

system rather than clinician or practice characteristics, or setting effects. For example, some disorders may not always begin with the features required for diagnosis (e.g. mania in bipolar disorder) and therefore diagnostic instability may reflect the time required to consolidate the diagnosis (Baca-Garcia *et al*, 2007).

Our nosological system is in constant evolution, with major revisions each 15 years. Unfortunately, administrative procedures change more slowly than psychiatrists. Recording from one ICD system to another may affect the validity of diagnoses but not stability, since any error in the conversion of diagnostic codes would likely be constant, given the use of computerised algorithms.

Diagnoses in pharmacological and clinical studies have good internal validity (appropriate diagnostic schedules and interviews). In general, follow-up periods are short and selection bias is likely since participants are selected from specific programmes or units, often based on meeting specific entry criteria. Of note, Perala *et al* (2007) recently reported that the National Hospital Discharge Register was the most reliable means of screening for psychotic and bipolar disorder and was much better than the Composite International Diagnostic Interview (CIDI). They concluded that multiple information sources are key to accurate diagnoses. Studies such as ours, where patients are followed over long periods and across several settings, are closer to this approach than clinical trials based on diagnostic schedules and interviews performed in a research unit over a short period or large cross-sectional epidemiological studies based on a single assessment.

Baca-Garcia, E., Perez-Rodriguez, M. M., Basurte-Villamor, I., et al (2007) Diagnostic stability and evolution of bipolar disorder in clinical practice: a prospective cohort study. *Acta Psychiatrica Scandinavica*, **115**, 473–480.

Perala, J., Suvisaari, J., Saarni, S. I., et al (2007) Lifetime prevalence of psychotic and bipolar I disorders in a general population. *Archives of General Psychiatry*, **64**, 19–28.

E. Baca-Garcia Department of Psychiatry, Fundacion Jimenez Diaz University Hospital, Autonomous University of Madrid, Spain. Email: ebacgar2@yahoo.es

M. M. Perez-Rodriguez Department of Psychiatry, Ramon y Cajal University Hospital, Madrid, Spain

M. A. Oquendo Department of Neuroscience at the New York State Psychiatric Institute and Colombia University, New York, USA
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Limitations of cognitive-behavioural therapy for sleep disorders in older adults

When the possible side-effects of hypnotics are considered, there is an argument for alternative treatments of sleep disorders in older adults. Sivertsen & Nordhus (2007) emphasised the role of cognitive-behavioural therapy (CBT) in the management of sleep disorders in this population. However, there are also limitations to this approach.

Mental health practitioners or physicians with formal sleep medicine training currently deliver CBT, but they are few in number and could not cater for all that need therapy (Wetzler & Winslow, 2006). This could be the main reason for the prescribing of hypnotics for older adults despite knowledge of their side-effect profile and potential for misuse. Therefore, more workshops are needed for training of mental health professionals in CBT so that they can incorporate these techniques in their routine care of older adults.

There are no clear guidelines about the optimum number and duration of treatment sessions for sleep disorders, particularly for the elderly. It is also unclear how long CBT continues to be effective. Moreover, CBT refers to a number of non-pharmacological treatments for insomnia, but which are the most effective needs more research. There is insufficient evidence to recommend sleep hygiene education, imagery training and cognitive therapy as single therapies or as additions to other specific approaches (Morgenthaler *et al*, 2006).

Research groups are also working on other effective non-pharmacological interventions for older adults such as acupuncture (Chen *et al*, 1999). Exercise (Montgomery & Dennis, 2004), although not appropriate for all in this population, may also help in inducing sleep. Nevertheless, Sivertsen & Nordhus gave a new insight into this neglected area and provided an impetus for more studies in the elderly.

Chen, M. L., Lin, L. C., Wu, S. C., et al (1999) The effectiveness of acupuncture in improving the quality of sleep of institutionalized residents. *Journals of*

Gerontology Series A: Biological Sciences and Medical Sciences, **54**, M389–394.

Montgomery, P. & Dennis, J. (2004) A systematic review of non-pharmacological therapies for sleep problems in later life. *Sleep Medicine Reviews*, **8**, 47–62.

Morgenthaler, T., Kramer, M., Alessi, C., et al (2006) Practice parameters for the psychological and behavioral treatment of insomnia: an update. *Sleep*, **29**, 1415–1419.

Sivertsen, B. & Nordhus, I. H. (2007) Management of insomnia in older adults. *British Journal of Psychiatry*, **190**, 285–286.

Wetzler, R. G. & Winslow, D. H. (2006) New solutions for treating chronic insomnia: an introduction to behavioral sleep medicine. *Journal of the Kentucky Medical Association*, **104**, 502–512.

O. Prakash Geriatric Clinic and Services, Department of Psychiatry, National Institute of Mental Health and Neurosciences, Bangalore 560029, India. Email: op@nimhans.kar.nic.in
doi: 10.1192/bjp.191.3.266

Authors' reply: Dr Prakash calls for more training workshops to improve implementation of cognitive-behavioural therapy (CBT) for older adults with sleep disorder. Although we agree that there are too few sleep specialists, we believe that the key to more effective implementation is to provide the same training for other health professionals, including primary care nurses. Although there is no consensus on which component should be included in CBT for insomnia, our experience is that sleep restriction and stimulus control are both crucial for improving sleep in this age group. These components can easily be adapted for use by most health professionals.

In Norway, the Norwegian Medical Association has started to offer training workshops on CBT for insomnia for its members and the Norwegian Psychological Association will soon follow this important initiative.

However, we share Dr Prakash's concern that there is still insufficient research on how to optimise the treatment and there is clearly a need for studies to determine which component works best and for whom.

B. Sivertsen Department of Clinical Psychology, University of Bergen, Bergen, Norway. Email: Borge.Sivertsen@psykp.uib.no

I. H. Nordhus Department of Clinical Psychology, University of Bergen, Norway
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