopram in social anxiety disorder. In a 24-week study the placebo response was 43.4 compared with 60.8 with 20 mg escitalopram and 53.1 with 20 mg paroxetine (mean change from baseline). The treatment difference (observed cases) between escitalopram and placebo was 17.4 (95% CI 11.5–23.2) with a standardised effect size of 0.77 (95% CI 0.51–1.03). The treatment difference for escitalopram and paroxetine (observed cases) was 7.71 (95% CI 2.0–13.4) in favour of escitalopram with a standardised effect size of 0.34 (95% CI 0.09–0.59). After 12 weeks the number needed to treat (NNT) based on the responders as per Clinical Global Impression – Improvement (CGI–I $\leqslant$2, LOCF) scores for Kasper *et al* (2005) was 6.4 (95% CI 4–19) and 4.8 (95% CI 3–10) for Lader *et al* (2004). To judge a single medication based on the NNT it is necessary to consider all available studies and, based on the evidence published in the literature, we therefore do not agree with the statement of Drs Lele and Joglekar that paroxetine is superior to escitalopram for the treatment of social anxiety disorder.

Declaration of interest

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Choosing psychiatry as a career

As a graduate of 2000 and a participant in Goldacre *et al*'s survey, I was keen to reflect on which influences led me towards psychiatry and how these compared with those of others. Interestingly, the paper reports that only a small percentage of those entering the specialty had intentions to do so before medical school (18%). Thus major influences on career choice are the curriculum, clinical experience and inspiring teachers. My own experience would be consistent with this, along with an interest held by my peer group at medical school. As an Edinburgh graduate I was interested to find that Edinburgh had the highest percentage of doctors choosing psychiatry, after 3 years, of all UK medical schools. Edinburgh has a notable academic department through which the curriculum is conducted but other medical schools with large academic units do not appear to attract as many candidates into the discipline. If recruitment into psychiatry became a problem, at what point should the curriculum at medical schools be reassessed at a national level or by the Royal College of Psychiatrists? Surely the future of psychiatry is dependent on the engaging of prospective students with the corpus of academic and clinical excellence.

Goldacre, M. J., Turner, G., Fazel, S., *et al* (2005) Career choices for psychiatry: national surveys of graduates of 1974–2000 from UK medical schools. *British Journal of Psychiatry*, **186**, 158–164.

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One hundred years ago

Family care of the insane

In drawing attention last March to the conclusions favourable to the family care of the insane which could fairly be arrived at from the reports of our Special Commissioner on the Care of the Insane Poor, we promised to return to the subject when our Commissioner should have had an opportunity of supplementing his report on the progress achieved on the Continent and in Scotland, and should have given an account of the boarding out of the insane as it is practically carried out in England.

We accordingly invite the careful perusal of the report appearing in this number of the British Medical Journal by our Commissioner on the Family Care of the Insane Poor in England and Wales. From beginning to end this document furnishes a very remarkable contrast to the earlier reports. In every country where family care has been carried out with an intelligent desire to improve the condition of the insane, the method has found warm advocates, and even where there has not been unanimity of approval in detail, family care is proudly pointed to as the most advanced and most beneficent mode of dealing with a great number of the most afflicted class of the population. But in England so little is known of the matter, and so little public interest has been excited in the topic, that many persons were probably unaware of the existence of an English form of family care. It would most likely be hardly justifiable to say that the procedure is carried out in a surreptitious manner, but certainly it is seldom spoken of. Nobody appears to be proud of it, and those who read our Commissioner's reports will not wonder at this. The system of dealing with these 5,000 and more unfortunate persons of unsound mind is not altogether creditable to a country which, in the early days of non-restraint, was proud to consider itself in the van of progress with regard to the treatment and care of the insane. This is the more remarkable seeing how much attention has been paid to the perfection of the family-care system in almost every other country in Europe.

The condition of the victims of this system is much the same practically as that of all the insane before there were any lunacy laws whatever. These patients are, as our Commissioner justly observes, detached from the general lunacy administration of the country. They are regarded merely as paupers, and are only supervised in so far as they are dependent upon the rates. The public appears to forget that these poor people are sufferers from a condition which renders them particularly dependent. It is notorious that custodians of the insane are particularly liable to the temptations of cupidity and of cruelty, leading, unless there be careful supervision, to the probability of ill-usage and almost the certainty of neglect. The elaborate precautions which the law has gradually made more stringent for the protection of the insane in asylums are well known. Here in great institutions, running like clockwork, where hundreds of eyes are upon everybody, the law provides the most elaborate machinery to prevent abuses. In ludicrous contrast to this is the official neglect of the wretched pauper imbecile, who, being unable from his poverty, friendlessness, and dementia, to make efficient representations for himself, should be the special object of care. At the bottom of all this absurdity and inconsistency is the perverse view of insanity which the English law has made familiar. The law is unwilling to recognize anything as insanity which does not involve danger to the person or the pockets of the lieges. Even where there is personal danger, however, that great nightmare "the liberty of the subject" is always ready to gallop across the scene. Society scarcely recognizes that it owes any duty to the insane who are not dangerous and are not in asylums. The duty of curing the victims of a pitiable disease or of securing kindly and sufficient care for those whose infirmity has obviously made them subjects for public protection, would seem to be insufficiently understood.

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