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International Perspectives on Depression in the Workplace

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Depression is a common global mental health condition. Depression is an “illness that involves the body, mood, and thoughts” (National Institute of Mental Health, 2007a). Depressive disorders consist of a number of related conditions as described later within this paper. In the United States, it is estimated that approximately one out of every two American families will have a family member suffering from depression at some point in the developmental life cycle (Goldberg & Steury, 2001; National Institute of Mental Health, 2007a). Approximately 5 to 10% of the United States population suffers from depression at any given time. As many as 20% of U.S. adults will experience depressive symptoms with a lifetime incidence of depression estimated at 20 to 55% of American adults (McClanahan & Antonuccio, 2004). It is thought that the approximately 30,000 suicides per year are likely associated with depression (Greenberg, Stiglin, Finkelstein, & Berndt, 1993).

Just as in the United States, depression is a common mental health problem from an international perspective. The World Health Organization reports that depression is the fourth leading cause of disease burden in the world and is expected to be the second leading cause of disease burden by 2020 (McClanahan, & Antonuccio, 2004; Williams & Strasser, 1999). In a survey involving fourteen countries in Africa, Asia, Europe, Latin America, and the Middle East, the World Health Organization’s Collaborative Study of

Data reported for selected nations highlight depression as a global health issue. In research cited by Wang and Patten (2001) and Myotto (2009), 5% of Canadian adults experience depression and 10 to 11% will experience depression at some point during their life cycle. Australia recognizes depression as a major public health challenge for developed countries and initiated a national depression recognition and treatment initiative referred to as Beyondblue (Hickie, 2004). This initiative as part of Australia’s National Mental Health strategy includes community, workplace, and health practitioner education and information strategies aimed at depression recognition, prevention and early intervention. McDaid, Curran, and Knapp (2005) describe depression as a major health problem in European Union nations. Nakao and Takeuchi (2006) cite evidence that depression rates in Japan have increased dramatically. Accordingly, worldwide epidemiological estimates for depression appear to be similar to those reported in the United States (Andrade et al., 2003; Kessler, Merikangas, & Wang, 2008; Ormel, VonKorff, Ustum, Pini, Korten, & Oldehinkel, 1994).

**Overview of Depression as a Mental Health Condition**

Depression has been conceptualized as involving emotional states that can range from distress to despondency to melancholy. In this conceptualization, depression can be viewed as a normal feeling state and a common experience that affects an individual’s physical, emotional, and cognitive functioning. Depression is also influenced by cultural, age, and gender factors. Depression can also be viewed as a symptom of another disorder. As a specific illness or disorder, the *Diagnostic and Statistical Manual of Mental Disorders IV-TR* (American Psychiatric Association, 2000) is widely recognized as the classification system that defines depression. The *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM; American Medical Association, 2008) and the *International Classification of Diseases – Tenth Revision* (ICD-10; World Health Organization, 2007) provide a disease classification system that allows for additional comparability of disease classification and morbidity/mortality statistics at an international level. These latter two classification systems differ slightly from the *Diagnostic and Statistical Manual of Mental Disorders IV-TR* with respect to classification of depressive disorders.

The *Diagnostic and Statistical Manual IV-TR* (American Psychiatric Association, 2000) classifies depressive disorders according to symptoms and duration. Within this framework, there are five principal depressive disorders: major depressive disorder, dysthymic disorder, adjustment disorder with depressed mood, adjustment disorder with mixed anxiety and depressed mood, and depressive disorder not otherwise specified. A provisional diagnostic category of minor depressive disorder as described by Morris and Hardesty (2002) is included within the *Diagnostic and Statistical Manual IV-TR*. The above references provide detailed descriptions of these depressive conditions.

Research suggests that depressive symptoms are mediated by gender and cultural considerations. Manifestation of symptoms and associated behavioral components,
likelihood to participate in treatment, and relationship to other mental health conditions are different for men and women as well as within different cultures. American Psychological Association OnLine (2006), Cox, Ness, and Carlson (2008b), Mental Health America (2007), and National Institute of Mental Health (2006, 2007a) describe gender associated characteristics of depression. Cultural dimensions of depression are described by Inaba et al. (2005), Kawakami et al. (2005), Murray and Lopez (1997), Simon, Goldberg, VonKorff, and Ustun (2002), and Vasiliadis, Lesage, Adair, Wang, and Kessler (2007).

**Depression as a Major Workplace Problem**

As depression is commonly found in the general population, this condition overlaps with functioning within the workplace. Both internationally and in the United States, depression has important economic impacts relative to lost productivity within the workplace (Myette, 2008). Lost productivity involves presenteeism, in which the employee is present in the work setting but productivity is reduced due to health concerns or depressive symptoms, or in terms of absenteeism from work (Bender, 2009). In the United States, depression affects approximately 10 to 17.5 million employees (Johnson & Indvik, 1997a; Shoor, 1994). Estimates of annual costs to U.S. businesses as a result of depressive symptomatology range from 70 billion to 83.1 billion U.S. dollars (Byrne, Kacmar, Stoner, & Hochwarter, 2005; Greenberg et al., 2003; National Mental Health Association Fact Sheet, 2006; Wang, Simon, & Kessler, 2008). It is estimated that business and industry lost 12 billion dollars from lost productivity, 12 billion dollars from absenteeism, 26.1 billion dollars from direct treatment costs, and 5.4 billion dollars from mortality (Greenberg et al., 2003; Lerner et al., 2004). Birnbaum, Cremieux, Greenberg, and Kessler (2000) report that depressed workers’ disability costs were 4.5 times greater than those for typical nondepressed employees.

In the European Union, it is thought that one-third of the workforce experiences a mental health disorder in which depression is a significant factor (McDaid et al., 2005). Early retirement, reduced opportunities for career development, reduced lifetime productivity, lost taxation revenue, hiring and training costs, reduced economic growth, higher social security payments, as well as absenteeism and presenteeism are elements of productivity losses consequential to depression and other mental health disorders within those nations comprising this geographical region (McDaid et al., 2005). These authors provide estimates of the significant economic burden of depression in terms of lost productivity for the various European Union countries. Annual lost productivity estimates range from 1.44 billion Euro in the Netherlands to 15.46 billion Euro in the United Kingdom.

Lost productivity estimates due to depression are also reported for other world regions. In Canada, it is estimated that workplace costs due to poor mental health and attendant loss of productivity amounted to 1.5 billion Canadian dollars (Baba, Galperin, & Lituchy, 1999). Wang (2009) indicates that depressive symptoms in Chinese workers significantly impaired their work life quality. In a study involving nurses in several Caribbean nations, Baba et al. (1999) found depression to be a significant mental health issue within this occupational group with absenteeism, and turnover intention being significant problems associated with depressive symptoms for this sample.
Depression in the workplace presents multiple work behavior performance and behavioral deficits (Lerner et al., 2004; National Institute of Mental Health, 2007b; Wallace, 2006; Wang et al., 2008). These include (a) inconsistent or reduced productivity, (b) absenteeism, tardiness, or frequent absence from the employee’s work site, (c) increased errors, reduced work quality, (d) procrastination, failure to attain deadlines, (e) withdrawal from interaction, cooperation, or conflicts with co-workers, (f) over sensitivity, over-reactive emotions, (g) decreased interest in work or work tasks, (h) slowed behavior or thought processes, (i) difficulty learning or remembering tasks associated with the work setting, (j) fatigue and impaired energy level, and (k) impaired attention, and (l) long term diminished educational and professional attainment.

Depressive symptoms may develop over time rather than presenting acute, full-blown manifestations of symptomatology. Wang et al. (2008), in reviewing cross-sectional and longitudinal studies, report that changes in the severity of depressive symptoms also result in changes in work impairment severity. The employee may initially experience anxiety and mild depressive episodes ranging from several weeks to several months. Ultimately these symptoms develop into more severe depressive symptomatology. Unfortunately, depression presents during the employee’s most productive years, namely ages 24 through 44 years of age (Byrne et al., 2005, Wang et al., 2008). Physical health problems may also be associated with the depressive condition (National Institute of Mental Health, 2007a).

Stressors and workplace conditions also contribute to depressive symptoms. Interpersonal conflicts, work demands, organizational politics, lack of faith in organizational management or leadership, and perceived control over job tasks and job environment are factors related to depressive reactions (Byrne et al., 2005; Melchior et al., 2007). These stressors combine into multiple work stressors that further compound their impact upon the employee’s mental health functioning.

Treating Depression in the Workplace

Counselors and other mental health providers can serve viable roles in assisting depressed employees. These roles include a consultative and collaborative role with employers, and a direct service role. Each of these intervention modes is described within this section.

Collaborative Interventions

Counselors can provide consultative, collaborative, and educational interventions within the workplace to address employee depression. Employer education regarding depression and manifestation of symptoms among employees can be provided. The mental health professional can provide psychoeducational services to educate supervisors, employee assistance workers, and occupational health personnel regarding depression and its symptoms as a mental health problem in the workplace (Johnson & Indvik, 1997a, 1997b). The Australian program (Hickie, 2004) is a good example of workplace and community outreach initiatives to reduce the burden of depression.

The counselor can assist employers in identifying and implementing interventions to mediate negative work-related stressors, social and psychological factors, and physical aspects of the work setting that may contribute to depression such as those described by
Couser (2008), Johnson and Indvik (1997a, 1997b) and Truax and McDonald (2002). Examples include unclear job expectations and descriptions, short work deadlines, routine, monotonous job responsibilities with few opportunities for creativity, limited social and psychological support from the work setting, or workplace depersonalization through technology, racism, sexism, and ageism factors. Counselors and employers can work together in a dual, collaborative stance to “depression proof” the work setting and promote a “healthy workplace”. Byrne et al. (2005), Caruso (2008), Johnson and Indvik (1997a), Frew (2004), and Podratz and Tetrick (2004) describe modifications to workplace characteristics and employer practices that can be implemented to reduce workplace influences that may contribute to employee depression. Couser (2008) summarizes primary, secondary, and tertiary prevention risk reduction processes to reduce depression onset and associated risk factors as well as promote positive mental health within the workplace. These workplace remediation practices could also serve to enhance employee protective factors through stress, conflict, and time management interventions as well as training managers and supervisors in identifying and reducing workplace stressors.

Counselors can assist employers in enhancing employee trust of the organization. Byrne et al. (2005) describes the role of perceived organizational support among employees as a mechanism for assisting employers in supporting employees and building trust within the organization. Supervisors can be selected and trained to be viewed by employees as exemplifying the organization’s character.

From an international perspective, the World Health Organization has prepared guidelines for developing policies and strategies to improve the health of working individuals to include policies and strategies for dealing with depression in the work environment (Bender, 2009; World Health Organization, 2005a). Relative to the European Union, the World Health Organization developed a detailed action plan, which specifically called for strategies to “create healthy workplaces” (McDaid et al., 2005: World Health Organization, 2005b). Counselors and other mental health professionals, both in the United States and internationally, can collaborate and advocate with employers and policy makers in developing such a work environment.

Counselors can assist in implementing or expanding an employee assistance program (EAP) to include programming to effectively deal with employee depression and other mental health conditions. McClure (2004) details considerations and strategies for implementing employee assistance programs within the work setting. Johnson and Indvik (1997a, 1997b), Rost, Smith, and Dickinson (2004), Turner (1995), and Wang et al. (2007) describe programs and policies that can be implemented to treat employee depression. Counselors can assist employers in identifying, developing, and implementing EAP programming, referral mechanisms, employee outreach, and policy considerations.

Consultation to assist employers to implement company or industry wide employee self-help programs for depression can be provided by the counselor. Physical exercise, leisure and social activity development, time management, task approach, problem solving, communication, and coping skill development programs are examples of strategies that employers can implement within the work setting (Flynn, 1995; National Institute of Mental Health, 2007b). Counselors and other mental health providers can serve an important role in developing and implementing these programs.
The counselor can identify and assist the employer or human resources professionals in instituting various workplace accommodations to assist the depressed employee in adjusting to the workplace environment. Job analysis processes may be necessary to evaluate essential job functions and the work environment to identify appropriate accommodations. Prien, Goodstein, Goodstein, and Gamble (2009) describe job analysis procedures useful for the workplace setting. Podratz and Tetrick (2004) describe the job accommodation process and potential job accommodations that could be incorporated within the work setting.

**Direct Service Interventions**

Counselors and other mental health providers can provide services directly to the depressed employee within the employment setting. The counselor can provide employee education regarding depression, the course of depressive symptoms, the impact of depression upon one’s functioning, and treatment options. Several researchers (Johnson & Indvik, 1997a, 1997b; National Institute of Mental Health, 2007b; National Mental Health Association Fact Sheet, 2006; Stewart, Ward, & Purvis, 2004) suggest that such education should focus upon assisting employees to self identify depressive symptoms.

The mental health professional can develop services or refer depressed employees to employee assistance professionals (EAP) or other mental health practitioners to identify and treat personal or family related crises that may produce stress and depressive symptoms. Franche et al. (2006) describes the impact and possible interventions in remediating the so-called spillover from employee personal and family demands on workplace depression. The National Institute of Mental Health (2007a, 2007b) and Wallace (2006) describes protective factors within employees’ personal and social milieu that can be utilized to treat depressed individuals. Counselors can institute or refer employees for treatment through short term, empirically based treatments for depression. Caruso (2008) and Couser (2008) provide evidence that brief oriented cognitive-behavioral and solution focused treatment processes is particularly efficacious in treating employee depression. Berndt, et al. (1998) cites evidence that reduction in the severity of depressive symptoms through various treatment modalities improves work performance.

Counselors and mental health practitioners can assist employers in implementing assessments measuring depression as an aspect of the work environment. Counselors can also work with other treatment specialists in establishing measures to evaluate the efficacy of treatment. The concept of broadband and narrow band assessment measures (Corcoran, 2004) has importance in assessing depression. Broadband instruments are global measurements that are designed to capture the broad spectra of psychopathology, behavioral, or emotional characteristics, but may not be sensitive to symptom changes that may occur due to treatment or environmental modifications. Narrow band assessment measures, on the other hand, are specific measurement devices assessing a single construct and focusing upon a confined number of conditions or symptoms. Both broadband and narrow band assessment measures can assess symptom severity and also serve as instruments to provide outcome information relative to interventions that may be instituted within the workplace to remediate employee depression. Resources to assist in the identification and evaluation of various assessment measures that may have utility in measurement of depression and evaluation of depression treatment outcomes are described in Cox (2007) and Cox, Ness, and Carlson (2008a, 2009).
Outcome Measurement Findings for Treating Depressed Employees

Employers may be reluctant to expend financial and personnel resources to treat workplace depression. There are several studies that report positive outcomes for treating depressed employees and present a cost effective rationale for providing such interventions. In a randomized clinical trial study, Wang et al. (2007) report positive workplace outcomes in treating 604 employees in a U.S. employment setting through a systematic program to identify and promote treatment for depression. This program included telephone outreach, case management processes, outpatient mental health services, and psychopharmacological treatments. A similar program sponsored by the National Institute of Mental Health entitled the Harvard Work Outcomes Research and Cost Effectiveness study has found significant increases in positive work outcomes using the before mentioned interventions along with the use of client psychoeducational workbooks (Wang et al., 2008).

In a U.S. national sample of 198 workers, Lo Sasso, Rost, and Beck (2006) found workplace benefits stemming from enhanced depression treatment provided by primary care medical providers. Wang et al. (2008) summarize other outcome studies that present positive evidence to support the treatment of employee depression as a cost effective intervention within the business and industrial sector. However, even considering evidence that depression treatments can be effective and have beneficial implications for workplace productivity, Wang et al. (2003) cite evidence that only 17% of workers receive depression management and treatment that meets minimal standards of adequacy. Greenberg et al. (2003) indicate that for every two depressed employees receiving treatment, an additional three employees remain untreated.

Conclusion

This paper has cited evidence that depression is a condition that negatively impacts global work environments. Appropriate treatment for depression can have positive benefits in reducing the negative symptoms associated with depression and improving productivity within the work setting. Several studies indicate that such treatment is a cost effective strategy that positively impacts employee productivity. The counselor or related mental health provider can serve an educative, collaborative, or direct service role in working with employees, employers, and policy development specialists in promoting what the World Health Organization describes as good mental health exemplified by “not merely the absence of depression, but a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (Couser, 2008, p. 423).

References


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