Bolton & Hill, 1996), and to the need for a new medical ethics (McIntyre & Popper, 1983).

Bolton, D. & Hill, J. (1996) *Mind, Meaning and Mental Disorder: The Nature of Causal Explanation in Psychology and Psychiatry*. Oxford: Oxford University Press.

Cowen, P. J. (1998) Pharmacological management of treatment-resistant depression. *Advances in Psychiatric Treatment*, **4**, 320–327.

McIntyre, N. & Popper, K. R. (1983) The critical attitude in medicine: the need for a new medical ethics. *British Medical Journal*, **287**, 1919–1923.

Radford, M. D. (1983) Psychoanalysis and the science of problem-solving man: an appreciation of Popper's philosophy and a response to Will (1980). *British Journal of Medical Psychology*, **56**, 9–26.

Dr Michael Radford Consultant psychiatrist, South Birmingham Mental Health (NHS) Trust, Vincent House, Vincent Drive, Edgbaston, Birmingham B15 2TZ, and Honorary Senior Clinical Lecturer, Birmingham University

Author's reply: To "stay in treatment", and indeed to get through the day when one feels unremitting despair, takes courage and endurance. I did not state this explicitly to an experienced psychiatric readership; perhaps I should have done. The practitioner in turn has several tasks, one of which may be the expert use of psychotropic medication. The successful use of medication in chronic depression is inevitably a collaborative exercise because unless patients understand and agree with what is being suggested, why should they be concordant with treatment?

I sense from Michael Radford's comments that his ability to detect patronising attitudes in his colleagues is unusually well-developed (although not necessarily evidence-based). As John Locke pointed out, passion often tempts men into error. Presumably your readers, some of whom will know only too well what it feels like to be depressed, will judge whether the thunderbolt was merited on this occasion.

Professor Philip Cowen Honorary Consultant Psychiatrist, MRC Clinical Scientist, Oxford University Psychopharmacology Research Unit, Warneford Hospital, Headington, Oxford OX3 7JX

Editor's reply: Michael Radford asks whether a statement in an article is endorsed by the Editorial Board. All articles in *APT* are peer-assessed, and articles that are accepted for publication are revised in the light of the assessors' comments. This does not make articles into an expression of either the assessors' or the Editorial Board's opinion, neither is *APT* meant to express any agreed 'party line' of the Royal College of Psychiatrists. Discussion and debate form the essential ethos of *APT* and that is why we are so glad to publish Michael Radford's letter.

Professor Andrew Sims Editor, *Advances in Psychiatric Treatment*, Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG

Sleep disorders in the elderly

Sir: I read with great interest the excellent review by Jagus & Benbow (1999). In a local sleep disorder clinic in north Cheshire, 463 patients were seen during a period of three years. North Cheshire has an estimated elderly population of 40 000. Of all the sleep disorder clinic attendees, 16% were over the age of 65 years, of whom 88% were males and 12% were females. Eighty-eight percent presented with primary snoring, 41% had sleep apnoea, and in 4%, restless legs syndrome and other reported periodic movements were diagnosed. Daytime complaints included irritability (3%), headache (5%), impotence (2%), and daytime sleepiness (45%). Associated physical features included: hypertension (30%), angina (20%), nocturia (11%), chronic obstructive airway disease (14%), and 23% had a large uvula. Of all elderly attendees, 40% reported using alcohol, 60% took regular night sedation and 22% smoked. Only three (4%) of the total 73 elderly attending the clinic were found to be known to the elderly psychiatric service.

In their review, Jagus & Benbow reported that up to 50% of the elderly suffer from sleep disorder which gives an estimated 20 000 potential sufferers in north Cheshire. Surprisingly, only 25 of those potential sufferers found their way to the sleep disorder clinic each year, a probability of 0.001 of being referred to the sleep clinic. The low rate of referral to specialist clinics may be due to the fact that sleep disorders in elderly patients are either underdiagnosed by their general practitioners or are not regarded as serious enough to warrant therapeutic intervention.

There is a need for proper education of health care professionals in the assessment of the neglected area of sleep disorders in the elderly population. Jagus & Benbow's article provides and excellent start.

Jagus, C. E. & Benbow, S. M. (1999) Sleep disorders in the elderly. *Advances in Psychiatric Treatment*, **5**, 30–38.

Dr Emad Salib Consultant Psychiatrist, Hollins Park Hospital, Hollins Lane, Winwick, Warrington WA2 8WA, and Honorary Research Fellow, Liverpool University

Treatment of sleep disorders in adults

Sir: I was disappointed when reading the article by Wilson & Nutt (1999) that very little was said about non-pharmacological interventions for insomnia, although what was said did involve a behavioural approach using sleep hygiene and stimulus control. I was looking for a more detailed discussion in these areas, although it is possible they were not allowed the space to discuss such interventions in detail.

I work in the field of substance misuse – I have been through the temazepam traumas (e.g. Ruben &

https://doi.org/10.1192/apt.5.5.396-c Published online by Cambridge University Press

Morrison, 1992) and am now in the zolpidem/zopiclone zone (e.g. Lader, 1997; Gericke & Ludolph, 1994) and would have valued rather more discussion on non-pharmalogical interventions, possibly along the line of Morin *et al* (1994). May I ask for an article on non-pharmacological treatment of sleep disorders in adults, particularly those with substance misuse problems?

Gericke, C. A. & Ludolph, M. D. (1994) Chronic abuse of zolpidem. *Journal of the American Medical Association*, **272**, 1721–1722.
Lader, M. (1997) Is there any dependence and abuse potential? *Journal of Neurology*, **244** (suppl. 1), S18–S22.
Morin, C. M., Culbert, J. P. & Schwartz, S. M. (1994) Non-pharmalogical interventions for insomnia. *American Journal of Psychiatry*, **151**, 1172–1180.
Ruben, S. M. & Morrison, C. L. (1992) Temazepam misuse in a group of injecting drug users. *British Journal of Addiction*, **87**, 1387–1392.
Wilson, S. & Nutt, D. (1999) Treatment of sleep disorders in adults. *Advances in Psychiatric Treatment*, **5**, 11–18.

Dr Andrew Robinson Consultant Psychiatrist, Substance Misuse Service, Fulton Clinic, Royal Cornhill Hospital, Aberdeen AB25 2ZH

Dentistry and psychiatry

Sir: I find it astonishing that in a recent issue of *APT* the paper on 'understanding the importance of oral health in psychiatric patients' completely ignored the problem of bruxism or tooth grinding – arguably one of the most common problems linking dentistry with psychiatry.

Cormac, I. & Jenkins, P. (1999) Understanding the importance of oral health in psychiatric patients. *Advances in Psychiatric Treatment*, **5**, 53–60.

Dr Raj Persaud Consultant Psychiatrist, Westways Rehabilitation Unit, 49 St James's Road, West Croydon, Surrey CR9 2RR

Changes in suicidal ideation and psychomotor retardation during electroconvulsive therapy

Sir: Porter & Ferrier (1999) describe the clinical impression that, during the early stage in treatment of depression, a reduction in psychomotor retardation may lead to patients with depression acting on suicidal thoughts. Consequently, this early stage in treatment is often viewed as the time of highest suicide risk. Slater & Roth (1969) and Himmelhoch (1987) raised similar concerns. However, as Mann & Kapur (1991) observed, no data exist to confirm or refute this.

If this stage of treatment of depression is the time of highest risk, one possible explanation is that the reduction in suicidal ideation lags behind the improvement in psychomotor retardation. We were interested in this issue with particular respect to electroconvulsive therapy (ECT) and prospectively studied changes in suicidal ideation and psychomotor speed in a group of 20 in-patients meeting DSM–IV criteria for major depression who were being treated with ECT. Prior to starting ECT and on the day after each application of ECT, subjects were assessed using the Montgomery–Asberg Depression Rating Scale (MADRS; Montgomery & Asberg, 1979), a modified version of the Suicidal Ideation Scale (SIS; Beck *et al*, 1979) and a test of psychomotor speed derived from a cognitive testing battery by Coughlan & Hollows (1985).

We studied changes in SIS and psychomotor speed scores over the first six applications of ECT in the subgroup of 16 patients who recovered or improved. With the overall changes expressed as percentages, a 92% reduction in suicidal ideation was observed during the first three treatment sessions, with only an 8% reduction over the next three sessions. Psychomotor speed improved 64% over the first three sessions and by 36% over the next three sessions.

Our results are similar to those reported by Rich *et al* (1986), who measured changes in the suicide ideation, decreased energy and decreased work/activities subscores of the Hamilton Rating Scale for Depression in 37 patients receiving ECT. They reported that the mean maximal improvements in suicidal ideation occurred significantly sooner, and after significantly fewer treatments, than the improvements in energy symptoms.

It would be naïve to suggest that suicide risk could simply be equated with the balance between suicidal ideation and psychomotor retardation, as various other factors unique to the individual patient are likely to affect any decision to attempt suicide. However, the hypothesis that improvements in suicidal ideation might lag behind improvements in psychomotor retardation appears to be incorrect – the opposite is the case. If the early stages of ECT treatment are really the time of highest risk, this may simply be due to suicidal ideation being at its highest then. Risk of suicide should be considered throughout the course of ECT while there is any evidence to suspect continuing suicidal ideation. What our study and that of Rich *et al* (1986) demonstrate, however, is that ECT is a remarkably effective treatment for rapidly reducing suicidal ideation in depression.

Beck, A. T., Kovacs, M. & Weissman, A. (1979) Assessment of suicidal intention: The Scale for Suicide Ideation. *Journal of Consulting and Clinical Psychology*, **47**, 343–352.
Coughlan, A. K. & Hollows, S. E. (1985) *The Adult Information Processing Battery*. Leeds: St James's University Hospital.
Himmelhoch, J. M. (1987) Lest treatment abet suicide. *Journal of Clinical Psychiatry*, **48**, 44–54.
Mann, J. J. & Kapur, S. (1991) The emergence of suicidal ideation and behaviour during antidepressant pharmacotherapy. *Archives of General Psychiatry*, **48**, 1027–1033.

https://doi.org/10.1192/apt.5.5.396-c Published online by Cambridge University Press