Depression-from remission to functional recovery

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Theme Article

Depression – from remission to functional recovery

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Keywords

Depression, remission, absenteeism, return to work

Summary

Depression occurs frequently in the general population and in the workplace and it leads to significant work absenteeism. Treatments aimed at improvement of depressive symptoms do not automatically lead to functional recovery in terms of return to work, and if they do, there is generally a long time lag. Several approaches have been suggested to improve return to work, that generally imply that the sick-listed employee should not wait for remission before resuming work, but rather try to return gradually. Personal as well as work factors influence the outcome of such a process, so that this approach has interpersonal as well as workplace implications that should be addressed at the same time as personal factors and the depressive symptoms.

Schlüsselwörter

Depression, Remission, Arbeitsfernbleiben, Rückkehr zur Arbeit

Zusammenfassung

Depression kommt oft in der allgemeinen Bevölkerung und am Arbeitsplatz vor, und es führt zu signifikantem Arbeitsfernbleiben. Auf die Verbesserung depressiver Symptome gerichtete Behandlungen führen nicht automatisch zu funktioneller Wiederherstellung in Bezug auf die Rückkehr zur Arbeit, und wenn sie es tun, gibt es allgemein eine große Zeitverzögerung. Mehrere Herangehensweisen sind vorgeschlagen worden, die Rückkehr zur Arbeit zu verbessern, die allgemein andeuten, dass der Erkrankte Arbeitnehmer nicht auf eine Remission warten sollte bevor er die Tätigkeit wieder aufnimmt, sondern eher versuchen sollte, allmählich zurückzukehren. Persönliche sowie Arbeitsfaktoren beeinflussen das Ergebnis solch eines Prozesses, sodass diese Annäherung zwischenmenschliche sowie Arbeitsplatz-Implikationen hat, die zur gleichen Zeit beachtet werden sollten.

Depression – von der Remission zur funktionellen Wiederherstellung
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One of the problems in psychiatry is the enormous social impact of mental disorder for the individual as well as society. Patients with mental disorders often have problems with general functioning, in personal relationships as well as at the workplace, and this often leads to loss of work for them (1). Moreover, once they lose their job due to a mental disorder, this produces stigma and diminishes their chances to re-enter the working population greatly (2) As depressive disorder is a common mental disorder that generally occurs in people who are still in their productive years, and that takes quite a while before remission occurs, if any, depressive disorder is a common cause for loss of work and remaining jobless thereafter. (3, 4) This situation should be tackled because of the obvious burden to individuals, their families, employers, and society at large, including economic costs (5). However, although several attempts have been made to address this issue, from a societal perspective (6–8), at community level (9), at general health care level (10–13), at occupational health care level (11, 14, 15), as well as from the perspective of psychiatry (16, 17), there are still several problems to be addressed as the results are inconclusive so far.

Problem: How to achieve remission from depression?

Although depressive disorder is a common mental disorder, adequate diagnosis and treatment of the disorder is

not self-explanatory. Patients with depressive disorder often do not report their depressive symptoms directly when they visit their family doctor; generally, they present with physical symptoms (18, 19). Also, recognition of depressive disorder by the family doctor is limited (20) and this is also the case for the occupational physician. To improve recognition, several scales for assessment of, amongst others, depressive symptoms have been developed in these settings (21, 22). However, these scales are not commonly used. But even in case of adequate recognition and treatment of depression, the course of depressive disorder tends to be protracted, with relatively low recovery rates, lower remission rates, and frequent relapse (23–27). Recovery from depression is therefore limited (28) especially in case of co morbid physical symptoms or disorders (29–31). Although physicians seem to prescribe antidepressants for the right indications (32), their effect may still be limited in terms of achieving remission in many, therapy resistant cases (33, 34). Cognitive Behavioral Therapy has been suggested to diminish relapse (35) but is not a suitable treatment for everybody, since it requires active engagement, cognitive abilities including good concentration, and quite an amount of discipline to do the assignments, which may all be lacking or diminished especially in depressed patients who called in sick maybe because of that. Other barriers to optimal treatment are lack of active monitoring of treatment outcomes and poor adherence to treatment guidelines by professionals as well as patients. Enhanced depression care has been suggested to address these problems, as it combines several effective treatment modes i.e. in a collaborative care model in an easily accessible health care setting such as primary care (36). Enhanced depression care increases the systematization and organization of care by providing closer follow-up on symptoms and adherence to treatment. However, in a recent collaborative care study with good treatment response for depression in the primary care setting, remission rates were still low, albeit higher than in usual care. Remission rates were in the range of 6–13% in usual care and 21–37% in collaborative care, which may suggest that depressive disorder is not easy to treat and that if a patient experiences depressive disorder, it may be too optimistic to expect remission as regular outcome of treatment (37).

Recommendations

Systematic attention should be paid to the possibility of depression by occupational or general physicians in their patients, whether they present with psychological or physical symptoms. When occupational or general physicians or psychotherapists start treatment, they should be aware of the need for a sustained effort, both by the physician and the patient. Enhanced depression care such as i.e. Disease management programs (38) have shown potential, as well as collaborative care models, especially if there is structural psychiatric consultation available (39–42). However, chances are high that remission will not be a lasting outcome of depression treatment, even if treatment is adequately provided. Therefore, the question should be addressed if functional recovery in terms of return to work can be attained earlier than only after remission of depressive symptoms.

Problem: how to improve return to work in treatment for depressive disorder?

For a long time, optimism existed not only regarding the expected outcome of treatment for depressive disorder in terms of depressive symptoms, but also for functional recovery in terms of return to work. The idea was that if the depression was properly treated, and the patient would take enough rest, return to work would occur as well. However, research shows that this optimism is unwarranted as treatment does not automatically lead to return to the workplace (43), and if it occurs, there is often a long time lag. Hees e.a. showed that there is an association between improvement of depressive symptoms and work functioning in persons receiving clinical depression treatment, but also suggested that treatment focused on qualitative functioning in the workplace may accelerate depression recovery; so, recovery at the workplace and improvement of depressive symptoms may be interrelated (44). Return to work however depends on other factors as well, such as co morbid physical disorders, personal factors and work related factors (45). For example, supervisor behavior (46) and high work pace and work load are work related factors influencing return to work (47). To sum it up, long-term remission of depression is predominantly predicted by diagnostic factors, but return to work is predicted by personal and work related factors as well (48).

Therefore, treatment should not only address the depressive symptoms, but also how to return at the workplace and this approach may be quite independent of addressing the depressive symptoms (17, 49). Combined interventions aimed at both remission as well as return to work have been developed in specialty mental health settings for clinical treatment of depression, as mentioned above; they have been developed in the primary care setting, by way of psychiatric consultation to the occupational physician and family physician (16); and they have been developed as collaborative care model in the occupational health setting (15). Providing occupational physicians with psychiatric consultation showed to be a prom-

ising approach in accelerating return to work of workers with common mental disorders (16) A more elaborate form of collaboration between occupational physicians and psychiatrists was applied within a collaborative care model, with trained occupational physicians fulfilling the treatment role and closely monitoring treatment outcomes. However, adherence to the protocol was low in the occupational physicians as well as in the workers, suggesting that having occupational physicians fulfilling the treatment role is yet a bridge too far (15). In the specialty mental health setting, adjuvant occupational therapy was examined twice. In the first study, adjuvant occupational therapy resulted in a reduction in work-loss days (17), however in the second study a shorter and improved version of the occupational therapy did not show significant benefit for improving overall work participation (49). This discrepancy in study findings may be explained by societal changes in the Netherlands that have occurred after the first study, such as legislative changes and changes in attitudes among health professionals (49). In addition, studies among workers with common mental disorders and stress-related disorders suggest that in order to promote return to work, work-focused cognitive-behavioral therapy (CBT) may be effective and that it may be particularly helpful to focus on the cognitions of workers with respect to return to work „while having symptoms" (8).

Research also showed that trying to accelerate return to work in sick listed employees who have not yet recovered from depression completely can actually prolong time to full return to work, if it implies steadily accumulating exposure at the workplace in persons who still are (partially) depressed (50). Thus, simply starting return to work earlier while still being under treatment for depression can be too rigorous and counter-effective and should not be done without close monitoring of depressive symptoms relapse as well as actual work performance.

The optimal approach that combines depression treatment with addressing personal factors and self efficacy regarding return to work of the employee, as well as with interventions aimed at improving the work setting and the behavior of the supervisor, has not yet been established. Such a treatment model may also have to differ depending on country as the organization of care and the handling of sickness leave protocols in companies, as well as related legislation, differ greatly between countries.

Recommendations

Interventions aimed at return to work in sick-listed employees with depressive disorder should both address the depressive symptoms and improve conditions in order to establish return at the workplace. These should be separate interventions focusing on either the depressive symptoms, or return to work, provided by separate specialists in that matter, who should work closely together (17, 51). Integration of the organization of such combined care would be desirable and was proven feasible i.e. in the specialty mental health setting (16), in the primary care setting (52) and in the occupational health care setting (15). The employee should receive specific support to address his or her self-efficacy and cognitions regarding return to work, as simply resuming work earlier may be counterproductive; thus, close monitoring of the symptoms as well as progress of return to work is needed in order to achieve optimal results without setbacks.

It is time now to develop combined interventions that also involve coaching of the work supervisor or manager in order to improve return to work, aimed at adaptation of work and improvement of understanding and support in the workplace (53). The specific organization of such models may depend on the country and health care system as well as the level of integration with company provided care, because of variation in occupational health services. However, the idea that simply treating mental disorder will automatically lead to return to the workforce has not been confirmed so far. It is deemed necessary to develop multidisciplinary approaches for that (54).

Future directions for innovation and research in this field may also include blended e-health interventions that address cognitions of the sick listed employee regarding return to work, that direct the occupational physician in providing or monitoring depression treatment, and that facilitate monitoring and managerial efforts to improve swift recovery and return to the workplace (55). Such a combination of regular treatment, a web based decision aid for the professionals involved, and web based treatment of the cognitions of the sick listed employee regarding return to work combined with monitoring of depressive symptoms as well as progress in terms of return to work, may be an efficient and cost effective treatment model that warrants further exploration in research.

Summary

Awareness is rising that absence from work in depressive disorder presents a huge burden to individuals, their families, employers and society. Depression treatment is best provided in some form of enhanced care, such as collaborative care, however even then remission of the disorder does not always occur. Return to work of employees with depressive disorder should be addressed earlier than that, preferably in some form of integrated treatment together with the treatment of the depressive symptoms, and with close monitoring of the symptoms as well as progress

of return to work. Treatment aimed at return to work should therefore complementarily address personal factors and work related factors in a multidisciplinary manner. Organization of such a treatment model may differ depending on the country. Blended e-health models may be of benefit to improve efficiency, adherence and costeffectiveness, but this still has to be established in future research.

Conflict of interest

In the last three years, the employer of Prof. Dr. van der Feltz-Cornelis received grants for an independent investigator initiated trial from Eli Lilly and from ACHMEA, a social insurance company. The employer received fees for lectures of Prof. Dr. van der Feltz-Cornelis from Eli Lilly and from a social insurance company, UWV. Prof. Dr. van der Feltz-Cornelis received royalties for books on the topic of psychiatry.

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