Sleep duration and quality as mediators of socioeconomic disparities in inflammatory burden

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# Introduction

Sleep deficiency, which includes insufficient and poor quality sleep, represents a growing public health problem in the United States. Nearly 30% of adults in the U.S. report sleeping 6 or fewer hours per night,1 20% report excessive daytime sleepiness, and 20-30% experience insomnia symptoms.2 A growing body of literature links poor sleep duration and quality to a number of health outcomes, including all-cause mortality,3,4 as well as incidence of type 2 diabetes,5,6 hypertension,7 coronary heart disease,8 and stroke9. Specifically, meta-analyses support a “U-shaped” association in which both short and long sleep (generally <6 and >8 hours, respectively) are related to elevated all-cause mortality risk.3,4

An important factor linking sleep and many chronic diseases may be low-grade, systemic inflammation, commonly measured by plasma concentrations of the immune markers interleukin-6 (IL-6), fibrinogen, tumor necrosis factor-a, and c-reactive protein (CRP). The most extensively studied biomarker of inflammation is c-reactive protein (CRP), an acute phase reactant (chemicals accompanying inflammatory pathway activation), for which high sensitivity assays are widely available.10 Based on Mendelian randomization studies, CRP itself is unlikely to be a causal risk factor of metabolic syndrome11 or ischemic vascular disease,12 although limited human experimental evidence suggests it has an etiologic role in atherosclerosis.13 CRP has a complex role in inflammation and its primary function may be anti-inflammatory;14 nonetheless, it is useful biomarker corresponding to general, potentially subclinical risk.

CRP is best characterized in relation to cardiovascular disease (CVD), as it is a strong predictor of cardiovascular events.15-17 Extensive experimental and observational evidence ties inflammatory processes marked by CRP to atherogenesis, the primary pathogenic process underlying coronary heart disease (CHD).18CRP is also a potent risk factor for all-cause mortality,19 and is associated with incidence of metabolic syndrome,16 colorectal cancer,20 and end stage renal disease,21 indicating inflammation may be an underlying pathogenic process shared by many chronic diseases. Short (<6 hours) and poor quality sleep have been shown to affect inflammation in experimental studies22,23 and to be associated with CRP and IL-6 in observational studies.24-26 Sleep restriction induces changes in glucose tolerance, thyrotropin concentration, evening cortisol concentrations, and sympathetic nervous activity, alterations which have implications in inflammation.27

A central challenge in public health is tackling socioeconomic disparities in health outcomes. Graded, inverse associations between socioeconomic status (SES) and a broad array of health outcomes, including CVD, diabetes, hypertension, a number of cancers, and all-cause mortality, have been extensively documented by a long history of research.28,29 More recently, a number of studies have observed socioeconomic disparities in inflammatory burden, with CRP, IL-6, and fibrinogen being consistently elevated in lower SES categories.30-33

Commonly hypothesized pathways for the impact of SES on inflammation are health status, behavioral (smoking, physical activity) and psychosocial (stress etc.) factors,31,34 and sleep may represent an underexplored link in this causal chain. Sleep restriction35 and poor quality sleep36,37 have been found to be more prevalent among individuals of low SES. Low income and low education are associated with adverse social and environmental conditions that impede adequate sleep38 and a growing number of lower-paid jobs involve precarious shift work and non-standard hours.39 Sleep is a modifiable risk factor for which efficacious non-pharmacological interventions exist.40 However, to our knowledge, no study has examined whether sleep mediates the relationship between SES and inflammation. The purpose of this study was to assess the role of duration and quality of sleep as a potential mediator between SES measures such as income and education, and inflammatory burden marked by plasma CRP.

# Methods

## Datasets

We used data from the continuous National Health and Nutritional Examination Survey (NHANES), an ongoing cross-sectional survey of the civilian non-institutionalized population in the United States. Data were collected by the National Center for Health Statistics and the Centers for Disease Control and Prevention (CDC) and involve a questionnaire, physical exam, and laboratory measures. Detailed descriptions of the survey methodology and operations are published elsewhere.41 In brief, approximately 5000 people were recruited each year using a stratified, multistage, probability sample. Individuals agreeing to participate completed a computer-assisted interview conducted by trained personnel, with physical and laboratory examinations conducted at the Mobile Examination Centers (MECs).

We used questionnaire, physical exam, and laboratory data from 3 waves spanning 2005-2010. We selected all respondents aged 20 years and older, who had complete data for CRP and answered questions on sleep duration and quality. We excluded individuals who had CRP concentrations greater than 10 mg/L, which indicate acute infection.17 We also excluded pregnancies, which demonstrate elevated and/or unstable CRP.17

## Measures

### Exposure Variables

In addition to raw family income, NHANES also reports the poverty income ratio (PIR), a ratio of family income to federal poverty level (FPL), which was chosen for this analysis because it takes into account family size and more accurately represents available financial resources. We categorized PIR as poor (below FPL), nearly poor (100-199% FPL), and middle and high income (≥200% FPL), according to the CDC’s Healthy People 2020 guidelines (<https://www.healthypeople.gov/2020/disparities-user-guide>).

In addition to family income, the most commonly used measure of SES, we also used highest educational level achieved, a measure that is more stable throughout the life course and a stronger predictor of inflammation than income.42 NHANES measures education with the question, “What is the highest grade or level of school [you have/spouse has] completed or the highest degree [you have/s/he has] received?”, with the options “Less than 9th Grade”, “9-11th Grade (Includes 12th grade with no diploma)”, “High School Grad/GED or Equivalent”, “Some College or AA degree”, “College Graduate or above”.

### Mediator Variables

Sleep quality was operationalized according to the method used by Bansil et al.:7 participants were characterized as having poor sleep quality if they reported 5 or more episodes in the previous month of one or more of the following events: (i) having trouble falling asleep; (ii) waking up during the night and having trouble getting back to sleep; (iii) waking up too early in the morning and being unable to get back to sleep; (iv) feeling unrested during the day, no matter how many hours of sleep he/she had; or (v) feeling excessively or overly sleepy during the day. Sleep duration was characterized according to the question, “How much sleep [do you/does SP] usually get at night on weekdays or workdays?”, and categorized as <6, 6, 7, 8, or >8, with the reference level set to 7 hours to capture any “U-shaped” association, similarly to other population-based studies.25

### Outcome Variables

C-reactive protein is measured from blood collected during the physical exam and processed, stored, and shipped to a Johns Hopkins University laboratory. Plasma CRP concentrations are quantified by high sensitivity assay using latex-enhanced nephelometry, with a lower limit of detection of 0.1 mg/L.41 We categorized CRP into two clinically relevant categories: <3 and ≥3mg/L, representing normal and elevated inflammation, respectively.17

### Confounding Variables

We considered a number of potential confounders of the relationship between sleep and CRP, based on being a potential common cause (or proxy to a common cause) of both sleep and CRP. Analyses were adjusted for age (in 5-year categories), sex (male or female), race/ethnicity (non-Hispanic White, non-Hispanic Black, Mexican American, Other Hispanic, and Other Race including Multi-Racial), physical activity (number of times per week exercising enough to sweat or breathe hard), smoking in the past 30 days, serum cotinine cutoff at 3 ng/mL[[1]](#footnote-1), obesity (body mass index (BMI) >= 30 kg/m2, measured in the physical exam), psychosocial stress (number of days in the past 30 when mental health was not good), use of birth control pills or hormone replacement therapy, and use of sleep medications often or almost always (5 or more times per month).

We separately considered potential confounders of the relationship between SES and CRP, which included only age. Although previous studies of this relationship have adjusted for serious chronic conditions,31,32 we chose to consider this variable a potential collider and not adjust for it. Final models were adjusted for all variables considered confounders of the SES → CRP and/or sleep → CRP relationships.

## Data Analysis

We summarized all variables in total as well as stratified by sleep duration and sleep quality. All variables are presented as unweighted n, as well as weighted percent for categorical variables, and weighted mean ± sd for continuous variables that are approximately normally distributed, or median [interquartile range (IQR)] for non-normally distributed variables. Crude associations were tested using chi-square tests for categorical variables and t-tests or ANOVA for continuous variables.

### Assessment of Mediation

We sought to assess whether sleep duration and quality were intermediate variables in the causal pathway between SES and inflammation. Therefore, data analysis focused on assessment of total indirect effect (TIE),43 or the proportion of inflammation that would be prevented if SES did not cause poor sleep.43 We used the product-of-coefficients method that allows for interaction between the exposure and the mediator, detailed by VanderWheel (2016). We determined that potential mediation existed if (a) the exposure was associated with the outcome, (b) the exposure was associated with the mediator, and (c) the mediator was associated with the outcome. If these conditions were met, we then fit two survey-weighted linear regression models: (1) we regressed the mediator on the exposure and all potential confounders, and (2) we regressed the outcome on the exposure, mediator, exposure-mediator product, and all potential confounders. We estimated the TIE by the formula (β1θ2 + β1θ3), where β1 is the exposure term in (1), θ2 is the mediator term in (2), and θ3 is the exposure-mediator product in (2). Ninety-five percent confidence intervals for indirect effects were calculated via bootstrap with 1000 replications.44 Two-sided statistical significance was determined for all tests at α<0.05. All analyses were conducted in SAS v. 9.4 and adjusted for the complex survey design.

# Results

Key characteristics of sample participants are displayed in table 1. The median (range) age in years was 45.4 (20—85). The sample was just over half male (51.2%) and 70% Non-Hispanic White, 11.3% Non-Hispanic Black, 8.1% Mexican American, 4.4% other Hispanic, and 6.1% other race including multi-racial.

The median (IQR) plasma CRP for the entire sample was 0.17 (0.06--0.41). Approximately half the sample reported sleeping less than 6 hours per night, and 13.8% reported poor quality sleep represented by 5 or more sleep disturbances in the past month. In SES measures, 19% of the sample reported income 0-100% and 100-199% of the federal poverty level, and 26.3% had a college degree, 30.2% had completed some college or an associate’s degree, 24.5% had a high school diploma, GED, or equivalent, 12.5% had completed 9-11th grade, and 6.6% had less than 9th grade education.

Table 2 provides one-way ANOVA comparisons in mean CRP by each covariate entered into final models. Higher CRP was related to lower education, lower income, poor sleep, short sleep (<6 hours), not being physically active, female gender, Non-Hispanic Black or Mexican American race/ethnicity, older age, currently being on hormonal birth control, tobacco exposure reflected by serum cotinine 3 or more ng/mL, currently using hormone replacement therapy, and using a sleep medication (p < 0.0001 for all comparisons).

Table 3 provides estimates of the crude and adjusted total effects, estimated with least squares linear regression. In unadjusted models estimating total effects, the arithmetic mean ratio (AMR) for 100-199% FPL was 1.21 (95% CI, 1.12—1.30), 1.21 (95% CI, 1.14—1.24) for 0-100% FPL, 1.17 (95% CI, 1.07-1.27) for some college or AA degree, 1.11 (95% CI, 1.03—1.19) for high school diploma or GED, 1.18 (95% CI, 1.07—1.29) for 9-11th grade, and 1.17 (95% CI, 1.07—1.27) for 9th grade. After adjusting the total effect models for age, gender, race/ethnicity, physical activity, birth control use, HRT use, sleep mediation use, plasma cotinine, and obesity, the AMR for 100-199% FPL was 1.11 (95% CI, 1.05—1.18), 1.17 (95% CI, 1.10—1.24) for 0-100% FPL, 1.2 (95% CI. 1.1—1.31) for some college or AA degree, 1.24 (95% CI, 1.16—1.32) for high school diploma or GED, 1.27 (95% CI, 1.17—1.39) for 9-11th grade, and 1.2 (95% CI, 1.1—1.31) for 9th grade.

Total indirect effect (TIE) estimates are also presented in table 3, adjusted for age, gender, race/ethnicity, physical activity, birth control use, HRT use, sleep mediation use, plasma cotinine, and obesity. The AMR for the TIE via poor sleep was 0.99 (95% CI, 0.99-1) for 100-199% FPL, 0.99 (95% CI, 0.98-1) for 0-100% FPL, and 0.99 (95% CI, 0.98-1) for all TIEs of education via poor sleep. The AMR for the TIE via short sleep was 1.0 (95% CI, 1—1.01) for 100-199% FPL, and 1.01 (95% CI, 1-1.01) for 0-100% FPL. TIEs were not estimated for education via short sleep as education was not associated with short sleep in the adjusted model.

# Discussion

Similarly to other studies, our study found that both lower income and lower education are associated cross-sectionally with higher c-reactive protein, indicating higher inflammatory burden in lower SES groups. Additionally, we found that poor quality sleep and short duration of sleep are associated with higher CRP, reflecting experimental evidence showing that sleep disturbance and restriction lead to increased systemic inflammation.

This study adds to the literature by being the first, to our knowledge, to formally test whether socioeconomic disparities in CRP-marked inflammatory burden are mediated by sleep duration or quality by generating indirect effect estimates. We were not, however, able to demonstrate that any portion of the effects of either education or income on plasma CRP are mediated by poor sleep quality or short sleep.

Our findings are potentially attributable to a number of factors. First, it is possible that the connection between SES and CRP is entirely mediated by other causal pathways, such as BMI and physical activity as identified by previous literature.

Another limitation of our study is the use of subjective sleep measurements. Self-reported sleep duration and quality are limited by poor recall, leading many recent studies in this area to utilize objective measurements such as polysomnography (considered the ‘gold standard’) and actigraphy (Kushida 2001). Objective and subjective sleep measures have been shown to have a relatively weak correlation (r=0.28 to 0.68) (Rowe 2008), and are suggested to be used in combination for best accuracy as they measure different aspects of sleep (Zhang 2007). A recent simulation study showed that non-differential misclassification of a mediator biases the indirect effect towards the null much more powerfully than misclassification of the exposure (Blakey 2013). Therefore, the null results of our study are unable to rule out true mediation and may be the result of misclassification. Future studies examining mediation of SES health disparities by sleep parameters should include objective measurements to avoid bias towards the null.

Our study has a number of limitations. First, it is cross-sectional, and therefore unable to assess temporal order. For instance, it is possible that the effect of early life SES on inflammation is mediated through sleep, but not current SES. This also makes it impossible to rule out reverse causality; i.e. that sleep problems cause socioeconomic difficulties, or that inflammation causes health problems which negatively impact SES.

Secondly, by nature of being an observational study, it is plausible that unmeasured confounding could have affected the results.

# References

1. Ram S, Seirawan H, Kumar SK, Clark GT. Prevalence and impact of sleep disorders and sleep habits in the United States. *Sleep and Breathing.* 2010;14(1):63-70.

2. Roth T. Insomnia: definition, prevalence, etiology, and consequences. *Journal of clinical sleep medicine: JCSM: official publication of the American Academy of Sleep Medicine.* 2007;3(5 Suppl):S7.

3. Gallicchio L, Kalesan B. Sleep duration and mortality: a systematic review and meta‐analysis. *Journal of sleep research.* 2009;18(2):148-158.

4. Cappuccio FP, D'Elia L, Strazzullo P, Miller MA. Sleep duration and all-cause mortality: a systematic review and meta-analysis of prospective studies. *Sleep.* 2010;33(5):585.

5. Cappuccio FP, D'elia L, Strazzullo P, Miller MA. Quantity and quality of sleep and incidence of type 2 diabetes. *Diabetes care.* 2010;33(2):414-420.

6. Ayas NT, White DP, Al-Delaimy WK, et al. A prospective study of self-reported sleep duration and incident diabetes in women. *Diabetes care.* 2003;26(2):380-384.

7. Bansil P, Kuklina EV, Merritt RK, Yoon PW. Associations between sleep disorders, sleep duration, quality of sleep, and hypertension: results from the National Health and Nutrition Examination Survey, 2005 to 2008. *The Journal of Clinical Hypertension.* 2011;13(10):739-743.

8. Ayas NT, White DP, Manson JE, et al. A prospective study of sleep duration and coronary heart disease in women. *Archives of internal medicine.* 2003;163(2):205-209.

9. Yaggi HK, Concato J, Kernan WN, Lichtman JH, Brass LM, Mohsenin V. Obstructive sleep apnea as a risk factor for stroke and death. *New England Journal of Medicine.* 2005;353(19):2034-2041.

10. Roberts WL, Moulton L, Law TC, et al. Evaluation of nine automated high-sensitivity C-reactive protein methods: implications for clinical and epidemiological applications. Part 2. *Clinical chemistry.* 2001;47(3):418-425.

11. Timpson NJ, Lawlor DA, Harbord RM, et al. C-reactive protein and its role in metabolic syndrome: mendelian randomisation study. *The Lancet.* 2005;366(9501):1954-1959.

12. Zacho J, Tybjærg-Hansen A, Jensen JS, Grande P, Sillesen H, Nordestgaard BG. Genetically elevated C-reactive protein and ischemic vascular disease. *New England Journal of Medicine.* 2008;359(18):1897-1908.

13. Bisoendial RJ, Kastelein JJ, Levels JH, et al. Activation of inflammation and coagulation after infusion of C-reactive protein in humans. *Circulation Research.* 2005;96(7):714-716.

14. Marnell L, Mold C, Du Clos TW. C-reactive protein: ligands, receptors and role in inflammation. *Clinical immunology.* 2005;117(2):104-111.

15. Ridker PM, Buring JE, Shih J, Matias M, Hennekens CH. Prospective study of C-reactive protein and the risk of future cardiovascular events among apparently healthy women. *Circulation.* 1998;98(8):731-733.

16. Ridker PM, Buring JE, Cook NR, Rifai N. C-reactive protein, the metabolic syndrome, and risk of incident cardiovascular events. *Circulation.* 2003;107(3):391-397.

17. Ridker PM. Clinical application of C-reactive protein for cardiovascular disease detection and prevention. *Circulation.* 2003;107(3):363-369.

18. Libby P, Okamoto Y, Rocha VZ, Folco E. Inflammation in atherosclerosis. *Circulation Journal.* 2010;74(2):213-220.

19. Marsik C, Kazemi-Shirazi L, Schickbauer T, et al. C-reactive protein and all-cause mortality in a large hospital-based cohort. *Clinical chemistry.* 2008;54(2):343-349.

20. Erlinger TP, Platz EA, Rifai N, Helzlsouer KJ. C-reactive protein and the risk of incident colorectal cancer. *Jama.* 2004;291(5):585-590.

21. Arici M, Walls J. End-stage renal disease, atherosclerosis, and cardiovascular mortality: is C-reactive protein the missing link? *Kidney international.* 2001;59(2):407-414.

22. Meier-Ewert HK, Ridker PM, Rifai N, et al. Effect of sleep loss on C-reactive protein, an inflammatory marker of cardiovascular risk. *Journal of the American College of Cardiology.* 2004;43(4):678-683.

23. Vgontzas AN, Zoumakis E, Bixler EO, et al. Adverse effects of modest sleep restriction on sleepiness, performance, and inflammatory cytokines. *The journal of Clinical Endocrinology & Metabolism.* 2004;89(5):2119-2126.

24. Prather AA, Epel ES, Cohen BE, Neylan TC, Whooley MA. Gender differences in the prospective associations of self-reported sleep quality with biomarkers of systemic inflammation and coagulation: Findings from the Heart and Soul Study. *Journal of psychiatric research.* 2013;47(9):1228-1235.

25. Hall MH, Smagula SF, Boudreau RM, et al. Association between sleep duration and mortality is mediated by markers of inflammation and health in older adults: the health, aging and body composition study. *Sleep.* 2015;38(2):189.

26. Jackowska M, Kumari M, Steptoe A. Sleep and biomarkers in the English Longitudinal Study of Ageing: associations with C-reactive protein, fibrinogen, dehydroepiandrosterone sulfate and hemoglobin. *Psychoneuroendocrinology.* 2013;38(9):1484-1493.

27. Spiegel K, Leproult R, Van Cauter E. Impact of sleep debt on metabolic and endocrine function. *The lancet.* 1999;354(9188):1435-1439.

28. Adler NE, Boyce T, Chesney MA, et al. Socioeconomic status and health: the challenge of the gradient. *American psychologist.* 1994;49(1):15.

29. Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for U.S. adults: national health interview survey, 2012. *Vital and health statistics Series 10, Data from the National Health Survey.* 2014(260):1-161.

30. Phillips JE, Marsland AL, Flory JD, Muldoon MF, Cohen S, Manuck SB. Parental education is related to C-reactive protein among female middle aged community volunteers. *Brain, behavior, and immunity.* 2009;23(5):677-683.

31. Kershaw KN, Mezuk B, Abdou CM, Rafferty JA, Jackson JS. Socioeconomic position, health behaviors, and C-reactive protein: a moderated-mediation analysis. *Health Psychology.* 2010;29(3):307.

32. Matthews KA, Chang Y, Bromberger JT, et al. Childhood Socioeconomic Circumstances, Inflammation, and Hemostasis Among Midlife Women: Study of Women's Health Across the Nation. *Psychosomatic medicine.* 2016;78(3):311-318.

33. Stepanikova I, Bateman LB, Oates GR. Systemic inflammation in midlife: race, socioeconomic status, and perceived discrimination. *American Journal of Preventive Medicine.* 2017;52(1):S63-S76.

34. Gruenewald TL, Cohen S, Matthews KA, Tracy R, Seeman TE. Association of socioeconomic status with inflammation markers in black and white men and women in the Coronary Artery Risk Development in Young Adults (CARDIA) study. *Social science & medicine.* 2009;69(3):451-459.

35. Piccolo RS, Yang M, Bliwise DL, Yaggi HK, Araujo AB. Racial and socioeconomic disparities in sleep and chronic disease: results of a longitudinal investigation. *Ethnicity & disease.* 2013;23(4):499.

36. Patel NP, Grandner MA, Xie D, Branas CC, Gooneratne N. " Sleep disparity" in the population: poor sleep quality is strongly associated with poverty and ethnicity. *BMC Public Health.* 2010;10(1):475.

37. Mezick EJ, Matthews KA, Hall M, et al. Influence of race and socioeconomic status on sleep: Pittsburgh Sleep SCORE project. *Psychosomatic medicine.* 2008;70(4):410.

38. Grandner MA, Patel NP, Gehrman PR, et al. Who gets the best sleep? Ethnic and socioeconomic factors related to sleep complaints. *Sleep medicine.* 2010;11(5):470-478.

39. Alterman T, Luckhaupt SE, Dahlhamer JM, Ward BW, Calvert GM. Prevalence rates of work organization characteristics among workers in the US: data from the 2010 National Health Interview Survey. *American journal of industrial medicine.* 2013;56(6):647-659.

40. Montgomery P, Dennis J. A systematic review of non-pharmacological therapies for sleep problems in later life. *Sleep medicine reviews.* 2004;8(1):47-62.

41. Zipf G, Chiappa M, Porter K, Ostchega Y, Lewis B, Dostal J. National health and nutrition examination survey: plan and operations, 1999-2010. *Vital and health statistics Ser 1, Programs and collection procedures.* 2013(56):1-37.

42. Dinwiddie GY, Zambrana RE, Doamekpor LA, Lopez L. The Impact of Educational Attainment on Observed Race/Ethnic Disparities in Inflammatory Risk in the 2001–2008 National Health and Nutrition Examination Survey. *Int J Environ Res Public Health.* 2015;13:0042.

43. Hafeman DM, Schwartz S. Opening the Black Box: a motivation for the assessment of mediation. *International Journal of Epidemiology.* 2009:dyn372.

44. Localio AR, Margolis DJ, Berlin JA. Relative risks and confidence intervals were easily computed indirectly from multivariable logistic regression. *Journal of clinical epidemiology.* 2007;60(9):874-882.

1. Benowitz NL, Bernert JT, Caraballo RS, et al. (2009). Optimal serum cotinine levels for distinguishing cigarette smokers and nonsmokers within different racial/ethnic groups in the United States between 1999 and 2004. Am J Epidemiol 169:236–48. [↑](#footnote-ref-1)