

Callous–unemotional traits and autistic psychopathy

Viding *et al* (2007) made no reference to autistic psychopathy (Asperger, 1944) nor did any of the other papers in Supplement 49 on assessment risk and outcome in severe personality disorder. The severe unempathic conduct and aggression problems were well recognised by Asperger (1944) and overlap with what Viding *et al* (2007) describe as ‘more severe, aggressive, and stable pattern of antisocial behaviour and a specific neurocognitive profile indicative of defects in affect processing’. This is precisely what children (and adults) with autistic psychopathy and antisocial behaviour demonstrate (Fitzgerald, 2001, 2003).

Asperger, H. (1944) Die ‘autistischen Psychopathen’ im Kindesalter. *Archiv für Psychiatrie und Nervenkrankheiten*, **117**, 76–136.

Fitzgerald, M. (2001) Autistic psychopathy. *Journal of the American Academy of Child and Adolescent Psychiatry*, **40**, 870.

Fitzgerald, M. (2003) Callous–unemotional traits and Asperger’s syndrome? *Journal of the American Academy of Child and Adolescent Psychiatry*, **42**, 1011.

Viding, E., Frick, P. J. & Plomin, R. (2007) Aetiology of the relationship between callous–unemotional traits and conduct problems in childhood. *British Journal of Psychiatry*, **190** (suppl. 49), s33–s38.

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Authors’ reply: Asperger’s use of the term psychopathy refers to personality disorder/psychopathology rather than to psychopathy as defined by current criteria. Recent research carried out with colleagues indicates that although there are individuals who have the neurocognitive profile associated with both autistic-spectrum disorders and psychopathy, most individuals with autistic-spectrum disorders (even those with antisocial behaviour) do not show neurocognitive deficits characteristic of psychopathy (Rogers *et al*, 2006). More importantly, a case review of 177 cases originally diagnosed by Asperger found no raised incidence of criminal offences compared with rates in the general population (Hippler & Klicpera, 2003). It is clear that there are individuals with Asperger’s syndrome/autistic-spectrum disorder who commit crimes (Baron-Cohen, 1988; Scragg & Shah, 1994). However, Asperger’s

psychopathy does not equal psychopathy as defined by current practice.

Baron-Cohen, S. (1988) An assessment of violence in a young man with Asperger’s syndrome. *Journal of Child Psychology and Psychiatry*, **29**, 351–360.

Hippler, K. & Klicpera, C. (2003) A retrospective analysis of the clinical case records of ‘autistic psychopaths’ diagnosed by Hans Asperger and his team at the University Children’s Hospital, Vienna. *Philosophical Transactions of the Royal Society of London. Series B: Biological Sciences*, **358**, 291–301.

Rogers, J. S. C., Viding, E., Blair, R. J. R., et al (2006) Autism spectrum disorder and psychopathy: shared cognitive underpinnings or double hit? *Psychological Medicine*, **36**, 1789–1798.

Scragg, P. & Shah, A. (1994) Prevalence of Asperger’s syndrome in a secure hospital. *British Journal of Psychiatry*, **165**, 679–682.

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Diagnostic stability: clinical v. research

Baca-Garcia *et al* (2007) highlight some of the important issues related to current nosological systems but other issues need consideration. They voice their concern that with such a high degree of diagnostic instability, the validity of epidemiological, clinical and pharmacological research is questionable. However, in most studies appropriate diagnostic schedules and interviews are used for assessment of patients and a high degree of diagnostic stability has been shown for patients assessed in this manner (Tsuang *et al*, 1981; Schimmelmann *et al*, 2005).

Baca-Garcia *et al* (2007) did not discuss factors such as the level of qualification and number of years of experience in psychiatry of the evaluators, whether the patients were evaluated by the same or different assessors at each visit, the place (i.e. in-patient, out-patient, emergency setting) of first contact, the mean duration of contact, etc., which can influence diagnostic stability. It is also not clear whether at each follow-up proper diagnostic evaluations of patients were performed before diagnosis was recorded.

Furthermore, diagnosis was recorded using ICD–9 codes, but clinicians were using the ICD–10 classification system and this might have led to errors in conversions and reconversions. Although Baca-Garcia *et al* reported that clinicians entered one or two diagnoses at the time

of evaluation, they have not presented any data regarding comorbidity. Furthermore, when we compare the ‘diagnosis received in at least 76% of evaluations’ the diagnostic stability in the emergency setting was more than in the out-patient setting for all disorders except eating disorders. This perhaps reflects the likelihood of the evaluators recording the previous diagnosis rather than doing a complete diagnostic evaluation in the emergency setting.

Baca-Garcia *et al* raise issues which are common in day-to-day practice and highlight the fact that the proper evaluation of the patient requires use of appropriate diagnostic schedules and obtaining information from all possible sources. It is inappropriate to conclude from the study that our diagnostic systems and all research based on this nosological system are flawed.

Baca-Garcia, E., Perez-Rodriguez, M. M., Basurte-Villamor, I., et al (2007) Diagnostic stability of psychiatric disorders in clinical practice. *British Journal of Psychiatry*, **190**, 210–216.

Schimmelmann, B. G., Conus, P., Edwards, J., et al (2005) Diagnostic stability 18 months after treatment initiation for first-episode psychosis. *Journal of Clinical Psychiatry*, **66**, 1239–1246.

Tsuang, M. T., Woolson, R. F. & Crowe, R. R. (1981) Stability of psychiatric diagnosis. Schizophrenia and affective disorders followed up over a 30- to 40-year period. *Archives of General Psychiatry*, **38**, 535–539.

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Authors’ reply: Our article reports on diagnoses of real patients in the real world and hence variability ranges and the diagnostic process may be affected by factors such as psychiatrist or practice characteristics.

Regarding the question of whether full assessments were performed at each visit, we believe that practitioners tend not to update diagnoses if there is no salient clinical change. We hypothesised that clinicians would be less likely to change diagnoses, biasing the data against our reported finding.

Perhaps the most compelling point is that not all diagnoses were unstable. Thus, it is more likely that our findings reflect inconsistencies in our nosological

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.

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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.

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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.

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