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Depression and professional activity

Editorial

D. Moussaoui

P1

Depression and work

M.F. Hirigoyen

P2

Economics of depression: from costs to quality of life

T.A. Okasha

P4

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E d i t o r i a l

The verb to depress comes from the Latin verb “deprimere”, meaning “to press down”. In depression, a person’s mood goes down, which in turn lowers his or her morale. In vulnerable people, traumatic life events lower mood and generate depression. Family, social and professional life becomes more difficult, setting up a vicious circle, which pushes the patient ever deeper into depression. Not only is the patient’s mental life affected, but life as a whole.

On the other hand, and in the globalised world in which we live, work increasingly occupies centre stage. The industrial environment of the marketplace and services promotes competition between companies, but also between employees within a given company. Ever greater productivity demands drive some companies to increase pressure on their employees, by means of incentives, but also reprimands that may end in job loss. When under sustained and increasing stress in such professional environment, people with fragile personalities may break down, as manifested in depressive disorders. They become demotivated, and burn-out syndrome follows. This reality is now so widespread that the occupational medicine services of some large companies are beginning to pay more attention to this type of disorder.

In a corporate setting, executives and managers may misuse their hierarchical power against weaker collaborators, building a pathological relation called moral harassment, or mobbing. M.F. Hirigoyen’s article highlights the frequency of such situations and the serious consequences for the employee’s well-being and productivity. Stress, burn-out syndrome, mobbing, even suicide, are not exceptional in the workplace, and cost the victim dearly, and also damage the productivity and finances of the company that creates such an environment.

T. Okasha considers the cost of depression, which can be counted in hundreds of billions of U.S. dollars every year worldwide. Yet these direct costs of drug treatment, psychotherapy, and hospitalisation account for just a small part of the overall cost, whose main economic component is loss of productivity, and hence loss of earnings for the company and for the whole country. Indirect costs include job losses due to depression, and when the victim is no longer young, it becomes difficult, or even impossible, to find work again. The depressed and their families are not alone in incurring financial losses: the company loses expertise and years of experience, as too does the whole country. Indirect costs also include the cost of death by suicide. The World Health Organisation reports that, worldwide, there is one death by suicide every second, compared with one death per minute due to AIDS. The fight against AIDS has a very high media profile, but the battle against suicide and its main risk factor, depression, is virtually ignored by the media.

Health economics tell us that iodine deficiency, for example, can cost up to 1% of the gross domestic product (GDP) of a developing country, because of the intellectual impairment hypothyroidism causes in children. This state of affairs could easily be remedied by adding iodine to the cooking salt sold in shops. Health economics also inform us that iron deficiency may cost up to 1% of a country’s GDP, because of the resulting anaemia and its impact on professional and social activities. This deficiency can be corrected by adding iron to foodstuffs, notably flour. Similarly, depression is extremely costly for countries around the world. One way to reduce its impact would be to set up, in all medium-sized and large companies, health departments whose remit would be to identify and treat depression. This would not only greatly benefit sufferers, but also the company, and the country as a whole. Unfortunately, corporate occupational medicine services pay scant attention to mental health management, which is by and large still in its infancy.

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Depression and work

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There is no doubt that the complete change in work organization, which focuses on competitiveness and economic efficiency, has led to new types of suffering and new pathologies of a mental and emotional order, and that as a result of stress and mobbing, mental health problems at work have become the main reason behind the increase in professional absenteeism.

■ Stress at work

In 2000, nearly one-third of all European workers (41 million) said they were affected by stress. It is the second largest health problem at work after musculoskeletal disorders. Current developments in work organization have completely changed working conditions at every hierarchical level. Working hours may have improved, but pressure relating to changes in production rates, urgent work carried out under direct pressure from customers, and greater emphasis on autonomy, initiative, and responsibility can lead employees to doubt their capacities and believe themselves incapable of meeting the demands that are made on them.

Professional stress arises when work-related demands or requirements exceed the employee's resources. However, there is no direct link¹ between the work load, that is, the employer's demands, and stress-related diseases. It is known that the risk of mental or physical illness, particularly depression, is much higher in employees who are subjected to a high level of pressure, but who, in other respects, have little autonomy and little possibility of expressing themselves or

reacting. The risk is much higher if those concerned are not supported by their professional environment.

Faced with overstimulation, the human body first tries to adapt in order to respond to the situation. Initially, it is the body which reacts: muscular tension, digestive problems, lumbago, migraines, and fatigue. The first psychological symptoms are fidgetiness, irritability, anxiety, and sleep disorders. If the situation persists, these are followed by loss of motivation, anorexia, apragmatism, and severe anxiety, gradually leading to major depression.

The next stage is burnout, which occurs when a person is completely worn out by work. It corresponds to the appearance of a state of disillusionment and frustration in relation to professional demands in a person who has put a lot of time and energy into the job. The person then loses all interest in work and colleagues and becomes more and more irritable, even aggressive and cynical, until total depression eventually sets in.

■ Mobbing

While stress only becomes destructive when it is excessive, mobbing is destructive by nature.² Numerous studies show the prevalence of emotional collapse as a response to mobbing.³ Unlike other types of violence in the workplace, mobbing is an insidious, long-term process. In the beginning, the victim does not understand what is happening and takes a long time to react. Whether the aggression comes from superiors or colleagues, it consists of small, repeated attacks, often without witnesses,

sometimes not verbal, often ambiguous, because they can be interpreted in different ways. Such attacks consist of unjustified criticism, humiliating remarks, and faultfinding. In the face of these underhand attacks, the victims of harassment try in vain to adapt and to prove their innocence, and end up exhausted and in a state of emotional collapse.

When mobbing is detected early on, and the victims have been able to talk about it in time, or still have the possibility of retaliating or finding a solution, the symptoms are fairly similar to those of stress. Anxiety increases with its multitude of somatic symptoms: digestive problems, chest pains, a feeling of constriction in the throat, anorexia, nausea, headaches, muscular pain, and so on.

But if the situation persists, victims gradually find themselves psychologically disabled. Their thought processes are disturbed and they can think of nothing else. At this stage, in addition to their symptoms of anxiety, depression starts to set in. The victims become dejected and lose interest in life; they have short-term memory loss, decreased concentration, and a feeling of powerlessness and worthlessness that they hide from their doctor, because they feel guilty about not meeting the expectations of their superiors, and from their family, because they are afraid of being thought weak.

Before depression sets in, it is the actual process of mobbing in the workplace which causes people to have feelings of worthlessness, self-doubt, and guilt, because they are made to believe that they are responsible for what is happening to them. Harassers begin by isolating

their future victims, criticizing their work without reason, belittling them, discrediting them in the eyes of their superiors, attacking their reputation, and preventing them from doing their job properly. Their job is used as a pretext to undermine victims in their private lives, making them feel ashamed and humiliated, and lose their dignity. Harassers subtly hone in on victims' vulnerability, so well that the harassment often seems to be an echo of issues outside the workplace, reviving past anxiety, which may have been forgotten, and lowering psychological defenses. None of the strategies set up by victims are effective; no one believes or understands them, so that they gradually withdraw and isolate themselves further.

So, at what moment can major depression as defined in DSM IV be diagnosed and antidepressants prescribed? The diagnosis will be based on the extent of the person's sleep disorders, anxiety, guilt, and morbidity, as well as the time of day at which the disorders occur, mainly in the morning. However, it is obvious that a therapeutic response will

not be fully effective if it is only based on medication. The person needs to be separated from the harasser by being given sick leave, and then put in touch with an organization that can provide legal and practical help. It is therefore advisable to contact the company doctor in order to examine the possibilities of a change of job or even of acquiring disability status. But first, people must be helped to recover their critical capacities so that they stand up for themselves.

■ **Suicide**

An employee who is the victim of mobbing will often have damaged self-esteem, believing that the situation is hopeless and job prospects grim; death wishes are frequent and can become suicidal.⁴ Suicides correlated with mobbing are probably underestimated, because the only suicides or attempted suicides that are recorded are those that occur in the workplace and therefore qualify legally as occupational, or those for which the person has left a written document clearly indicating the responsibility

of the employer, or of a harasser in the workplace.⁵ As mentioned earlier, victims of mobbing experience guilt and shame, and do not always voluntarily talk about their suffering in the workplace.

The dimension of impulsivity and anxiety that often precedes suicide, and which is particularly present in mobbing, should not be ignored. The perverse procedures employed in this sort of aggression tend to paralyze the victim and lead to self-destruction. Also, in a context in which the victim is reified, suicide can be a victim's message to the harasser, as well as an attempt to transfer the victim's feelings of guilt to the aggressor.

■ **Conclusion**

It is important to emphasize the enormously destructive nature of this type of situation. Unfortunately, although the repercussions of professional dysfunction on a patient's health can be treated, a physician is powerless to combat the internal dynamics of companies that permit this type of situation.

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Economics of Depression: from costs to quality of life

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Introduction

Mental illness constitutes a major health burden, both socially and economically. Recent economic policies, within the context of globalization, threaten the achievements of the past decades. Physicians, policy makers and others, who are active in health care systems around the world, continue to struggle to maintain a balance between the need to contain costs and the efforts to maintain or improve access to services and the quality of provided care.

There are many sophisticated methods for economic evaluation of services and cost of an illness, but to simplify it, we can divide costs into three major parts:

- first is the direct cost of the illness which includes hospitalization, medication and health care professional fees;
- second is the indirect costs which include days lost at work, unemployment, familial and social consequences of the disease, suicid;
- and lastly, the intangible cost which is the emotional suffering of the patient which is very difficult to assess financially.

The economic burden of depression is substantial and rivals that of serious physical illnesses. In the global distribution of health burden in 1999, the percentage of disability adjusted for life years (DALYs) lost due to mental health problems was 12%, compared to maternal and perinatal problems 9.5%, respiratory problems 9%, cancer 5.8%. By

the year 2015, it is expected that mental health problems will reach 15%.

If we breakdown the disability from mental health problems, we will find that depressive disorders constitute 17.3%, compared to Alzheimer dementia 12.7%, alcohol dependence 12.1%, psychosis 6.8%. By 2015, depressive disorders are expected to reach 20% in disability with-in psychiatric disorders.

The World Health Organization (WHO) estimated that by 2020, depression is predicted to be second only to heart disease as a cause of worldwide disability in both males and females; however, it is the first cause of disability in women and the fifth in men if we divide it by gender.

Economics of Depression

The WHO stated in its "Atlas" report published in 2001, that one in every four people will suffer from a mental or a neurological disorder during their lifetime. Currently there are about 459 million people suffering from these disorders. There are approximately 121 million people suffering from depression, 24 million suffering from schizophrenia and 50 million suffering from epilepsy.

Currently, 43% of countries around the world have no mental health policy, 23% have no legislation on mental health, 38% have no community care facilities and in 41% of countries, treatment of severe mental disorders is unavailable in primary health care.

About 71% of people around the world have access to less than one psychiatrist

per 100,000 population, and 46% have access to less than one nurse per 100,000 population.

If we look at health expenditure, 33% of countries allocate less than 1% of their total health budgets to mental health and another 33% spend just 1% of their budgets on mental health. Unfortunately, nearly 25% of countries do not have the 3 most commonly prescribed drugs to treat schizophrenia, epilepsy and depression at the primary health care level.

Major depression is one of the most prevalent psychiatric conditions with an annual basis of 10.3%, with a life time prevalence rate of 17.1%. Depression is 8 times more frequent than schizophrenia and 16 times more frequent than Parkinsonism.

The condition also has a relatively young age of onset (early adulthood) as compared to other debilitating physical conditions.

The main presenting symptoms of depression in general practice are:

- 1) physical which account for nearly 60-70% of patients (fatigue, multiple somatic complaints including headache, stomach ache and vague poorly localized pain, and loss of appetite);
- 2) psychological (anxiety, nervousness, and reduced concentration); and
- 3) behavioral (social withdrawal and isolation). Neglecting the treatment of fatigue, low energy, and painful physical symptoms in depressed

patients can lead to unsatisfactory outcomes, characterized by a failure of depressed patients to return to normal personal and occupational functioning.

Sixty to seventy per cent of patients with depression are not seen by psychiatrists but by the general practitioners due to the presentation of depression with physical symptoms, and only 15% of patients with depression suffer from severe depression presenting with delusions, hallucinations and suicidal attempts which come to the attention of the psychiatrist.

Depression is also prevalent in many medical disorders and the non-psychiatrist should be able to recognize, diagnose and treat depression, in order to avoid unnecessary hospitalization, laboratory investigations and interventions. In a study looking at the prevalence of depression in different patient populations, it was found that 6% of the general population had depression, 9% in chronically ill patients, 33% in hospitalized patients, 36% in geriatric patients, 33% in cancer outpatients, 42% in cancer inpatients, 47% in stroke patients, 45% in patients with myocardial infarction and 40% in patients with Parkinson's disease. It is easy to imagine the economic burden for these patients that had to undergo unnecessary investigations and consultations, before being properly diagnosed.

On the other hand, untreated depression is a significant risk factor for the development of coronary disease and stroke. After an episode of major depression, the risk of myocardial infarction increases 4 to 5 fold compared to the general population. Even sub-syndromal forms of depression have a 2 fold increased risk of myocardial infarction. It is believed that stress and depression by the activation of the sympathetic system lead to:

- 1) reduced vagal tone which is protective for the heart;
- 2) impairment of endothelial function, endothelial injury leading to thrombosis;

- 3) increased platelet aggregation and adhesion;
- 4) haemoconcentration leading to increased blood viscosity, and chronicity;
- 5) activation of the cortisol system.

All these factors, as is well known, are precipitating factors for heart disease and stroke. The mortality rate from heart disease after a myocardial infarction is 17% in patients with depression compared to 3% in patients not suffering from depression. Similarly, 12 months after cardiac bypass patients with depression had a higher incidence of subsequent cardiac events such as angina, heart failure, myocardial infarction and repeated surgery.

Women with current or past history of depression had a decreased bone mineral density at each trabecular bone site studied of 10%; this increased the risk of hip fracture rates by more than 40% over a ten year period, probably due to the increase in cortisol levels with chronic depression. This same reason was suggested as a contributing factor for the higher incidence of Alzheimer disease in women with a past history of untreated depression.

The main obstacles to the recognition of depression is the stigma of the diagnosis, the presentation of depression with physical symptoms, other co-morbid medical illness, time constraints of the physicians and the demand to see more patients in a limited time giving only a few minutes to a single patient, and tacit collusion where both the physician and the patient know that there is a diagnosis of depression, but they would rather not bring the subject up.

Therefore, early treatment of depression has favorable economic consequences and allows the person to lead a healthier life. Over time, these symptoms impact both the patient's medical treatment patterns and work place activity. In 1993 the economic burden of depression in the USA was estimated between 43.7 and 52.9 billions USD in direct and indirect costs, based on all costs of depression

treatment, lost earnings due to suicide and workplace absenteeism.

More than 50% of their costs were found to be borne by employees in the form of lost workplace productivity. In 1998 this figure reached 65 billion USD.

In England, depression was estimated to cost over £9,000 million in 2000, of which only £370 million were direct costs. The largest cost element was productivity losses: Over one year there were 109.7 million working days lost and 2615 deaths due to depression.

Another study looking at the cost of hospitalization found that it was 15% in developed countries, 35% in South East Asia, and more than 50% in Africa and the Middle East.

In Egypt, a study was conducted on absenteeism of factory workers with physical complaints; 60% of these workers were suffering from depression and were under-recognized, under-diagnosed and under-treated.

A study in Pakistan, working on the out of pocket expenditure for depression among patients attending private community psychiatric clinics, found that the cost of treatment kept the vast majority of the population away from on going treatment which contributes to the misery of the illness and the associated loss of productivity.

Another reason for paying more attention to economic issues is the apparently growing cost of treatment. Some of the newer modes of treatment for depression are marketed at higher prices than the older treatments they could potentially replace. This has raised questions as to whether the newer treatments are cost-effective.

Untreated depression produces a significant burden on;

- 1) medical resources,
- 2) work absenteeism,

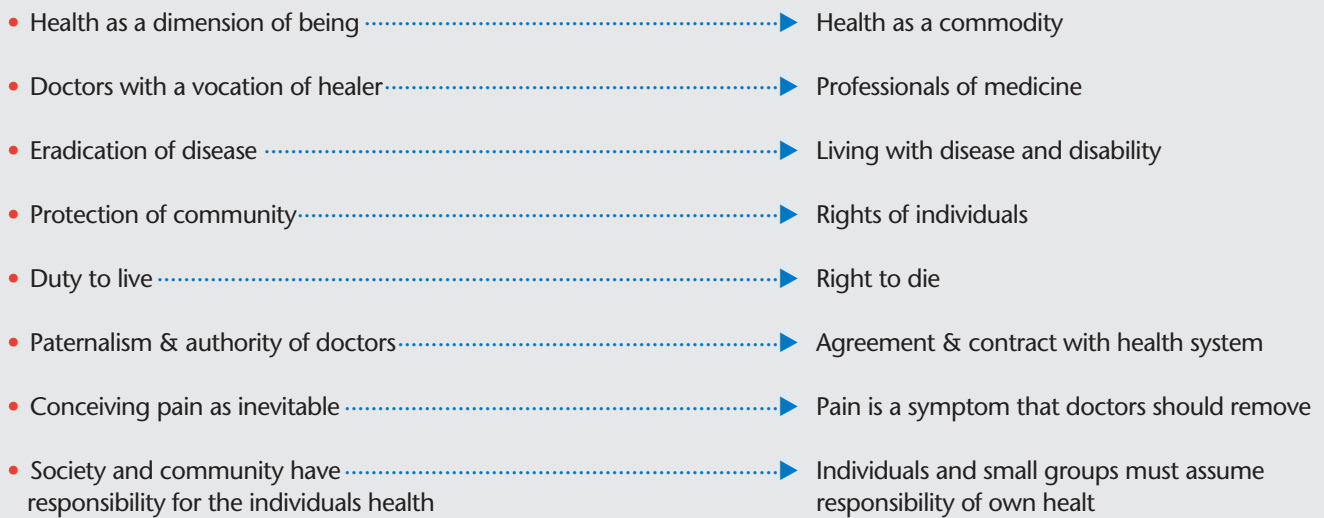


Figure 1. Trends in health care (After Sartorius, 1999).

- 3) early retirement,
- 4) premature mortality,
- 5) co-morbid medical conditions and
- 6) quality of life.

Only a small number of mental health economics studies from developing countries have been conducted. They were mainly cost of illness and cost effectiveness studies. Psychiatric disorders impose a significant burden in developing countries, and it is not always possible to extrapolate findings from developed countries to developing countries.

Depressive disorders satisfy all the criteria necessary to consider the condition as being a major public health problem: they are frequent, they cause significant suffering and incapacity, effective and acceptable treatment interventions are available which are accepted by both the patients, their families and society, and finally their prevalence is likely to rise over the coming years.

Early intervention with the proper treatment is essential whether it is with antidepressant medication, psychotherapy or in cases of severe and psychotic depression electro-convulsive therapy (ECT).

Among the priorities that should be taken into consideration, is the conveyance of knowledge about depression to everyone concerned including patients, their family, primary care workers, psychiatrists, and decision makers, in order, among others, to decrease the stigma of the disease.

Impact on Performance and Quality of Life

Depression is the most painful of medical disorders. It is often chronic, recurrent, and may be responsible for suicidal attempts. Fifteen per cent of patients with depression commit suicide, 30 % attempt suicide and up to 50% of patients have suicidal ideations.

The WHO estimates that there are nearly one million suicides every year, more than wars, natural disasters and any other causes of death. Seventy per cent of these suicides are due to depression, which can be prevented if diagnosed and treated early.

Depression causes lack of interest, loss of volition and inability to concentrate at work properly. As an example, any physician suffering from cancer, heart disease, diabetics can work in his outpatient clinic, but if he or she suffers from depression

alone, or as a co-morbid condition with one of these disorders, he/she will not be able to work.

In a study in the USA looking at the impact of depression on the academic productivity of university students, they found a very high correlation between depression and deterioration of academic performance.

Currently, psychiatrists are trying to go beyond the symptomatic recovery or the improvement of symptoms to functional recovery or improving the quality of life of a patient. In most of the studies in developed and developing countries, functional recovery often lags behind syndromal or symptomatic recovery. In most studies over a period of 5-10 years, the syndromal recovery reached 85%, but the functional recovery was not more than 30-35%. However, the actual concept of quality of life is not yet defined in a uniform way, as it lacks clarity and may even create confusion. In psychiatry, and particularly in depression, quality of life has to be taken into consideration for the patient, the family and the society. But what is quality of life? In medicine, the term is a concept for all those human needs which are often neglected in a health care field, increasingly dominated by technology, finances and insurance. It

is usually characterized by the patient's own subjective feeling of well being. There is evidence that both acute and chronic depressions are associated with social dysfunction. Depression seems to impair the ability to interact appropriately with the social environment, in terms both of the fulfillment of more formal roles and interacting with the immediate environment. Depressed persons, therefore, undermine positive feedback from others, which in turn prevents them from acting properly; the rejection of depressed persons by others is a consistent finding. It is argued in treatment

of depression that pharmacotherapy leads to the feeling of well being, while psychotherapy leads to the feeling of satisfaction which are both integral in treatment and improving the quality of life of depressed persons.

Measuring the quality of life and making its improvement prominent in all health work is an essential corrective to a number of trends in modern health care (*Figure 1*). Each of these trends has the potential of dehumanizing medical care and more importantly mental health care.

■ Conclusion

Depression has a destructive effect on affected individuals, causing them to suffer physically, mentally and socially.

The patient and the families also suffer and experience economic losses; both employers and employees can be affected directly by depression and repercussions usually affect society as a whole, with consequent loss to the national

Further Readings

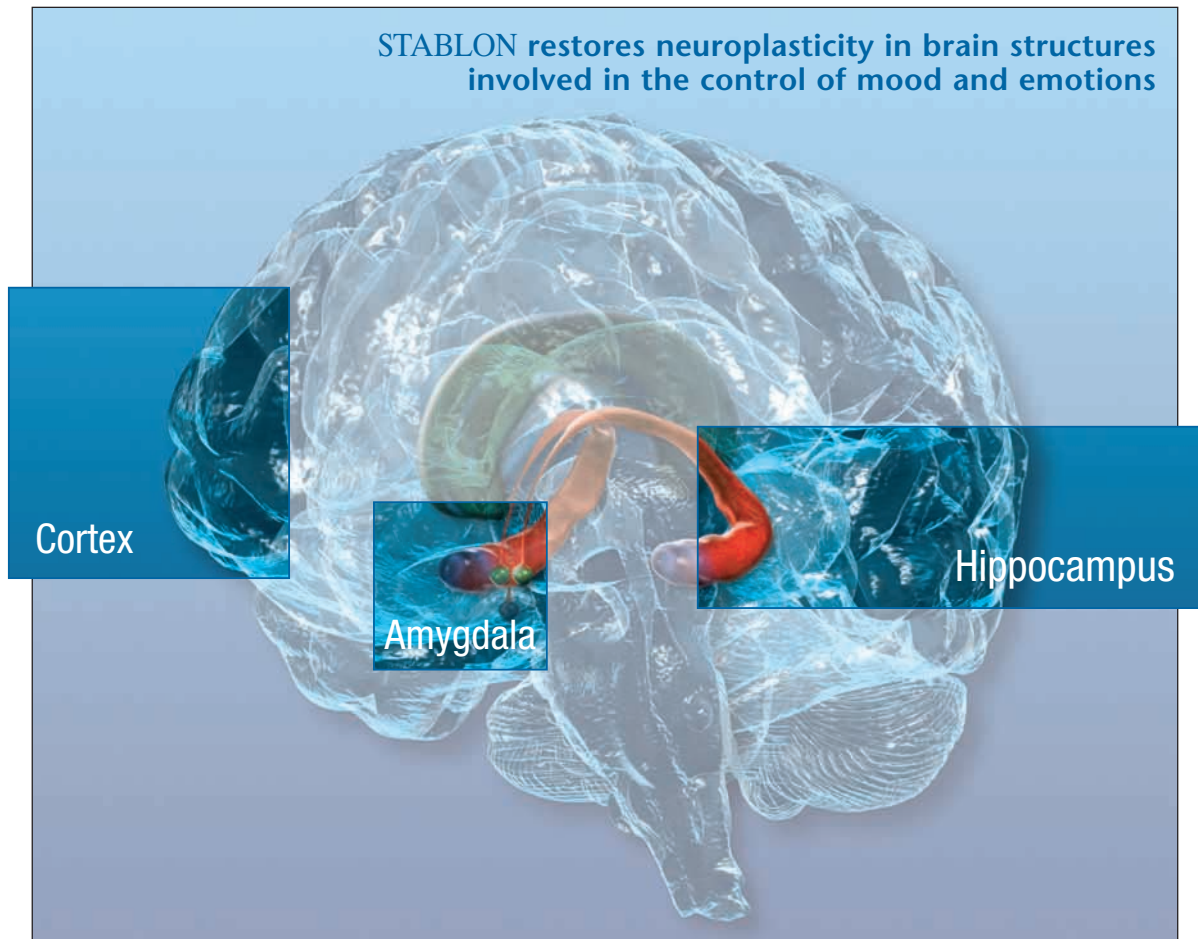
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