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**Author's reply:** As Laidlaw *et al* point out, there is little evidence to support the theory that increased suicide early in treatment with ECT occurs because of an earlier and 'larger' improvement in psychomotor retardation compared with mood symptoms and suicidal intent. Two previous studies have looked at this question. Rich *et al* (1986) did not measure psychomotor retardation at all but used modified items from the Hamilton Rating Scale for Depression, of reduced energy and reduced work/activity, to compare with suicidal intent. In contrast, Browning & Cowen (1986) using a small group of 10 patients receiving ECT, report an earlier improvement in psychomotor retardation as measured by a subscale for psychomotor retardation (Asberg *et al*, 1973) than in mood symptoms measured using the Montgomery–Asberg Depression Rating Scale (Montgomery & Asberg, 1979) but did not report directly on suicidality.

Laidlaw *et al* report an encouraging early reduction in suicidality during a course of ECT and attempt to compare this with changes in scores on a test of psychomotor speed. The results, however, raise important questions. First, the Coughlan Information Processing Test (Coughlan & Hollows, 1985) used measures not only psychomotor speed but also other aspects of attention, which may be adversely affected by ECT. This may provide an explanation for the slow rate of improvement in this measure. The error score would help to determine whether this is the case, but this is not given. Second, no detail is given of the methods used to control for practice effects, which are a particular problem when assessing rate of change. Third, it is questionable whether percentage changes can be validly used for a scale such as the Beck Suicidal Ideation Scale (Beck *et al*, 1979) which is not a fixed ratio scale or a fixed interval scale. Even if percentage decrease provides a rough measure for comparison within a non-fixed interval scale, it is doubtful whether it is valid to make a comparison in this way between two different scales. Finally, it would be interesting to know what happened to the subgroup of four patients who did not meet criteria for "recovery or improvement" and whether there was an improvement in psychomotor speed in this group, who by virtue of lack of global improvement may be at particular risk of suicide.

Many other factors may be important in determining risk of suicide during ECT treatment and research is difficult since the rate of suicide and attempted suicide is low. None of the three studies discussed reports any cases in whom a suicide or attempt took place. Only a very large prospective study of patients receiving ECT is likely to shed light on the issue of emerging suicidality and the underlying reasons for this. Psychomotor retardation is a relatively rare symptom which is difficult to rate reliably. A recent development is the measurement of motor activity with a wrist activity monitor, the results of which correlate well with scores on the Salpêtrière Retardation Rating Scale (Raoux *et al*, 1994), a clinical rating scale for psychomotor retardation.

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