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Diagnosis and Referral of Workplace Depression

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Learning Objectives

- Outline the processes of screening for and diagnosing the many forms of depressive illness encountered at the workplace.
- Describe the relationship between depressive mood and physical illnesses.
- Contrast the symptomatic features of dysthymic disorder, atypical depression, and major depressive disorder.

Abstract

Objective: *Effective treatment requires understanding of the many possible reasons for employees and patients to complain of "depression."* ***Methods:*** *This process of differential diagnosis includes panic anxiety, thyroid and other medical conditions, as well as several distinct types of depression (including atypical depression and melancholia).* ***Results:*** *Much of workplace depression care can be delivered by occupational health and mental health professionals. Optimal treatment requires accurate and specific diagnosis, and focused care. And, some cases require urgent psychiatric referral, while less urgent referral is important for some others.* ***Conclusions:*** *Optimal diagnosis and specific treatment is a cost effective approach that saves money for employers, while helping employees.* (J Occup Environ Med. *2008;50:396–400*)

What does it mean when a patient says "I feel depressed?" Depression is a common chief complaint for patients in any health care setting, yet the term has a wide variety of potential meanings.[1,2] Spoken to a clinician, it is a way of conveying some sort of unhappiness. As a written diagnosis on a health insurance claim form, it may only indicate some sort of mental health encounter. Appearing on a disability claim form, it offers mental health issues in general as an explanation for impaired functioning at work. And then again, there are many unhappy people who make no mention of "depression" or of any of its synonyms. Many of the most-depressed people do not even think of themselves as depressed, and might not even agree with a doctor's diagnosis. Instead, they are more focused on the gloomy life problems that they perceive, or on the physical symptoms that they feel. Like any other syndrome, accurate diagnosis of depression requires careful attention to component symptoms, and to differential diagnoses.

Diagnosing Depression: A Hierarchy of Specificity and Referral

So how can true depression be diagnosed? From a workplace perspective, signs are often noticed by coworkers, managers, human resources personnel, and occupational health workers. They might take notice because of the many workplace clues (Table 1). Employees may seem sad, withdrawn, angry, unmotivated, or tired. Their personalities may be restrained, exaggerated, or

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TABLE 1
Some Workplace Signs of Depression

1. Social withdrawal (from meetings, meals, chatting)
2. Physical complaints or increased medical utilization
3. Sadness, fatigue, "laziness"
4. Irritability or anxiety
5. More interpersonal conflict
6. Absenteeism and presenteeism
7. Reduced productivity (sometimes despite increased effort)
8. Accidents and errors
9. Increased passivity or rigidity
10. Increased concern from coworkers
11. Weight change or poor grooming
12. Increased alcohol and drugs

TABLE 2
Sample Clinical Presentations of Depression

1. Emotional symptoms and signs
   a. Complaints of sadness, hopelessness, loneliness, self-denigrating
   b. Appears tired, sad, tearful, avoidant, reserved
   c. Evaluator feels increased sadness, sympathy, or irritation
2. Physical symptoms and signs
   a. Insomia/hyersomnia
   b. Anorexia/hyperphagia
   c. Retarded motion or slowed speech
   d. Complaints of headache, nonspecific symptoms
3. Medical contexts with increased prevalence
   a. After MI, CVA, cancer, injury, other serious illness
   b. Any ICU/CCU patient
   c. Physical disability (even when verified)
   d. Multiple medical visits (even for valid reasons)
   e. Controversial illness (Chronic Fatigue, PTSD)
4. Personal contexts with increased prevalence
   a. Family (marriage, separation, divorce, new child, illness, death)
   b. Financial (loss, gain, retirement)
   c. Social (residence change, social network change)
5. Occupational contexts with increased prevalence
   a. Real or perceived supervisor problems
   b. Real or perceived harassment
   c. Need for executive coaching
   d. Increased work hours or other job demands
   e. Job loss or retention (survivor guilt)
   f. Job demotion or promotion

MI indicates myocardial infarction; CVA, cerebrovascular accident; ICU/CCU, intensive care unit/critical care unit; PTSD, posttraumatic stress disorder.

TABLE 3
Urgent Indications for Psychiatric Referral*

1. Risk of suicide or self harm
2. Risk of violence to others
3. Marked symptoms (anxiety, depression, psychosis)
4. Cognitive disorganization or acute cognitive changes
5. Substance abuse (substance abuse clinician)
6. Child abuse (notify appropriate authorities where required)
7. Life issues or emotional crises requiring rapid and integrated treatment

*Referral to a specialized evaluator is indicated whenever these phenomena are present and are beyond the expertise of the initial evaluator. Always consider possible need for urgent referral.

different. Their thoughts can be pessimistic, overly insistent, or unrealistically positive. Their performance can be diminished, erratic, or error prone.[3] Perhaps most importantly, their relationships can be more distant, troubled, or diminished. Observations like these are cause for thoughtful consideration and supportive conversation. Where there is any question, referral to appropriate resources is in order. Voluntary screening programs are often used to foster self-identification of depressed employees. The screening instruments in most common use are useful for identifying those who need a careful diagnostic evaluation, but do not produce specific diagnoses themselves. While these tools are very helpful to some, the most-depressed employees will not always present for screening. Broader confidential screening of employee populations with more specific diagnostic instruments would theoretically be more useful, but has not caught on in the employer community. However, newer techniques may bring such approaches into more common use (WorkPsych Associates, unpublished data).

The most useful diagnoses are made by well-trained and experienced clinicians during an interview of sufficient length. There is a wide variety of common chief complaints that may indicate evaluation for depression (Table 2), and there are also many depressed patients who do not report any related symptoms. Mental status observations and particular clinical contexts should trigger careful diagnostic evaluation. As elsewhere in medicine, a thorough interview includes detailed review of the present illness (symptoms, syndromes, differential diagnosis), including work, personal, family, medical and psychiatric history, and review of systems. Since patients often do not recognize the emotional connections between life events and psychiatric symptom exacerbation, a psychiatric evaluation includes the concept of a "parallel history" to explore chronological associations. For example, a patient may report that tearfulness and insomnia inexplicably began 10 weeks earlier, and separately report that a favorite coworker had retired some 2 months before. Importantly, while depression may sometimes be "understandable" (ie, occurring with cancer or after job loss), it is a debilitating illness nonetheless, and patients need appropriate diagnostic evaluation and treatment.

Initial psychiatric evaluation is usually carried out by occupational nurses and physicians, employee assistance programs, social workers, and psychologists.[4] These mental health professionals are responsible for initial recognition, differential diagnosis, and, often, treatment of depression. In all of medicine, specialty referral is important for some cases. Psychiatric referral is sometimes urgently needed (Table 3), and may be important in some other situations (Table 4). Psychiatric training includes broad skills in psychiatric and medical diagnosis, formal psychotherapies, and psychopharmacology.

TABLE 4
Other Indications for Psychiatric Referral

1. Support during an emotional crisis
2. Longer term life issues
3. Interpersonal or personality issues
4. Concerns about suicide or violence
5. Less than full remission (inadequate treatment response)
6. Reconsidered or more definitive diagnosis or treatment planning
7. Troublesome patient or clinician emotions (that interfere with treatment)
8. Significant concurrent medical illness
9. Distressed executives (heightened confidentiality concerns)
10. Management consultation issues

TABLE 5
Some Other Causes of "Depression"

1. Panic Disorder (and other anxiety disorders)
2. Bereavement, demoralization, adjustment disorder
3. Alcohol, drugs, medications
4. Endocrine (especially thyroid)
5. Anemia, B12 deficiency
6. Hidden psychosis
7. Occult malignancy, infection, or CNS disorder
8. Exaggerated reporting (hidden personal issues or malingering)

CNS indicates central nervous system.

Broader skills and experience improve the odds of accurate diagnoses and prompt effective treatment.[5]

Well if it Isn't Depression, Then What is it?

Important Differential Diagnoses. A substantial percentage of patients who appear depressed or who report their unhappiness as a depression, don't actually have one (Table 5). Since specific treatment is important, it is always important to keep certain other diagnoses in mind. Perhaps most common among these is panic disorder. Although previously undiagnosed patients will rarely be aware of panic attacks, they will sometimes know when anxiety is a prominent symptom. More than anxiety alone, a diagnosis of panic disorder requires a careful and specific diagnostic interview that reveals a history of panic attacks. Other common psychiatric differential diagnoses include other anxiety disorders, substance abuse and withdrawal, and psychosis. Finally, some people with a depressed mood do not have a formally diagnosable depression. Rather, they have modest and time-limited bereavement, disappointment, or demoralization syndromes in appropriate response to adverse events in their lives.

Significantly, depressed mood is often the presenting symptom of a physical illness.[1] Common diagnoses include hypothyroidism, hyperthyroidism (especially in older patients), anemias, other endocrine and metabolic abnormalities, cancer, medication side effects, Parkinson's disease, and any illness that causes feelings of lethargy. Physical examination, medical review of systems, chemistry panel, blood count, and thyroid panel will help screen for many of these. Physical illness can mimic depression, exacerbate depression, and trigger depression. Importantly, depression is commonly comorbid with documented physical illnesses and other psychiatric diagnoses, and it may also contribute to the development of cardiac and other diseases.

Common Types of Depression

Different types of depression have different symptoms and natural histories, respond to different treatments, and have different treatment-response patterns and prognoses, so, it is important to know which one(s) a patient has. The common sub-types detailed below are presented roughly in order of their prevalence in clinical settings. The characteristic diagnostic symptoms are adapted from the Diagnostic and Statistical Manual, 4th revision, text revision (DSM-IV-TR), but simplified here, and with some minor changes.[6]

Atypical Depression and Dysthymic Disorder. Dysthymia can be thought of as an umbrella diagnosis for patients with chronic mild to moderate depressions. It may be the most common diagnosis for patients who present with a chief complaint of "depression." Dysthymia does not often cause sufficient acute impairment to require disability status; however, Dysthymia can have more pronounced long-term effects on work and relationships than an acute Major Depression does, due in part to its chronic symptoms and interpersonal consequences. With optimal and ongoing medication and psychotherapy, the prognosis is very good. Medication response for all depressions typically begins at 3 to 4 weeks, although full benefits of medication and psychotherapy usually take longer.

Many, if not most, cases of Dysthymia meet the more specific criteria for the ironically named Atypical Depression. Perhaps the most commonplace form of depression, Atypical Depression usually responds well to selective serotonin reuptake inhibitor (SSRI) antidepressants, often augmented with so-called booster medications.

Diagnosis of Dysthymic Disorder

1. During most days for at least 2 years, the patient reports depressed mood or appears depressed most of the time.
2. When depressed, the patient has two or more of the following:
   a. Appetite decreased or increased
   b. Insomnia or Hypersomnia
   c. Fatigue or low energy
   d. Low self-esteem
   e. Reduced concentration or indecisiveness
   f. Feels hopeless or pessimistic
3. During the 2 or more years, these symptoms are never gone for longer more than 2 straight months.

4. During the first 2 years, there has not been a Major Depressive Episode.
5. The patient has had no Manic, Hypomanic, or Mixed Episodes.
6. The patient has never fulfilled criteria for Cyclothymic Disorder.
7. The disorder does not exist solely during a chronic psychosis.
8. Symptoms are not directly caused by a general medical condition or the use of substances, including prescription medications.
9. The symptoms cause clinically important distress or impair work, social, or personal functioning.

All diagnostic lists are adapted and abbreviated from the DSM-IV-TR.[5]

Diagnosis of Atypical Depression

1. Mood reactivity (cheers up at least temporarily in response to positive events).
2. At least two of the following:
   a. Significant weight gain, increase in appetite, or food cravings
   b. Oversleeping (schedule permitting)
   c. Perceived physical lethargy (especially "leaden paralysis")
   d. Longstanding pattern of interpersonal rejection sensitivity at all times that results in distress or occupational impairment even when not depressed
3. Criteria are not met for Melancholic Depression during the same episode.

Major Depressive Disorder. Major Depression can also be thought of as an umbrella diagnosis for a variety of acute depressions. Although it may have a more overt presentation, patients will often see the world through a depressive lens, and thus focus on the problems they see in the world around them, or on their physical symptoms. It is hard for some to accept that they have depressive perceptions that make their actual situation look worse than it really is. Lifetime prevalence of major depression is about 20%, and patients who have had one are at increased risk of another acute episode. Prognosis with optimal treatment is excellent. Either anti-depressant medication or formal psychotherapy can be effective alone, but combined treatment is faster, safer, and more reliably effective. Even though Major Depression sometimes causes sufficient impairment that disability leave is advisable,[7] appropriately prompt return to work is usually helpful to the patient.

Diagnosis of Major Depressive Episode

1. At least 5 of the following symptoms have been present during for at least 2 weeks (including either a or b):
   a. Depressed mood most of the day, nearly every day, by either self-report or others' observation.
   b. Significantly decreased interest or pleasure in all, or nearly all, activities of the day, nearly every day by either self-report or others' observation.
   c. Significant weight loss (not from dieting) or weight gain, or decrease or increase in appetite nearly every day.
   d. Insomnia or oversleeping nearly every day.
   e. Psychomotor agitation or retardation nearly every day.
   f. Fatigue or loss of energy nearly every day.
   g. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
   h. Decreased ability to think or concentrate, or indecisiveness, nearly every day, by either self-report or others' observation.
   i. Recurrent thoughts of death (not just fear of dying) or suicidal ideation without a specific plan, or any suicide attempt or a specific plan for committing suicide.
2. The symptoms do not meet criteria for a Mixed Episode.
3. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
4. The symptoms are not due to the direct physiological effects of a substance or a general medical condition.
5. The symptoms are not better accounted for by bereavement (ie, the symptoms include marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation, or else the symptoms persist for longer than 2 months after bereavement).

Melancholic depression is an important sub-type of Major Depression. This is the classically described ("typical") severe depression in which patients can not eat, sleep, or smile. Prognosis is excellent with combined medication and formal psychotherapy.

Diagnosis of Melancholic Depression

1. At least one of the following:
   a. Loss of pleasure in all or most activities
   b. Lack of mood reactivity (does not cheer up in response to positive events)
2. At least three of the following:
   a. Distinct quality of depressed mood (ie, the depressed mood is experienced as distinctly different from the kind of feeling experienced after the death of a loved one)
   b. Depression is regularly worse in the morning
   c. Early morning awakening (at least 2 hours before usual time of awakening)
   d. Marked psychomotor retardation or agitation
   e. Significant appetite loss or weight loss

f. Excessive or inappropriate guilt

Other Forms of Depression. Several other forms of depression are worth brief mention. Bipolar Disorder (formerly known as Manic-Depressive Illness) includes episodes of Mania, as well as episodes of Major, Melancholic, or Atypical Depression. Bipolar Disorder is usually treated with specific anti-manic medication, sometimes in combination with antidepressants. A milder form, known as Bipolar II Disorder, may not be physiologically related, and sometimes reflects more specific depressive and anxiety disorders that remain undiagnosed. In an historical reversal, Bipolar Disorders are these days commonly overdiagnosed, so specific reevaluation of diagnosis is essential, as it would be for any prior medical diagnosis. Delusional Depression is a psychotic form of Melancholic Depression, with fixed false beliefs about guilt, bodily decay, or impending catastrophe. Anti-psychotic and antidepressant medication are used in combination. Mania and Delusional Depression often require hospitalization, and usually cause substantial impairment requiring disability status. Prognosis is very good for both, although treatment compliance is especially important, and the risk of future episodes is especially high for Mania.

Many patients are unhappy, yet do not meet criteria for medication-responsive depression or anxiety disorders. Uncomplicated bereavement and demoralization can happen in a variety of settings. Reassurance and emotional support can be quite helpful. When sadness does not diminish over time, or when symptoms of depression do develop, more specific treatment may be indicated. Importantly, the presence of an obvious cause for unhappiness does not mean that "understandable" depressive symptoms should be ignored. For example, Major Depression after a serious illness is commonplace, but should always be carefully diagnosed and treated.

Conclusion

Occupational mental health professionals are the first line for diagnosis and treatment of workplace-related depression. Depression is a commonplace and readily treatable condition. Undiagnosed and untreated depression (and seeming depression) leaves employees in distress, but also incurs such productivity costs as increased absenteeism, presenteeism, and utilization of medical care for physical illness, among others. Fortunately, specific differential diagnosis and optimal treatment will typically effect full remission of depression.

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