PSYCHIATRIA ET NEUROLOGIA JAPONICA

Special Feature Article

Understanding Depression in Workplace and Collaboration between Psychiatrists and Occupational Physicians

Takahiro SHINKAI, MD, PhD
Department of Psychiatry, University of Occupational and Environmental Health
Psychiatria et Neurologia Japonica 123: 75-80, 2021

Abstract

Depression in workplace has become an important issue with prolonged recession, employment diversification, a declining birthrate, and an aging population. The suicide rate in Japan remains relatively high, and the number of patients with mood disorders is increasing along with the sales of antidepressants. The aging and shrinking population may be behind the burden of working generation. Clinical practice around depression in workplace is complicated as depression has a variety of types depending on balance between "bio-psycho-social" factors. In particular, non-endogenous depression is more common in younger generation, mild in general, and difficult to identify compared with endogenous depression. Its symptoms are affected by the environmental factors such as overload or problems of human relationships in the workplace, and thus disappear during out of duty or in the leisure time. It is pre-morbid with case's personality that is immature, self-centered, and that tend to blame others. Finally, it may recover rapidly due to environmental changes, which is uncommon in endogenous depression. Non-endogenous depression is difficult to understand and treat with in the workplace. It is puzzling for occupational physicians to deal with, since it may raise a conflict between cases and the company. This article tries to explore a better solution for attending physicians and occupational physicians to deal with the complicated depression problems in the workplace with the keywords of "bio-psycho-social" approach.

Keywords: depression, workplace, non-endogenous, bio-psycho-social factors, occupational physician

Introduction

In recent years, mental health problems have been observed in Japan in various settings, including workplaces, schools, and homes, due to a sense of national stagnation caused by the prolonged recession. The number of suicides in Japan exceeded 30,000 for 14 consecutive years since 1998, then has declined since 2010, reaching less than 22,000 in 2016. However, the suicide rate due to work-related problems is higher than in the past (Figure 1)[3].

According to the Ministry of Health, Labor and Welfare (MHLW) Japan, the number of patients with mood disorders, including depression, increased 2.4-fold (reaching up to a million cases yearly) in 2008 from the previous 12 years[2], as the sales of antidepressants have increased five-fold (up to 100 billion yen). The situation may continue in the future along with a more severe declining birthrate and aging population.

Depression and other mental illnesses often occur in the working-age population, resulting in extreme social costs. The cause of depression is substantially unknown, and the symptoms and treatment of depression for both outpatient and inpatient are often prolonged. In addition to medical costs (direct costs), lost time from work (indirect costs) is also incurred, and a MHLW, Japan survey estimates that the indirect costs for depression is 14 times more costly than the direct costs for depression, suggesting that depression would make an impact in terms of social costs (Table 1)[1].

I. The rights and wrongs of Manipulative Diagnosis of Depression

Up to 90% of patients who present with depression first visit a non-psychiatric clinics or hospitals[4]. Most patients present with physical problems and visit medical departments such as internal medicine. Therefore, non-psychiatrists often take a place in the primary care for the treatment of depression. According to the Diagnostic and statistical manual of mental disorders 5 by the American Psychiatric Association (DSM5), depression is defined as five or more of the following nine symptoms (including at least one of (1) and (2)) that persist for at least two weeks and interfere with one's daily activities such as work or school activities. The symptoms are as follows: (1) depressed mood, (2) loss of interest or pleasure, (3) decreased appetite and weight loss, (4) insomnia, (5) agitation, (6) fatigue, (7) sense of worthlessness,

(8) difficulty thinking and concentrating, and (9) suicide ideation. In other words, the number of symptoms, severity, and duration are the only factors defined to make an diagnosis. On the other hand, environmental factors and personality tendencies, that have traditionally been taken into account, are omitted from the diagnostic procesure .

While the DSM's operational diagnostic criteria is of clear-cut and easy to understand for everyone, it also has limitations. Depression is a condition that should be understood in the context of a life story. It includes not only biological factors but also psychological and social factors, which should be understood as a whole. The former DSM-IV proposed the concept of a multiaxial diagnostic system (consisting of five items: (1) primary illness, (2) personality and intelligence, (3) physical illness, (4) psychological and social stress, and (5) social adjustment level). (Not adopted in DSM-5.)

However, it is difficult to objectively standardize the assessment of psychological and social factors. It is challenging to categorize stressors in one's life and their degree of severity. They are difficult to standardize and evaluate because they are influenced by various circumstances including one's life history, personality, nurturing environment, familial economic status, school or workplace-related factors and so on (almost impossible to name everything). Obiously, to establish an international standard criteria with these various factors is challenging because of the differences in the social and cultural background among countries or regions.

Because the objectivity and reproducibility is required in research and statistics to enable international comparisons, diagnostic criteria should be made according to the symptomatology of the present illness. This may lead to exclude the causative psychological and social background (usually not applicable to standardized) from the diagnostic basis. Although it may make the diagnostic criteria world standerd, it also losts sence of narratives, that is essential to understand psychiatric conditions comprehensively.

II. Comprehensive understanding of depression in the workplace

Depression is caused by the complex interaction of biological factors (functional impairments of the brain), psychological factors (personality, one's values or cognition), and social (environmental) factors (e.g., work environment, human relationship or stress). These three factors should take into account to make a diagnosis, so that the diagnosis and treatment of

depression in workplace would became more realistic and productive for both employees and the company. Analysing the proportions of these three factors in cases with depression may lead to a better understanding and efficient treatment strategies (Figure 2). For depressibe cases having a biological factor as a major part of the three (bio-psycho-social) factors, giving them a rest and medication (i.e., antidepressants such as SSRIs or SNRIs) would be a main theraputic strategy. For cases with a psychological factor as a major part of the three factors, psychotherapy (i.e., cognitive behavioral therapy: CBT) would be a main strategy, making them have a chance to change their way of thinking or perception, which may lead to a better coping with their stress from human relationship in the workplace. For those with social (environmental) factor as a major, Environmental adjustment (e.g., work restrictions such as reducing woking hours or overloads).

III. Correspondence to Depression Based on the Three Factors: Biological, Psychological, and Social

For many cases with psychological factors (personality or cognitive tendencies) as a dominant constituent factors of depression, the standard treatment of depression (having a rest and taking an antidepressant) could not be successful. As Tarumi (2005) pointed out in his paper as “disthymia-type depression” (non-academically called “new-type depression” or “modern-type depression”), younger generation tends to manifest “psychological moratorium” (avoiding to become independent psychologically as a member of the society) in the workplace. The main focus of treatment for such cases is the way their way to think or perceive things or matters. CBT provides the patient opportunities to review their cognition and lead to release from their psychological negative pattern by themselves. Counselors is thus metaphorically called "a psychological mirror of the patient". It is also necessary for patients to follow the minimum workplace rules and encourage their selfesteem as a company member.

Endogenous (i.e., melancholic) depression would be largely caused by biological factors. The primary theraputic strategy for such cases would be having a rest and taking antidepressants. When the treatment response is no good for lon tme, the constituent balance evaluation between the three elements of depression should be looked again.

Tarumi (2005) summarize the two different types of depression from various aspects (Table 2)[5].

Mood disorders include manic

depressive illness (bipolar disorder) besides depression. In bipolar II disorder, manic state remains maild (hypomania), and more than 90% of the disease period is occupied by depressive state whereas hypomanic state appears only in a short time. Clinically, bipolar II disorder is often hard to distinguish from unipolar depression, maiking it difficult to treat with in both theraputic setttings and workplace.

Usually, patients with depressive state (with no history of mania or hypomania) is treated with antidepressants as having depression (not bipolar disorders). Some of them may develop manic episodes later on (antidepressant-induced mania), considered having bipolar II disorder rather than unipolar depression. The diagnostic change and perscription change to mood stabilizers may happen only after observed hypomanic episode(s) during antidepressant treatment. In such case, switching from antidepressants to mood stabilizers (and/or some antipsychotics) is needed. Suitable choice of drug may help patients to return to work sooner.

IV. An Old and New Problem: The Difficulty of Comprehensive Understanding of Depression in Workplace

In workplace, the boss and colleagues face difficulties to deal or to treat with those with "non-endogenous" depression (e.g., dysthymic type of depression). There are no biological markers, and it is difficult to distinguish what type of depression, even for specialists in psychiatry. Often it takes time to make a differential diagnosis. The "non-endogenous" component has a variety of factors, including adjustment disorder-like components, developmental disorder-like components, and personality components.

If a worker depressed with evident "non-endogenous" component, the workplace may struggle with how to deal with the case. In other words, the debate arises whether the workplace should deal with the case as a medical matter or as personnel affairs. Actually a similar problem would happen for the attending physician (psychiatrist) as it is difficult to distinguish between endogenous and nonendogenous factors. The attending physician (psychiatrist) wouldn't (chouldn't) give a definitive diagnosis becase there is no biological markers. As a result, labor relations may have a delicate relationship, and the company side has difficulty to deal with.

V. How Long the "Protective Policy" Continues?

In large companies or government offices in Japan, employees are

generally well protected in terms of employment. When depression cases occur in the workplace, reducing the workload or reffering to mental health services including mental clinics should be taken place primarily. If the depression recovers with these arrangements, the worker could return to the normal job. In refractory depression cases to such normal therapeutic strategy with prolonged sick leave, better start to take cases' "non-endogenous" factors into account. The normal "protective" strategy (the rest and drug treatment) may not be the essential solution. Sometimes it may be necessary to make them confront their own psychological issues (personality or way of cognition) at some point, switching from the "protective" strategy. This may include telling the worker that there is a limitation in treating with a medical model, and at some point it would be deal with as a matter of human resources. Although, there is no evidence for us to know when is the appropriate timing of switching the theraputic policy.

In any case, the collaboration between the attending physician (psychiatrist) and the occupational physician may be important particularly in such "non-endogenous" cases of depression. Discussing the background factor of depression, including the case's personality or way of cognition, may lead to a better understanding and finding a point of compromise in terms of conditions for returning to work..

Conclusion

After all, depression in the workplace is somewhat challenging to deal with, especially in atypical "non-endogenous" cases. It should not be too protective for the cases. Although, it could not easily determine that the problem comes fully from the case's personnel issues, since it is relatively common for depression cases to have a mixed factors in behind. Until the balance of background factors is revealed, it can not be helped to take a "wait-and-see policy". However this policy must be ended at some point, at least before the expiration of sick leave period of the belonging company.

The attending physician (psychiatrist) and occutional physician should cooperate for better understanding and solution for the recovery from depression and help workers back to work with better resilient coping capacity.

*The author declares no conflicts of interest associated with this article.

References

1) Keio University: Comprehensive Promotion 2010 Subsidy in Welfare for Persons with Disabilities by Ministry of Health, Labor and Welfare, Japan, "Estimation of Social Costs of Mental Illness" Project Performance Report, 2011. (https://www.mhlw.go.jp/bunya/shougaihoken/cyousajigyou/dl/seikabutsu30-2.pdf)

2) Ministry of Health, Labor and Welfare, Japan: Patient survey overview, 2008. (https://www.mhlw.go.jp/toukei/saikin/hw/kanja/08/index.html)

3) Ministry of Health, Labor and Welfare, Japan: 2007 White Paper on measures to prevent *Karoshi* (Death from overwork) (www.mhlw.go.jp/wp/hakusyo/karoushi/17/index.html)

4) Osamu M. The Clinical Feature of Depression with Psychosomatic Medicine in Primary Care. *Jpn J Psychosom Med* 42 (9): 585-591, 2002.

5) Tarumi S. The 'new' variant of depression: The dysthymic type. *Jpn J Clin Psychiatr* 34 (5): 687-694, 2005.

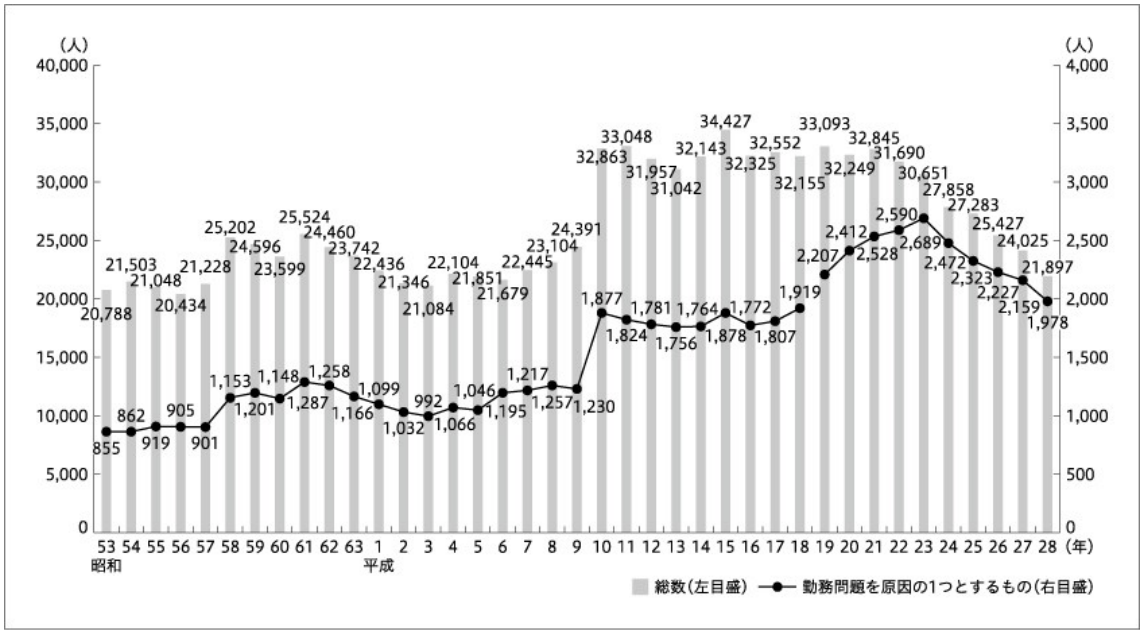

図1　年間自殺者数の推移（総数および勤務問題を原因の１つとするもの）
注：平成 19 年の自殺統計から，原因・動機を最大 3 つまで計上することとしたため，平成 18 年以前との単純比較はできない．
（文献 3 より引用）

Figure 1. Annual number of suicides in Japan since 1978 (Showa 53 th) to 2016(Heisei 28th).

The gray bar indicates total number in left scale. The line graph indicates the number of suicides with labor-related problems in right scale.

Note: This statistic counts only one cause related to suicide until 2006 (Heisei 18th), whereas since 2007(Heisei 19th), it counts up to three causes. Thus, simple comparisons cannot make before and after 2007. (Quoted from Reference #3)

	Psychosis	Mood disorders	Anxiety disorders
Direct costs (e.g., medical expenses)	770 billion yen (5.83 billion USD)	209 billion yen (1.58 billion USD)	49.7 billion yen (376 million USD)
Indirect costs (e.g., loss of absence from work)	2,004.3 billion yen (15 billion USD)	2,881.0 billion yen (21.8 billion USD)	2,343.4 billion yen (17.7 billion USD)
Total costs	2,774.3 billion yen (21 billion USD)	3,090.0 billion yen (23 billion USD)	2,393.1 billion yen (18 billion USD)

Table 1. The social annual costs of mental health problems are enormous. (Japan, 2008) (Quoted from Reference #1)

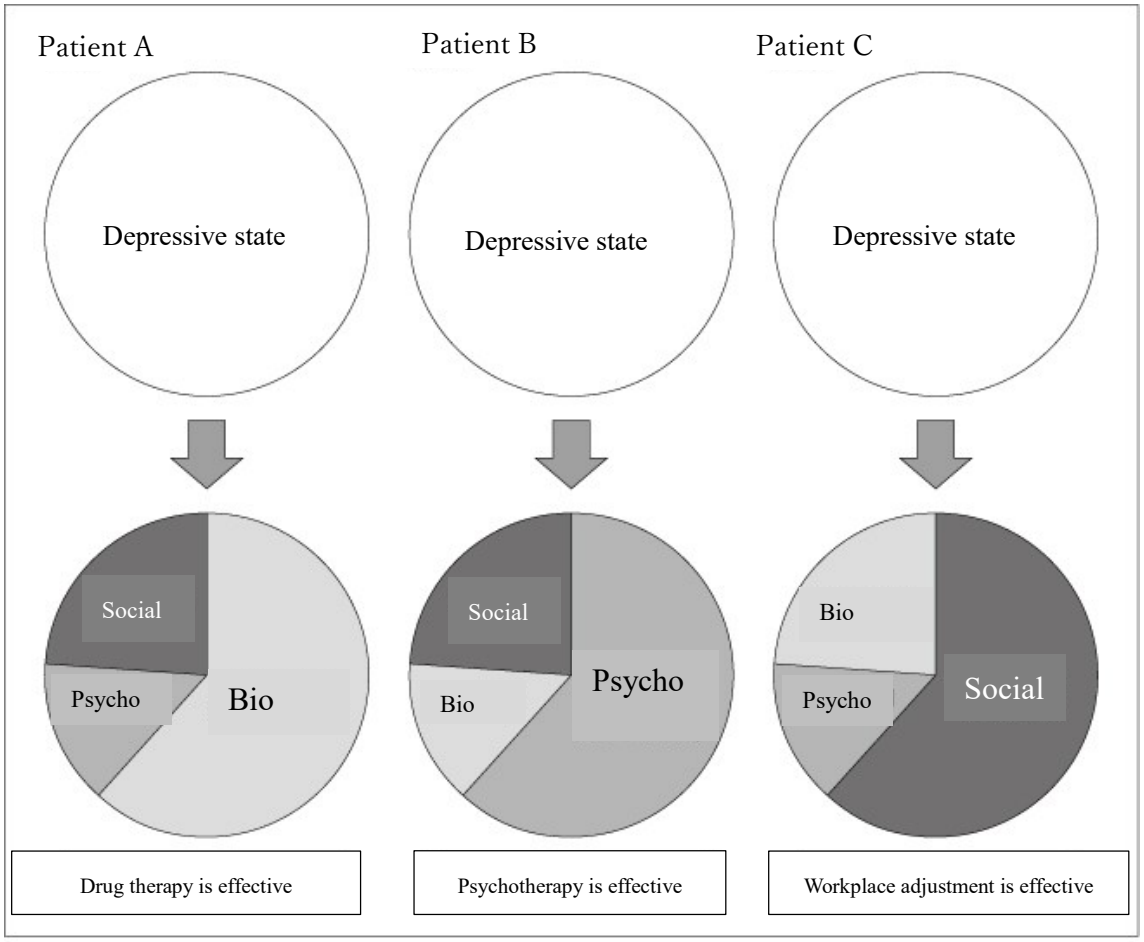

Figure 2. Heterogeneity of depression and its backgrounds.
Drug therapy may be effective for those depressive state with biological factors (i.e., endgenious depression) as a main role (patient A). Psychoterapy may be effective for those with psychological factors (one's way of cognition or personality) as a main role (patient B). Workplace (environmental) adjustments may be effective for those with social (environmental) factors as a main (patient C).

	Melancholic depression	Dysthimia type depression
Age group	Middle-aged (born before 1970?)	Adolescents (born after 1970?)
Related temperament	Immobilithymie Melancholic type	Student apathy Retreat neurosis-like
Premorbid Personality	Attachment to social roles and norms Favoritism and identification with norms Order-loving, considerate, meticulous Workaholic	Attachment to self (without functions) Resists norms as "stressful" Resistance to order and baseless versatility Essentially unenthusiastic about work
Symptomatology	Agitation and suppression Exhaustion and guilt feeling (expressing apologies) Deliberate suicide attempts that may be completed	Feeling of inadequacy and malaise Avoidance and other-punitive feelings (blaming others) Impulsive self-harm, thoughtless “mild” suicide attempts
Cognitive and behavioral patterns	Behavioral changes due to illness are evident	Indistinguishable the way cases are from symptoms
Response to medications	Mostly well-respond (recover from sickness)	Partial sesponse only (never ending phathophysiology)
Prognosis and environmental changes	Getting well by medications and the rest in general	Often getting chronic Rapid improvement with environmental changes on the other hand

Table 2. Conparision between the Conventional Melancholic Depression and the Dysthymia Type Depression (Partially modified and quoted from Tarumi (2005)[5])