

PSYCHIATRIC MORBIDITY IN PATIENTS REFERRED TO AN INSOMNIA CLINIC

Dear Sir,

I read with interest the recently published article by Mahendran et al in your prestigious journal.⁽¹⁾ Insomnia may have important consequences for both the individual and society as it could be responsible for road, work or domestic accidents.⁽²⁾ However, I beg to differ with the authors on some points.

Firstly, the rigour of the methodology is an important issue, since it will determine the reliability of the data gathered. The authors admitted the selection bias of their sample by stating in the last paragraph of the discussion that "the referral selectivity to a psychiatric hospital could have sent many of those with medical and/or surgical comorbidity to other settings". Given that insomnia complaint is part of the symptomatology of a mental disorder, and since 52.5% of the sample had Axis I diagnosis and 80.9% of it had Axis II diagnosis, then the authors displayed in their study the psychiatric profile of psychiatric patients with insomnia. Therefore, I wonder if it would be better to add the phrase of "in a psychiatric setting" at the end of the study title. The existing title implied that the insomnia clinic was at a general health setting and might disappoint the reader by giving the feeling that the study added less knowledge than its title had promised.

Secondly, I was confused on reading the conflicting numbers and percentages of Axis I diagnosis in the results section in the second and third paragraphs. The authors stated in the third paragraph that 26 cases had the diagnosis of generalised anxiety disorder whereas in Table I and the second paragraph, it was only 20 cases.

Thirdly, in the last few lines of the methods section, the authors mentioned the tests of significance used to determine the association of primary insomnia with length of sleep problems before referral. Astonishingly, I did not succeed in locating any results of that kind nor did I find the tests of significance values and its p-values for the non-significant association between primary insomnia and personality disorders or medical comorbidity.

Fourthly, the reader could be anxious to know the participants' mean (standard deviation [SD]) age, the median and/or the mean (SD) length of sleep problem, percentage of participants with difficulty initiating or maintaining sleep, those feeling un-refreshed at awakening, transient versus persistent episode, percentage receiving sleep promoting medication before referral to the clinic, and the percentage with an old versus fresh diagnosis of psychiatric disorders. Since previous research proved the association of being separated, divorced or widowed with insomnia⁽²⁾ as well as its association with shift or night work,⁽³⁾ it would be better to (dis)prove this association in the current study.

Fifthly, in the first paragraph of the discussion, the authors alluded that gender and age were not associated with insomnia albeit they did not display that in their results' tables nor text. They also misplaced the reference number of Byerley and Gillin at the end of their sentence. Gender differences in sleep habits,⁽²⁾ sleep efficiency,⁽²⁾ insomnia,⁽²⁾ and mental health⁽⁴⁾ were proven in previous studies. Therefore, it would be better to explain the inconsistency of research findings with previous research in the discussion.

Sixthly, in the fifth paragraph of results, the authors mentioned that "the prevalence of medical and surgical problems was relatively low in this study population". Prevalence could not be estimated from this study design and when medical problems constituted 30.5% of the sample, we could not describe it as "low". Also, the reader might expect the authors to describe the comorbidity between physical and mental disorders and its percentage from the sample with insomnia. Moreover, hypertension, type 2 diabetes mellitus and metabolic syndrome are associated with increased likelihood of obstructive sleep apnoea syndrome (OSA). Astonishingly, the authors did not allude to OSA despite its importance in the assessment of insomnia especially if the treatment of the latter is unsuccessful.

Seventhly, although cluster C personality disorders constituted 95% of Axis II personality disorders, and 76.6% of the whole sample, the authors overlooked explaining that in the discussion and discussed instead the association of borderline personality disorder with sleep complaints.

Finally, the use of up-to-date references reflects the rigour of discussion and the whole paper. More than three-quarters of the references used in the paper were from the 1980s and 1990s, whereas only less than 25% of it belong to the 21st century.

Yours sincerely,

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REFERENCES

1. Mahendran R, Subramaniam M, Chan YH. Psychiatric morbidity in patients referred to an insomnia clinic. *Singapore Med J* 2007; 48:163-5.
2. Ohayon MM, Lemoine P. [Sleep and insomnia markers in the general population] *Encephale* 2004; 30:135-40. French.
3. Ohayon MM, Lemoine P. [A connection between insomnia and psychiatric disorders in the French general population] *Encephale* 2002; 28 (5 Pt 1):420-8. French.
4. Afifi M. Gender differences in mental health. *Singapore Med J* 2007; 48:385-91.