

# Depression

## *The hidden workplace illness*

By Eric Lanier

*"I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would be not one cheerful face on earth. Whether I shall ever be better, I cannot tell. I awfully forebode I shall not. To remain as I am is impossible. I must die or be better it appears to me."*

—Abraham Lincoln

APPROXIMATELY 20 MILLION PEOPLE SUFFER from some form of depression during any given year in the U.S. In fact, depression has become one of the most common medical problems around the world (Kramlinger 3). According to the World Health Organization, depression is the fourth-leading cause of disease burden in the world; by 2020, it is expected to be the second-leading cause, behind only heart disease (Reyes). Despite these statistics, discussion of this issue and the unique problems it presents to employers is limited. This is largely due to the fact that the illness itself is not well understood; the scope of the illness among the employee population is not generally known to employers; and employers assume that depression is a personal matter better left to mental health professionals. While this may be true, it has been reported that two-thirds of those who suffer from depression do not seek treatment. If these people are employed and are able to come to work, they are doing so with an illness that impairs them physically, mentally and emotionally. This presents a unique set of challenges to the employer.

### What Is Depression?

Depression has been around as long as humans have existed. It has been described in early biblical writings (Job 3:20-22), the writings of Hippocrates (who thought depression was due to an excess of black bile), early Christian writings, writers of the Renaissance, Elizabethan poets, and doctors and psychologists of the 17th through 19th centuries (who used the word "melancholia" or "melancholy" for depression). By the 1930s, there was "much writing and discussion about the diagnosis and classification of the various types of depression and their relationship to mania" (Wolpert 14).

Today, depression is regarded as more than just a mood disorder. It is considered "a serious illness that causes memory and thinking, mood, physical and behavioral changes. It affects how you feel, think, eat, sleep and act" (Kramlinger 3). Kramlinger adds, "It is when these feelings persist, recur or become

severe that a person may be experiencing depression and should seek medical help" (5). Most physicians define true depression as being characterized by a low mood that lasts at least two weeks and often longer, and the sufferer "exhibits specific symptoms related to mood, behavior, thinking and outlook that impair their ability to function normally on a daily basis" (Kramlinger 5).

For the purposes of study and research, doctors and scientists have placed depression on a continuum based on its severity and duration—from functional depression to incapacity. Depending on the researcher, these classifications can be very broad or very narrow with minute differences that only a skilled psychologist would understand. In *On the Edge of Darkness*, Cronkite offers a helpful classification scheme that divides depression into three major categories:

1) **Major depression.** A condition in this category is clearly and easily defined. It is characterized by intense, incapacitating sadness for two weeks or more plus four or five other symptoms of depression.

2) **Dysthymia.** This category could be called "mild" depression in that the sadness is not as intense; however, it is more protracted or long-term. The sufferer of this type of depression also has at least two additional symptoms of depression and is somewhat functional.

3) **Symptomatic depression.** Also called "adjustment disorders" by the Mayo Clinic (Kramlinger 51), this category encompasses possibly eight to nine percent of the population who are depressed; they have only one or two symptoms but do not qualify for the diagnosis of major depression or dysthymia. Nonetheless, "these people have significant disability. We believe that this is an extremely important, under-recognized public health problem. . . . They are the ones that go in for a vitamin shot who say, 'I have low energy,' or 'I don't feel up to snuff.' They are on their way to major depression that can be prevented with early intervention" (Cronkite 26).

### Symptoms of Depression

Depression can disrupt a person's entire life routine. It can affect sleeping and eating patterns, reduce sex drive, diminish self-esteem and one's outlook on life, and can affect how a person acts

**Eric Lanier** is the benefits administrator for Mecklenburg County, NC. In this position, he is responsible for managing the benefits programs for the county's 5,000 employees. Lanier holds a B.A. and an M.A. in Political Science from Appalachian State University, and is pursuing an M.A. in Theology from Gordon-Conwell Seminary. He is member and past president of the North Carolina Assn. of Local Government Employee Safety Officials, a past president of the Charlotte Chapter of the American Society of Public Administrators and has been certified as an occupational safety and health standards trainer for general industry.

**Table 1****Job Stressors**

Category	Stressor
Control	Low decision-making latitude.
Demands	<ul style="list-style-type: none"> <li>•Nightshift work.</li> <li>•Long work hours.</li> <li>•Too much to do in too little time.</li> </ul>
Environment	Work is performed in a high-hazard environment where exposure to hazards such as noise, temperature extremes, air pollution, chemicals and ergonomic problems may be routine.
Role	<ul style="list-style-type: none"> <li>•Roles not well-defined.</li> <li>•Major changes in procedures and policies are not well communicated.</li> </ul>
Relationships	Conflicts exist between employees or groups of employees that work together.
Support	<ul style="list-style-type: none"> <li>•Job insecurity.</li> <li>•Intensive effort but few rewards.</li> </ul>

Source: Belkic and Schmall; "Stress at Work."

(rationally, irrationally, decisively or indecisively, focused or unfocused). According to the Mayo Clinic, depression exhibits itself in four major ways:

1) **Mood Changes**

- sad, helpless, hopeless;
- crying spells;
- agitation and irritability;
- bored easily; nothing is of interest;
- recurrent thoughts of suicide.

2) **Cognitive Changes**

•trouble remembering details, concentrating and making decisions;

- difficulty accomplishing tasks;

3) **Physical Changes**

- sleeps or eats too much or too little;
- diminished sex drive;
- lack of energy / fatigue
- general aches and pains;

4) **Behavior Changes**

- neglects appearance;
- loses track of things;
- withdraws from people;
- conflicts with people;
- misses deadlines;
- poor self-esteem;
- gloomy outlook (Kramlinger 9-10).

A person is said to have major depression if s/he exhibits at least four of the symptoms from any of these four categories, and has been depressed for at least two weeks. If a person exhibits at least two symptoms and has been depressed for at least two weeks, then s/he is thought to have dysthymia.

**Triggers of Depression**

Although experts agree that depression is seldom traceable to a single cause, people usually become depressed in response to certain stressors in their lives. However, not everyone reacts the same way to the same circumstances. Potential "triggers" includes:

- stressful situations;
- death and other losses (such as the loss of a job);

- relationship problems;
- major life events (e.g., turning 50, approaching retirement, children leaving home);
- past experiences (e.g., child abuse, war, crime victim, growing up with an alcoholic parent);
- chemical dependence (drugs or alcohol);
- prescription medications;
- medical conditions (e.g., cancer, heart disease, sleep apnea, chemical imbalance);
- chronic pain;
- psychological issues.

**Who Gets Depressed?**

**Men vs. Women**

Much of the research has reported that twice as many women suffer from depression as men (Papolos and Papolos 66). Growing evidence suggests that this is not the case, however. For example, during a study of the Amish, Egeland discovered that a ratio of 1 to 1 existed for males and females with depression (Papolos and Papolos 66). Egeland concluded that this was because the Amish culture prohibits drug and alcohol use, which are used to mask depression in other cultures and societies, especially among men. In *I Don't Want to Talk About It*, Real states:

Men have been taught that depression was a woman's disease. . . . There is a terrible collusion in our society, a cultural cover-up about depression in men. The very faces that create it keep us from seeing it. Men are not supposed to be vulnerable. Pain is to be risen above. Men, therefore, are more likely than women not to seek help, preferring to place themselves at risk rather than acknowledge distress either physical or emotional (36).

As a result, men are more likely to be treated for the symptoms of depression rather than for depression itself. Hidden depression, then, drives the problems considered "'typically male': alcohol abuse, drug abuse, domestic violence and relationship problems" (Real 22).

**Stressful Occupations**

The level of depression found in certain jobs is linked to the amount of stress and tension found in them, although research in this field is limited. Some studies have compared the number of doctors suffering from depression (27 percent) to managers who suffer from depression (six percent) (Wolpert 59). This difference is attributed to tensions between work and home life, nature and gravity of decisions that may cause self-doubt, and self-criticism.

Two independent studies of farmers also offer interesting findings. One found that farmers had the highest rate of death as a result of stress-related conditions (NIOSH). Another study, conducted by the Institute of Rural and Environmental Health, found farmers reporting higher rates of depression and suicide than other occupations (Scarth, et al 302+).

Furthermore, a study by Teruichi Shimomitsu found that occupations which offered "a low number of days off, the inability to switch off, a lack of a sense

of control and a sense of a lack of support from the supervisor” caused undesirable levels of occupational stress (Shimomitsu). Most researchers agree that high levels of occupational stress can lead to depression in workers (e.g., Meyers). “Occupational stress is directly related to the development of depression (or symptoms of depression)” (Meyers).

### **Why Should Employers Worry About Untreated Depressed Employees?**

Until recently, depression in the workplace has not been the focus of workplace health—despite studies which have revealed that rates of depression are highest between the ages of 25 and 44 (prime working years) and that at any given time 10 percent of the adult workforce is depressed [NIMH(b)]. The cost of this depression to employers in direct services and productivity is estimated to be \$24 billion per year, a figure that does not include the medical costs associated with this illness, which could drive the cost as high as \$88 billion (Weaver).

Additionally, depressed workers are prone to have work-related injuries and accidents because of depression’s interference with the ability to concentrate and focus. The injury itself may cause further depression. A depressed worker might miss work due to sickness, and have personal problems such as marital and/or substance abuse problems that affect productivity [NIMH(a)]. As noted, even people who suffer from a mild form of depression often have poor physical and social functioning, and they risk future, more severe depression if they remain untreated (Kramlinger 13). In “Depression in the Workplace: Costs and Barriers to Treatment,” Goldberg and Steury state that “patients with depression showed impairments in functioning that were comparable to or worse than those of patients with medical disorders” (1639).

With respect to depression, occupations classified as “high hazard” should be of particular concern to employers for two reasons. First, such jobs carry a high level of stress, which is directly related to the development of depression in workers. “. . . The cumulative effects of stress can cause a person to approach what researchers call a ‘coping threshold.’ When that threshold is exceeded, a person’s ability to function is at risk” (Johnson and Indvik 359).

Second, high-hazard jobs are most likely to be occupied by men, who are most likely not to seek treatment for depression. Since 10 percent of the working adult population is depressed, and high levels of depression are found in occupations of high stress, one can surmise that an employer with several high-hazard jobs can expect to find a number of untreated, depressed employees in these jobs. These employees are performing life-threatening tasks while their physical and cognitive abilities are impaired due to depression. It may also mean that many of these employees have secondary problems such as drug and alcohol abuse which further impair their abilities.

### **What Can an Employer Do?**

Ironically, depression is one of the most successfully treatable of all illnesses. Eighty percent of

depressed people who seek treatment are successfully treated within a short period of time and return to work. Despite this success rate, only one-third of all sufferers seek treatment. Of these, only 10 percent seek help from a trained psychiatrist (Papolos and Papolos 10). Often, the symptoms of the illness itself—apathy, lack of motivation, hopelessness—keep its victims from seeing a doctor.

People also consciously avoid seeking treatment because of the stigma that continues to be attached to depression. Depressed persons have been characterized as lacking motivation or will power, or as being weak or failures. When their illness becomes known, they may suffer on the job (e.g., lack of responsible tasks, bypassed for promotions, first to be transferred or laid off) and in their private lives (relationships).

So, what can an employer do? First, employers should train supervisors to recognize the early symptoms of depression so that an employee can be referred to the company’s employee assistance program (EAP), occupational health nurse or the employee’s primary care physician as soon as possible. Much of the cost associated with depression can be avoided if the condition is recognized in its early stages.

Supervisors are not counselors or therapists and should not attempt to be such. However, they play a key role in early recognition and treatment. Before approaching the employee, supervisors should document the signs of depression, such as:

- marked decrease in job performance;
- frequently missed deadlines;
- working more slowly than usual;
- making excuses for not completing work;
- frequently calling in sick;
- appearing listless, unable to concentrate;
- frequently looking distracted or “far away”;
- showing decreased involvement in work;
- withdrawal from interaction with coworkers (Johnson and Indvik 362).

Supervisors should be trained not to moralize or “even introduce the idea of illness to employees” (Johnson and Indvik 363). Workers should be informed by supervisors about the resources available through the employer and the need to use them. When an employee’s productivity and performance are suffering, supervisors should make mandatory referrals to the company’s health resources.

In addition, employers should train employees to recognize the symptoms of depression and emphasize the high success rate in treating it. Such training and information sharing can be performed by the company’s qualified health professionals, EAP counselors, outside resources (such as the American Red Cross, which offers a “Managing Stress” module) or health consultants. These resources should also be allowed to share their web addresses and confidential employee self-rating sheets with workers who can complete them at home and mail them directly to the resource for evaluation. Furthermore, senior management should clearly support the use of the health and wellness programs—so that supervisors and employees will use them routinely.

*“After the flood I couldn’t concentrate. I had lost everything; my house, everything in my house, my cars. Everything I owned was gone. And the city needed me to work just two days after it happened. They had me out riding around looking for manhole covers that had floated away. I was driving the city truck thinking about the flood, and worrying about what I was going to do and suddenly I would realize that I was 10 miles from nowhere and didn’t know how I had got there. I didn’t find many manhole covers.”*

—City worker who lost everything in the flood after Hurricane Floyd.

## What Can SH&E Professionals Do? Learn, Identify & Assess

SH&E professionals need to know about depression, the types of stressors likely to cause or enhance depression, and the types of stressors present in the workplace. Resources on depression abound, both in print and electronic media. A good starting point is articles written by staff of respected health or safety organizations such as the Mayo Clinic, National Institute of Mental Health or NIOSH. Other professional resources, such as certified counselors, occupational health nurses or health consultants, experienced ministers or chaplains, can also provide valuable insight into the nature of employee depression.

It has been said that people react to stress differently—what is stressful to one person may not be stressful to another. Based on this point of view, some SH&E professionals have developed individual strategies for dealing with—but not eliminating—job stress. A more current school of thought holds, “Although the importance of individual differences cannot be ignored, scientific evidence suggests that certain working conditions are stressful to most people” (NIOSH). As Table 1 shows, most job stressors found to cause or enhance depression fall into one of six categories: control, demands, environment, role, relationships and support. SH&E professionals can play an integral, proactive role in alerting their organizations to stressors that if unresolved can have affect productivity and worker physical and mental health.

Using the six categories of stressors as a guideline, an annual risk assessment would provide useful information to the SH&E professional who is trying to determine what stressors exist in the workplace, especially with respect to high turnover, high absenteeism and high injury/accident rates. Using injury/accident data, sickness and absence reports, and turnover reports to determine the areas of priority, the SH&E professional can conduct focus groups and individual interviews to determine the exact nature of the stressors. In the author’s opinion, the category that holds the greatest potential for untreated, depressed workers is environment, where workers regularly face hazards. Statistically, most of these workers will be male, who, as noted, do not seek treatment for depression.

Once these work areas and the nature of the stressors are identified, action can be taken to address the underlying issues. Care must be taken to ensure that these actions do not cause or compound the problem of untreated depression in workers.

## Conclusion

Untreated depression is a hidden workplace illness. Employers may not have caused a worker to become depressed directly (that is, a worker may have brought the depression to the job), but employers may unknowingly be contributing to the condition. Depression affects a greater number of workers than employers recognize. Two-thirds of those who suffer from depression never seek treatment, with many continuing to work despite physical, cognitive and

behavioral impairments. High-hazard occupations hold the greatest liability for the employer due to the stress associated with these positions and the link between occupational stress and depression. The cost of this illness to business is staggering, yet may be largely avoidable if the illness is recognized and treated in the early stages. SH&E professionals should be familiar with what depression is, its causes and how to recognize and address it in the workplace. ■

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“Because depression is a medical condition and not something one can just ‘will’ himself out of, I was not ‘fixed’ once I escaped my turbulent home life.”

—Brianna, “Personal Stories of Depression” (DBSA)