

Under-Diagnosis of Sleep Disorders by Mental Health Professionals

J. Thomas Dalby, Ph.D*

Departments of Psychology and Criminal Justice, Athabasca University, Suite 300, 160 Quarry Park Blvd, Calgary, Alberta, Canada T2C 3G3

***Corresponding Author:** *J. Thomas Dalby, Ph.D, Departments of Psychology and Criminal Justice, Athabasca University, Suite 300, 160 Quarry Park Blvd, Calgary, Alberta, Canada T2C 3G3, Email:thomas.dalby@shaw.ca*

SHORT COMMUNICATION

Sleep plays an important role in general physical and mental health globally and sleep disorders are very common. For example, in Canada a survey found 40% of persons sampled presented with at least 1 symptom of insomnia for a minimum of three nights per week in the previous month.¹ The co-occurrence of insomnia and mental disorders constitutes the most prevalent diagnosis pattern found in sleep disorder clinics.² DSM-5 posed the diagnostic necessity of coding sleep disorders with clear criteria for recording these complaints: “The diagnosis of insomnia is given whether it occurs as an independent condition or is comorbid with another mental disorder (e.g., major depressive disorder), medical condition (e.g., pain), or another sleep disorder (e.g., a breathing-related sleep disorder).” (p. 363)³ This change from DSM-IV was to underscore the need for independent clinical attention to insomnia regardless of concurrent mental issues and was considered by some a revolutionary change. By independently coding both a sleep disorder and mental or physical disorder the fact that they are bidirectionally interactive is highlighted. Insomnia treatments stem from proper diagnosis and these include short-term hypnotic treatment supplemented with behavioral and cognitive therapies.⁴

But do mental health professionals today explicitly diagnose insomnia as indicated by DSM-5 or just assume it under provisions of other conditions that have sleep problems as collateral symptoms? This was investigated by examining the files of 100 adult patients (61 female, 39 male) referred for an independent medical evaluation for litigation or insurance purposes. All patients had diagnoses of primary

mental disorders (PTSD; major depression; somatic symptoms disorder with predominant pain etc) convergently confirmed through our formal psychological testing and interviews. Each patient also received a diagnosis of chronic insomnia disorder using DSM-5 criteria concurrent to their primary condition. All patients had indicated a minimum two-year struggle with insomnia and all had received prior assessments by independent psychiatrists and/or psychologists during the time that they indicated insomnia was a significant issue (142 assessments by 38 professionals were examined).

Embedded in a body of psychological tests, we added the 8-item short form (PROMIS Sleep Disturbance)⁵ with all patients having met at least the cut off for mild insomnia and the mean score for these 100 patients was 36 (corresponding to T-score of 67.5). This was a simple method of quantifying patient’s casual reports of insomnia.

Of the 100 patients, only two had a prior diagnosis of insomnia during the time they were assessed by psychologists and psychiatrists. These two diagnoses were by family physicians not mental health professionals. Many of these patients were receiving pharmacological sleep aids (primarily zopiclone) with no accompanying sleep disorder diagnosis to rationalize the prescription medication.

The clear finding of this uncontrolled observation is that mental health professionals tasked with evaluating patients do not turn their mind to including a formal diagnosis of insomnia or other sleep disorders and assumedly just consider it an adjunct symptom despite clear indications from DSM-5 that this is insufficient.

We do not know if mental health practitioners are even aware of this change in diagnostic direction in 2013. Mental health workers should always consider the appropriateness of including a DSM-5 diagnosis of insomnia after the primary mental disorder has been coded. This will emphasize the need to monitor this vital aspect of the patient's mental health which can have direct impact on their cognitive and emotional functioning.

REFERENCES

- [1] Morin CM, LeBlanc M, Belanger L, Ivers H, Merette C, Savard J.: Prevalence of insomnia and its treatment in Canada. *Canadian Journal of Psychiatry*, 2011, 56, 540-548.
- [2] Ohayon MM, Caulet M, Lemoine P.: Comorbidity of mental and insomnia disorders in the general population. *Comprehensive Psychiatry*, 1998, 39, 185-197.
- [3] American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition. Arlington, VA: American Psychiatric Association, 2013.
- [4] Schutte-Rodin S, Broch L, Buysse D, Dorsey C, Sateia M.: Clinical guidelines for the evaluation and management of chronic insomnia in adults. *Journal of Clinical Sleep Medicine*, 2008, 4, 487-504.
- [5] American Psychiatric Association Level 2 – Sleep Disturbance – Adult. PROMIS Health Organization (PHO) and PROMIS Cooperative Group, 2013.

Citation: J. Thomas Dalby. *Under-Diagnosis of Sleep Disorders by Mental Health Professionals*. *ARC Journal of Psychiatry*. 2019; 4(1):26-27

Copyright: © 2019 Authors. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.