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Editorial

Depression in the sleep center: are we treating the whole patient?

The paper by Vandeputte and de Weerd [1] replicates previous findings of an alarmingly high incidence of depressive feelings in patients presenting at the sleep disorders center. This is true not only of patients with insomnia, but also those with periodic limb movement disorder and obstructive sleep apnea. The authors advocate routine use of a depression scale such as the Beck Depression Inventory. This provides an easy method of quantification for clinicians who have been taught to focus on the leg movement index, apnea index and Epworth scale. The inventory may sensitize physicians to psychological co-morbidity prior to diagnosis of the sleep disorder, and should lead to follow-up after the sleep disorder has been diagnosed and treated.

For many years it was assumed that sleep disorders caused depression. The thinking was, "if you were that sleepy, you would be depressed, too." Depression in sleep disorders patients was considered to be 'reactive', with the expectation that it would resolve when the sleep disorder was treated. However, this is not always the case. For example, treatment of sleep apnea with CPAP often leaves patients with residual sleepiness or fatigue, which may be more a function of depression than of sleep disordered breathing [2].

Depression can be treated. Pharmacological and behavioral therapies have proven efficacy. Perhaps the most important element is the time and interest of a health professional. As sleep centers focus on adjustment of CPAP pressures, ferritin levels in restless legs patients and new stimulants for treatment of narcolepsy, expertise in psychology and time to apply it may be lacking. However, the solution to this problem may be close by.

The standards for center accreditation of the American Academy of Sleep Medicine require that each center have experience in the treatment and long-term follow-up of patients with insomnia. A stack of pamphlets on sleep hygiene is not adequate; an established relationship with an experienced provider of insomnia therapy must be documented if none is present at the center. Psychologists can and should be part of the sleep center evaluation.

To this end, the Academy has established a Behavioral Sleep Medicine committee, which has established training guidelines and is preparing to offer its inaugural examination for certification in June of this year. The goal is to train and certify enough clinicians to enable every accredited sleep center to establish a relationship with an expert. As might be expected, the field of behavioral sleep medicine encompasses treatment of insomnia with methods such as biofeedback, cognitive behavioral therapy, stimulus deconditioning and sleep restriction. It includes CPAP mask desensitization and sleep hygiene training. In addition, behavioral sleep medicine clinicians are expected to be familiar with the use of standardized measures of mood, interview techniques and evaluation of the need for intervention.

Why should sleep centers deal with mood disorders? First, given the stigma associated with mood disorders, many patients are unwilling to admit that they are in need of treatment. Many patients are perfectly willing to believe that their fatigue and malaise are due to a purely physical cause, such as sleep apnea, and are willing to come to a sleep center for evaluation. When polysomnograms and multiple sleep latency tests are normal, depression may be the underlying cause of the patient's symptoms. Second, due to managed care restrictions, the sleep center may be as close to professional mental health care as some patients are able to get. Third, as Vandeputte and de Weerd have shown, mood disorders are extremely common in patients who walk through the door of a sleep center.

For years, sleep specialists have bemoaned the lack of insight among primary care physicians in recognizing sleep disorders in their patients. With five questions an experienced sleep expert can justify referral of a patient for a polysomnogram. Vandeputte and de Weerd have shown that with 20 questions any clinician can identify patients in need of evaluation of depression. This leaves us with little excuse. With regard to depression, we should not have the attitude of "we see that sometimes." We see it often, and should have the attitude of "we see it, and we do something about it."

References

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