The Link between OSA and Depression: Another Reason for Integrative Sleep Medicine Teams

Commentary on Chen et al. Obstructive sleep apnea and the subsequent risk of depressive disorder: a population-based follow-up study. *J Clin Sleep Med* 2013;9:417-423.

Patricia Haynes, Ph.D., C.B.S.M.

Department of Psychiatry, University of Arizona; Southern Arizona VA Health Care System, Tucson, AZ

The study by Chen and colleagues¹ represents a significant step in documenting a link between obstructive sleep apnea (OSA) and depression. Because the analyses were conducted on a dataset of patients in Taiwan, a place where most OSA patients are left untreated due to lack of insurance, this study is able to offer a unique examination of the impact of newly diagnosed and untreated OSA on depression one year later. Previous research suggests much lower rates of depression in Taiwan than the U.S., potentially due to stigma and other cultural differences in symptom reporting. Depression was measured by psychiatric diagnosis in this report. Therefore, the results showing a temporal link between OSA and MDD may actually be conservative.

Overall, these findings challenge us to question how well our sleep medicine and mental health systems interface in the detection and treatment of depression. Depression is a serious and insidious disorder. In 2002, depression was ranked as the fourth leading cause of disability throughout the world, and it is projected to be the second leading cause in the coming decades.² Depression is associated with increased all-cause mortality, and individuals with depressive disorders have significantly shortened life expectancy (for depressed males 11 years; for depressed females 7 years).³

In addition to OSA, depression is often comorbid with other sleep disorders, such as insomnia⁴ and narcolepsy.^{5,6} As such, sleep physicians are likely to treat a high number of individuals with depression. Unfortunately, depression often remains undetected or undertreated. A systematic review of 36 studies found that non-psychiatric physicians miss the diagnosis of depression in more than half of patients seen.⁷ In my experience, depression has the tendency to fall through the cracks with physicians who are struggling to manage a host of medical and sleep-related concerns in 15-30 minute appointments.

Given these data, I am disheartened by trends in our field leading to separate clinical practice by sleep psychologists and sleep physicians. Referrals between practices can be costly, often requiring excessive clinic staff time for insurance pre-authorization. Depressed patients often lack the motivation to seek care or follow through on referrals. Referrals are not the long-term answer for this population.

We should pay attention to the findings presented by Chen and colleagues, along with results linking depression and other

sleep disorders. Mental health providers are uniquely trained and positioned to assess and treat depression. Successful clinical systems like Kaiser Permanente and Veteran's Health Affairs have increasingly recognized financial and health care benefits of integrative care by including psychologists as integral members of interdisciplinary pain and primary care teams. Mental health collaboration has the added benefits of improving medical outcomes. Mental health providers can administer motivational interviewing and cognitive behavior therapy to facilitate PAP machine adherence, OSA prevention (weight loss, smoking cessation), and CBT for insomnia. We should learn from the top sleep centers in the nation that are successfully incorporating mental health providers as equal members of integrative sleep medicine teams.

Depression and OSA have many similarities. They are both share symptoms like fatigue, loss of concentration, and insomnia. Both may present subtly and are easily ignored by patients for some time. Both disorders can lead to early mortality—whether it occur due to car crash, suicide, or poor health-related behaviors. It is unclear which disorder should be prioritized in treatment. Is it solid clinical practice to prioritize sleep in a depressed patient if the patient is presenting in a sleep center? And conversely, do we prioritize depression, if an untreated OSA patient is presenting to a mental health clinic?

I feel fortunate that in my career working in a significant number of mental health outpatient clinics with depressed, anxious, and impulsive individuals, I have had only one patient successfully commit suicide. I did not see that 28-year-old single mother with depression in a mental health clinic. *I saw her in my sleep clinic.* It's time to start bridging mental health and sleep medicine so that sleep centers are truly interdisciplinary and integrative. An excellent place to start may be a higher level of classification by the American Academy of Sleep Medicine (AASM) for those accredited sleep centers that include the presence of mental health or behavioral sleep medicine providers on staff. The findings by Chen and colleagues provide further support for this recommendation.

CITATION

Haynes P. The link between OSA and depression: another reason for integrative sleep medicine teams. *J Clin Sleep Med* 2013;9(5):425-426.

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SUBMISSION & CORRESPONDENCE INFORMATION

Submitted for publication April, 2013

Accepted for publication April, 2013

Address correspondence to: Patricia Haynes, Ph.D., University of Arizona, Department of Psychiatry, 1501 N. Campbell Avenue, PO Box 245002, Tucson, AZ 85724; Tel: (520) 626-1855; Fax: (520) 626-6050; E-mail: thaynes@email.arizona.edu

DISCLOSURE STATEMENT

Dr. Haynes has indicated no financial conflicts of interest.