Depression

Discussion paper prepared for

The Workplace Safety and Insurance Appeals Tribunal

September 2008
Revised: July 2013

Prepared by:

Dr. Emmanuel Persad
Counselor, WSIAT

Dr. Emmanuel Persad graduated from the University of Durham, England in 1964. He received his post-graduate training in Psychiatry at the University of Toronto from 1966 to 1969. He was granted his Fellowship in Psychiatry in 1972. He was awarded a Gold Medal in Psychiatry from the University of Toronto where he served as faculty until 1988. He then joined the Faculty at Western University and was Chairman of the Department of Psychiatry from 1994 to 2001. He is an Adjunct Professor at Queen’s University and a Professor at the Northern Ontario School of Medicine. His clinical and research interests were in Mood Disorders, and he has published widely in that area. He is currently a consultant at the Markham-Stouffville Hospital. He serves on the Consent and Capacity Board of Ontario. Dr. Persad was an Assessor for the Tribunal from 1991 to 2002.

This medical discussion paper will be useful to those seeking general information about the medical issue involved. It is intended to provide a broad and general overview of a medical topic that is frequently considered in Tribunal appeals.

Each medical discussion paper is written by a recognized expert in the field, who has been recommended by the Tribunal’s medical counsellors. Each author is asked to present a balanced view of the current medical knowledge on the topic. Discussion papers are not peer reviewed. They are written to be understood by lay individuals.

Discussion papers do not necessarily represent the views of the Tribunal. A vice-chair or panel may consider and rely on the medical information provided in the discussion paper, but the Tribunal is not bound by an opinion expressed in a discussion paper in any particular case. Every Tribunal decision must be based on the facts of the particular appeal. Tribunal adjudicators recognize that it is always open to the parties to an appeal to rely on or to distinguish a medical discussion paper, and to challenge it with alternative evidence: see Kamara v. Ontario (Workplace Safety and Insurance Appeals Tribunal) [2009] O.J. No. 2080 (Ont Div Court).
**DEPRESSION**

**Introduction**

Depression is a commonly used word to describe a mood (sad), a reaction (getting bad news) or a Disorder (a clinical syndrome). This paper addresses the category of Depressive Disorders. Such disorders are diagnosed on the basis of internationally agreed upon criteria (ICD 10 or DSM 5*). These disorders are defined as disturbances of mood accompanied by difficulties in thinking (slowed down), behavior (withdrawn or agitated), and inability to perform activities of daily living. Depressive Disorders can occur as single episodes or as recurrent episodes. A diagnosis is made if the symptoms last for two weeks or more. If not treated, the disorder can affect the person for months or years and could lead to acts of self harm.

This paper deals with the following features of depression:

- Prevalence in the community and in the workplace
- Co-morbidity
- Causation
- Adjudication issues
- Treatment

**Prevalence**

Depression occurs across all cultures and is an important global public health problem with a life time prevalence of 2% - 15% varying from country to country. (Prevalence is defined as the percentage of people who report having had an episode of a disorder at some point in their life). It is rated as the 4th leading cause of disability and is projected to be the 2nd leading cause of disease burden after heart disease by 2020\(^1\). Disease burden is the impact on a society of the social and economic costs of the disease. Depression is responsible for significant disability and death. Approximately 15% of people who suffer from depression are likely to commit suicide. It occurs throughout the life span. According to the Canadian Community Health Survey\(^2\), the life time prevalence of Depression in Canada is 12.2%. The prevalence of Depression was not related to level of education but was related to having a chronic medical

---

condition such as heart diseases, arthritis, diabetes and stroke, unemployment, and lack of income. Married people had the lowest prevalence. Most of those affected by Depression are in the age group of 25 to 64 years. In the older age group Depression is often accompanied by chronic medical conditions. It is felt that greater awareness of Depression leads to more people seeking professional help and therefore higher rates are reported in the developed countries. This issue requires greater study.

Depression as a workplace issue is relatively common. With an estimated 10 million Canadians in the workforce, Canada loses approximately 35 million work days per year due to poor mental health\(^{(3)}\). Depression and Anxiety Disorders cause more work absences than any other medical condition. Studies have found that some specific workplace issues are likely to contribute to the onset and/or perpetuation of Depression. These include poor morale, perceived unreasonable demands, loss of control of one’s work environment and perceived criticism. The question is, why do not all people exposed to these workplace stressors become depressed? The (likely) answer is that some people, by reason of genetic disposition, personality and/or previous life experiences, are more vulnerable to these workplace stressors. Even though millions of dollars are spent in treating Depressive Disorders in Canada, many individuals who suffer from Depression do not receive adequate care because of lack of service, undiagnosed Depression or lack of motivation to seek help. Lack of access to psychiatric services might be a barrier to treatment, but it is known that Depression can be effectively treated in primary care settings by family doctors\(^{(4)}\).

Co-Morbidity

This refers to the co-occurrence of two or more clinical disorders. Depression as a clinical disorder can co-occur with Anxiety Disorders, substance abuse, physical or medical illnesses, Post Traumatic Stress Disorder and chronic pain. Some less well established conditions, i.e. without solid clinical evidence, which co-occur with Depression are Chronic Fatigue Syndrome, Fibromyalgia, Borderline Personality Disorders and the dementias. Pseudo-dementia is a condition in which a depressed patient presents with symptoms of dementia. The diagnosis can be clarified through an in-depth assessment and with the use of cognitive testing.

How Depression is Diagnosed

The Diagnosis of Depression requires a full Psychiatric assessment aided by a complete understanding of the individual’s medical history, social and cultural background. The Psychiatric report should attempt to place the psychiatric symptoms and diagnosis in the context of the individual’s life circumstances. This will be elaborated upon later.
Rating Scales

A variety of rating scales are available for clinical use. They can augment the clinical assessment but cannot replace it. They can be useful screening devices. These scales (Montgomery-Asberg, the Burns or the Hamilton Depression Scales) can provide an indication of severity. Self administered rating scales (e.g. the Beck Rating Scale) can help patients assess their mood on a daily basis. Rating scales, both the self administered and the ones completed by clinicians, have limited applications. They provide a score which can be an index of severity and can reflect change over time.

Depressive Disorder

Five or more of these symptoms should be present for at least a two week period according to the current classifications such as the DSM 5 and the ICD 10.

- Depressed mood all or most of the day
- Diminished interest
- Significant weight loss/gain
- Insomnia or hypersomnia
- Agitation or retardation
- Fatigue or loss of energy. In some cultures somatic or physical symptoms such as pain, loss of drive are more common.
- Feelings of worthlessness, guilt
- Diminished ability to think or concentrate
- Recurrent thoughts of death and suicide

Depressive Episode - Recurrent

Same as Depressive Disorder above, but the individual may have discrete recurrent episodes which occur at varying intervals. Treatments are available to prevent recurrences.

Depression as part of a Bipolar Mood Disorder

Mood Disorders include two main clinical types: Unipolar (Depression only) and Bipolar (Depression alternating with mania or hypomania). Mania is a mood state in which the affected individual experiences elation, euphoria or irritability. This is
accompanied by increased physical activity, lack of the need for sleep, and poor judgment leading to social indiscretions. Some of these individuals may become psychotic: that is, out of touch with reality. Some individuals who suffer from a Bipolar Mood Disorder can experience “mixed states”. In these states, the individual may experience symptoms of both depression and mania at the same time. That is, they report being energized, but depressed, and they appear as restless and agitated. In the depressive phases of a Bipolar Disorder, the symptoms are the same as for the Depressive Disorders. However, some individuals who are Bipolar experience symptoms such as overeating and oversleeping during the depressive episodes. Occasionally, antidepressants can precipitate episodes of hypomania (less severe) or mania. It is unusual for a workplace event to “cause” a Bipolar Disorder. However, as with Depression, a workplace event can contribute to the onset of the disorder.

Depression as part of Seasonal Affective Disorder (S.A.D.)

Depression can also occur as part of Seasonal Affective Disorder. S.A.D. is characterized by the occurrence of depression in the fall and winter months in the Northern Hemisphere. The symptoms include lethargy, overeating and oversleeping. There is usually a spontaneous remission in the spring. Hypomanic episodes (a less severe form of mania) may also follow the depressed episodes.

Dysthymia

Dysthymia is a type of Depressive Disorder which is longstanding and lasts for several years. Dysthymia is a depressive condition in which the affected individual may feel depressed but is able to function. The following features are usually present: poor appetite or overeating, insomnia or oversleeping, low energy, low self esteem, poor concentration. The symptoms are less severe and these are individuals who may report “I have never been happy”. Dysthymia is the new term for “Depressive Neurosis” (See Appendix 1).

Adjustment Disorder with Depression

An Adjustment Disorder refers to the development of emotional or behavioral symptoms in response to an identifiable stressor occurring within three months of the onset of the stressor. Bereavement is excluded. Adjustment Disorders can present with a depressed mood, with anxiety or with disturbance of behavior. The symptoms of Depression in an Adjustment Disorder are less severe and relate to a specific stressor. Stressors could include workplace related problems, relationship problems, or dealing with a terminal illness. The symptoms would not meet criteria for a Depressive Episode.
Other Depressive Disorders

Depressive Disorders can occur in the context of specific life events: e.g. Post Partum onset (after childbirth), or as co-morbid (see paragraph above) with Post Traumatic Stress Disorder or Chronic Pain. Also, Depressive Disorders can occur as a result of a medical condition, e.g. diabetes or cancer. A diagnosis of Depressive Disorder or Episode is made after a thorough clinical assessment which will include a full psychiatric history and mental state examination.

The diagnosis of Depression may change over time in the same individual and additional features might appear. These can include psychotic or chronic features. The former applies when the affected individual experiences loss of touch with reality; the latter term is used if the episode persists for more than two years.

What Causes Depression

There is no single factor responsible for Depressive Disorders or other Mood Disorders. However, several factors may contribute to the development of a Depressive Disorder. It is no longer thought that they arise simply from a “biochemical problem” in the brain.

Predisposing factors (i.e. factors which contribute to the person’s vulnerability to Depression) include family history of Depression, physical abuse, sexual abuse, Substance Abuse Disorders, and trauma. The elderly may be vulnerable, but as noted above, this is usually associated with chronic medical conditions.

Precipitating factors (i.e., factors which were related to the onset of Depression) may or may not exist. Episodes (i.e. periods in which the person is suffering from a Depressive Disorder), especially if they are the recurrent form, can occur spontaneously. For adjudication purposes the workplace event or the sequelae may be claimed as resulting in Depression. As a stressor, such events may serve as a precipitant, but in most cases, there are predisposing factors. This applies to Bipolar Mood Disorders as well. The adjudicator has to weigh whether the workplace event was a significant contributor. In some cases no predisposing factors can be identified, and the adjudication then revolves around the nature of the psychological, social, and economic impact of the workplace event.

Perpetuating factors can include lack of diagnosis, lack of adequate treatment, chronic stress, severe medical illnesses, chronic pain or other psychiatric conditions. Chronic stress in the workplace such as perceived harassment, unequal opportunities and shift work may not be compensable.

A Psychiatric report should provide a comprehensive account of all the factors which may be contributing to an episode. In most instances, the diagnostic formulation will indicate that the individual who becomes depressed may have had an inherited
predisposition but external factors as noted above precipitated and perpetuated episodes of Depression.

**Adjudication and Workplace Issues**

The following statement is taken from a conference held in 2008 in Edmonton. Consensus Statement on Depression in Adults, Alberta Health Services, 2008(5).

“Mental health problems are often first noticed by others at work. There is a growing recognition that depression has a significant impact on workplace productivity, yet Canadian employers are only now beginning to understand the importance of depression in the workplace and how to deal with it. Misperceptions and lack of knowledge about depression may lead to a poisoned work environment. Many employers fear that the productivity of the depressed employee, even when recovered, will be reduced in the future. Co-workers are often uncomfortable around the employee with depression. In addition, because of stigma and the lack of a supportive work environment, the depressed worker may not seek help. As a result, the impact on employees and employers is needlessly high. Informed employers can put in place structures and policies that facilitate early intervention and a healthy workplace. This would substantially reduce the cost of depression to the employer.”

For the adjudicator, a non supportive workplace is not in itself compensable. However, it is necessary for this aspect of a claim to be included in the analysis of claims.

The Mental Health Commission of Canada has also issued a position paper on Depression and the workplace(6). The Commission notes the staggering financial burden and calls attention to the stigma which discourages workers from talking to their employers and end up as “silent sufferers”, adding to loss of productivity.

Adjudication of claims for Depression often presents a challenge for the Tribunal. This challenge exists because of the lack of specificity in medical reports carrying a diagnosis of Depression.

A medical report should include a Psychiatric assessment and a diagnostic formulation as per the DSM 5 or the ICD 10.

The introduction of the 5th Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 5) in May 2013 carries significant changes which will, in time, be reflected in Psychiatric reports. These are some of the changes in the DSM 5 as compared with the DSM IV.

- The elimination of the Multi-axial system.
• All Diagnoses, i.e. the first 3 Axes in the DSM IV have been replaced by one list that contains all mental disorders including Personality Disorders, intellectual ability and medical diagnoses.

• The Global Assessment of Functioning Scale (GAF) i.e. Axis V has been eliminated.

• The DSM 5, Section III, includes separate measures of symptoms, severity and disability. This is consistent with the World Health Organization’s (WHO) International Classification of Impairment, Disabilities and Handicap.

In the assessment of a worker claiming for Depression, an assessor in Psychiatry would enquire into the worker’s personal history, including the emotional and developmental history, family history, educational and vocational histories as well as coping abilities. A comprehensive inquiry into the symptoms, duration, severity, daily variation of mood, interpersonal relationships and self harm thoughts, if any, would be included in such an assessment. A Psychiatric report would carefully weigh the contributions from several of the injured worker’s life’s domains including the workplace and provide a diagnostic formulation as per the DSM 5 system. It should be noted that the diagnostic procedure relies a great deal on the subjective reporting by the affected individual, but the mental state examination can provide some objectivity to the subjective reports. The reliability of the patient is often a challenge; therefore, collateral information from significant others does help in the diagnostic procedure. It is not unusual that psychiatric reports lack the precision found in other medical reports where the disorder or pathology is validated by objective tests. However, a report which does not provide an analysis of the individual’s presentation and the rationale for a diagnosis should carry less weight. Reports from clinical Psychologists are usually based on standardized tests and are valid for adjudication purposes. They should include a history and an examination of the individual and an analysis of corroborative information. Such reports use the same Diagnostic classification such as DSM 5.

Treatment

Treatment for Depressive Disorders can be effective. Treatment usually combines medications (antidepressants/mood stabilizers), psychotherapy, and lifestyle changes. Antidepressants fall into the chemical classes of cyclic antidepressants and Mono-Oxidase Inhibitors. The former group includes Serotonin Re-uptake Inhibitors and Selective Serotonin Norepinephrine Re-uptake Inhibitors. Older antidepressants are used less frequently. Response to antidepressants can take four to six weeks. All antidepressants have side effects, including weight gain and sexual dysfunction. Ongoing treatment with medication and/or psychotherapy may be necessary to prevent relapse and recurrences. Some depressed patients do not respond to treatment. They are then said to have chronic features: that is, often over two years of no response. Some patients appear never to recover completely and, in these
Depression situations, questions about adequacy of treatment, chronic stress and comorbid conditions need to be addressed. Such patients may require expert help from centers which specialize in Mood Disorders.

There are various forms of psychotherapy for Depression. Cognitive behavioral therapy and interpersonal psychotherapy are well established forms of psychotherapy which require specialized training.

Electroconvulsive therapy (ECT) remains an effective, infrequently used treatment for Depression\(^{(8)}\). Debates in the public domain and in the media tend to portray ECT in negative terms. In some situations, it can be life saving. ECT is administered under a general anaesthetic. An electrode is placed on the head of the patient and an electric current is passed through the brain. The convulsion caused by this is modified by muscle relaxant drugs. The actual procedure takes 3 - 4 minutes. A recent treatment is Repetitive Trans-cranial Magnetic Stimulation, but its effectiveness is still being studied.

Photo therapy or Light therapy has been used by individuals who suffer from Seasonal Affective Disorders. This may be used in conjunction with antidepressants.

See Appendix 2 for a summary of commonly used treatments for Depression.

The DSM 5 and other recent comments about the assessment, diagnosis and treatment of Psychiatric disorders emphasize the importance of cultural relevance. This includes the cultural identity of the individual, cultural conceptualizations of distress, cultural factors of vulnerability and resilience, and especially the cultural features of the relationship between the clinician and the patient. These factors must be kept in mind in seeking an assessment or treatment for an individual.

**Summary**

Depression is a treatable disorder which affects between 2% to 15% of the adult population in most developed countries. Some studies suggest that the rates of Depression are increasing. Depression is a major reason for workplace absences. Depression causes significant impact on the affected individual’s personal, social, family and vocational life and can lead to suicide.
Appendix I

The following terminology changes should be noted:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Neurosis with Depressive Features</td>
<td>Anxiety Disorder</td>
<td>Same</td>
</tr>
<tr>
<td>Anxiety Neurosis with Psychosomatic Manifestations</td>
<td>Somatoform Disorder</td>
<td>Somatic Symptom and related Disorders</td>
</tr>
<tr>
<td>Conversion Neurosis</td>
<td>Conversion Disorder</td>
<td>Conversion Disorder (Functional Neurological Symptom Disorder)</td>
</tr>
<tr>
<td>Obsessive-Compulsive Neurosis</td>
<td>Obsessive- Compulsive Disorder</td>
<td>Same Hoarding Disorder added</td>
</tr>
<tr>
<td>Anxiety Neurosis with Phobic Features</td>
<td>Generalized Anxiety Disorder</td>
<td>Same</td>
</tr>
<tr>
<td>Anxiety Neurosis with Hypochondriasis</td>
<td>Hypochondriasis</td>
<td>Illness Anxiety Disorder included with Somatic Disorder Category</td>
</tr>
</tbody>
</table>

In DSM 5, Pain is now classified under the heading of Somatic Symptoms and Related Disorders and coded as follows: Somatic Symptom Disorder with predominant pain. Can be specified as persistent, and graded as mild, moderate and severe.

Appendix II

1. Principles in the selection of an Antidepressant:
   a. Previous response and side effects.
   b. Comorbidity
   c. Symptom profile
   d. Patient preference and compliance
   e. Costs

2. No antidepressant is more effective than another. The current practice is to begin with a Serotonin Reuptake Inhibitor such as Citalopram, Sertraline, or another drug from a different class, such as Venlafaxine or Wellbutrin. All antidepressants have side effects and a response is not usually seen for four to six weeks after initiation.
3. It is well established that antidepressants work best when augmented by other interventions such as lifestyle changes and psychotherapy.

References


Recommended


