Workplace Safety and Insurance
Appeals Tribunal

Tribunal d'appel de la sécurité professionnelle et de
l'assurance contre les accidents du travail

Depression

Discussion paper prepared for

The Workplace Safety and Insurance Appeals Tribunal

September 2008
Revised: July 2013
Revised: August 2020

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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 Discussion papers are not peer reviewed.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).

For more information about these papers, please consult the *WSIAT Guide to Medical Information and Medical Assessors*.

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 Major Depressive Disorders. Such disorders are diagnosed on the basis of internationally agreed upon criteria (International Classification of Diseases (ICD) 11th Edition.(2018) or the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM) 5th Edition. (2013).

In North America, the DSM 5 classification is used in practice rather than the World Health Organization's ICD 11. (See **Appendix I** for information about the changes of classification over time). The Depressive Disorders are defined as disturbances of mood accompanied by difficulties in thinking (slowed down), behaviour (withdrawn or agitated), and inability to perform activities of daily living.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 persist for two weeks or more and if the symptoms interfere with a person's ability to function. If not treated effectively and in a timely manner, the Depressive disorder can affect the person for months or years. Furthermore, ineffective treatment of a Depressive Disorder could result in 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 and work place issues
- Treatment

Prevalence:

Depression occurs across all cultures and is an important global public health problem with a life time prevalence of 2% to 15% varying from country to country. (Life time 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 can occur at any point throughout a life time. 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 found to be related to level of education, but was found to be related to having a chronic medical condition such as heart disease; arthritis; diabetes, stroke and unemployment as well as lack of income. Married people had the lowest prevalence of depression. Most of those affected by Depression are 25 to 64 years old. 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 there are higher rates of reporting of depression 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 about 35 million workdays 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 only some people exposed to some 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 to treat Depressive Disorders in Canada, many individuals who suffer from Depression do not receive adequate care because of lack of service, lack of diagnosis 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 treated effectively in primary care settings by family doctors. [4]

Co-morbidity:

Co-morbidity 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, those 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 and social and cultural backgrounds. The psychiatric report should attempt to place the psychiatric symptoms

and diagnosis in the context of the individual's life circumstances. This idea will be elaborated upon later.

Rating Scales:

A variety of rating scales are available for clinical use. Rating Scales can augment the clinical assessment but cannot replace it. They can be useful screening devices. These Depression scales include the Patient Health Questionnaire-9 (PHQ-9), the Beck Depression Inventory (BDI), the Montgomery-Asberg Depression Rating Scale, the Burns Depression Checklist and the Hamilton Depression Scale. These scales are helpful in providing an indication of severity. Self-administered rating scales (e.g., the BDI and the PHQ-9 Scales) can help patients assess their mood daily. Rating scales, both the self-administered and the ones completed by clinicians, have limited applications. They are most useful as providing an index of severity and reflecting change over time.

Major Depressive Disorder:

In DSM 5, a diagnosis of Major Depressive Disorder (MDD) requires that there must be: five or more of the following nine symptoms, present for the same two week period with a change from the previous level of functioning; at least one of the symptoms is either(1), depressed mood or (2),loss of interest or pleasure.

1. Depressed mood all or most of the day, nearly every day as indicated by either subjective report (e.g. feels sad, empty, hopeless) or observation made by others (e.g. appears tearful, withdrawn.)

2. Diminished interest or pleasure in all or almost all activities most of the day, nearly every day

3. Significant weight loss or gain or decrease or increase in appetite nearly every day

4. Insomnia or hypersomnia nearly every day

5. Agitation or retardation nearly every day

6. Fatigue or loss of energy nearly every day

7. Feelings of worthlessness, guilt or excessive or inappropriate guilt nearly every day

8. Diminished ability to think or concentrate or indecisiveness nearly every day

9. Recurrent thoughts of death and suicide (not just fear of dying) and recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

For a diagnosis, the symptoms must cause clinically significant distress or impairment in social, occupational or other important areas of functioning and the Depressive episode cannot be due to the physiological effects of a substance or to another medical condition. There must also not have been a manic or hypomanic episode, a history of which suggests a diagnosis of a Bipolar Affective Disorder (formerly known as manic-depressive illness).

An individual may have discrete recurrent depressive 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 who suffer from a Bipolar Mood Disorder can experience “mixed states”. In these states, individuals 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 of Depression are the same as those found in Unipolar 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 form of Bipolar) 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 in a vulnerable person with a history of a bipolar disorder.

First line treatments for the Depressive phase in a Bipolar disorder include atypical antipsychotics rather than antidepressants which are typically ineffective for bipolar Depression.

Depression as part of Seasonal Affective Disorder (SAD):

Depression can occur as part of Seasonal Affective Disorder. SAD 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.

Persistent Depressive Disorder (PDD):

This term has replaced the category-Dysthymic Disorder and Chronic Major Depressive Disorder.

The symptoms of Persistent Depressive Disorder (PDD) are: Mood is depressed for most of the day, for more days than not, as indicated by either subjective account or observation by others, for at least two years.

While Depressed there must be two or more of the following:

1. Poor appetite or overeating
2. Insomnia or hypersomnia
3. Low energy or fatigue
4. Low self esteem
5. Poor concentration or difficulty making decisions
6. Feelings of hopelessness.

Major Depressive Disorder (MDD) may precede Persistent Depressive Disorder (PDD) and major depressive episodes may occur during PDD. Individuals whose symptoms meet MDD criteria for 2 years are given a diagnosis of PDD as well as MDD.

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. Normal bereavement is excluded.

Adjustment Disorders can present with depressed mood, anxiety, mixed anxiety and depressed mood, and with disturbance of conduct or behaviour. The symptoms of Depression in an Adjustment Disorder are less severe and relate to a specific stressor. There is marked distress that is out of proportion to the severity or intensity of the stressor. Stressors could include workplace-related problems, relationship problems, or dealing with a terminal illness. The symptoms do not meet the criteria for a Depressive Episode. Once the stressor or its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

Other Depressive Disorders:

Depressive Disorders can occur in the context of specific life events: e.g. Post-Partum onset (after childbirth), or as co-morbidity (see paragraph above) with Post Traumatic Stress Disorder or Chronic Pain. Depressive Disorders can also occur

as a result of a medical condition, for example, 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 symptoms of a Major Depressive Disorder may change over time in the same individual and more features might appear including psychotic and chronic symptoms. Psychotic symptoms include loss of touch with reality and delusions. The diagnosis of a Persistent Depressive Disorder (see above) 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 and it is no longer thought that they arise simply from a "biochemical problem" in the brain.

The cause of Depressive Disorders is considered multi factorial. There are the four Ps of Mood Disorders: Predisposing, Precipitating, Perpetuating and Protective Factors

Predisposing factors (factors contributing to a 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 (factors 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 the recurrent form, can occur spontaneously. For adjudication purposes the workplace event or the sequelae may be claimed as resulting in Depression. As stressors, 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 accordance with relevant policy and legislation. 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 (factors that prolong and perpetuate the symptoms of Depression), can include lack of an accurate 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 under applicable WSIB policies.

Protective Factors (factors that help prevent or reduce symptoms of Depression. These factors can promote recovery as well), include a strong family support system, access to excellent and timely care and a supportive work environment.

A Psychiatric report should provide a comprehensive account of all the factors that 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. It appears in the Consensus Statement on Depression in Adults.[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 work place 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".*

It is up to the adjudicator to determine how to assess the role of a non-supportive workplace in the analysis of a claim.

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 that discourages workers from talking to their employers leads to their becoming "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.

The introduction of the 5th edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 5) in May 2013 brought significant changes that 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. Prior to the DSM 5 the Psychiatric assessment involved 5 areas or axes of investigation. Each axis described a different area of information. Axis 1 included the clinical disorders. Axis 2 included Personality disorders and Mental Retardation. Axis 3 included general medical conditions. Axis 4 included Psychosocial and environmental problems. Axis 5 was a calculated score reflecting a global assessment of functioning (a GAF score)

- 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) Axis 5 has been eliminated.

- The DSM 5, Section III, includes the World Health Organization's (WHO) Disability Assessment Schedule 2.0 ("WHODAS") The WHODAS is a self-administered 36 Item measure that assess disability in adults 18 years and older.

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 domains, including the workplace, and provide a diagnostic formulation as per the DSM 5 system.

It should be noted that the diagnosis 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. 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), psychotherapy, and lifestyle changes. Almost all antidepressants fall into the chemical classes of Selective Serotonin Reuptake Inhibitors (SSRIs), Serotonin Norepinephrine Reuptake Inhibitors, (SNRIs), Tricyclic Antidepressants (TCAs) and Mono-amine oxidase Inhibitors (MAOIs). Another antidepressant, Wellbutrin, alters the transmission of dopamine and norepinephrine and is known as a dopamine norepinephrine modulator (NDM). The tricyclic antidepressants (e.g. such as amitriptyline), are older antidepressants, which are used less frequently because of their greater side-effect burden and their greater toxicity when taken as an overdose.

Response to antidepressants can take four to six weeks. All antidepressants have side effects, including weight gain and sexual dysfunction.[7] However, differences in side effect profiles exist and medications are often chosen based on side effect burden. Ongoing treatment with medication and/or psychotherapy may be necessary to prevent relapses and recurrences. The course of Major Depressive Disorder is quite variable with some individuals not responding to treatment but rather developing a chronic depressive illness. When patients appear never to recover completely, questions about adequacy of treatment, chronic stress and co-morbid conditions need to be addressed. Chronicity of depressive symptoms substantially increases the likelihood of underlying personality, anxiety and substances use disorders. Such patients may require expert help from centres that specialize in Mood Disorders.

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

Electroconvulsive therapy (ECT) remains an effective, infrequently used treatment for Depression.[8],[9] 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 procedure takes 3 to 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 II** 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 concept encompasses 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% and 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. It causes significant impact on the affected individual's personal, social, family and vocational life. It can lead to suicide.

Appendix I

DSM III R (1996)	DSM IV TR (2000)	DSM 5 2013
Anxiety Neurosis with Depressive Features	Anxiety Disorder	Same
Anxiety Neurosis with Psychosomatic Manifestations	Somatoform Disorder	Somatic Symptom and related Disorders
Conversion Neurosis	Conversion Disorder	Conversion Disorder (Functional Neurological Symptom Disorder)
Obsessive-Compulsive Neurosis	Obsessive-Compulsive Disorder	Same, Hoarding Disorder added
Anxiety Neurosis with Phobic Features	Generalized Anxiety Disorder	Same

DSM III R (1996)	DSM IV TR (2000)	DSM 5 2013
Anxiety Neurosis with Hypochondriasis	Hypochondriasis	Illness Anxiety Disorder included with Somatic Disorder Category

In DSM 5, Pain Disorder is now classified under the heading of "Somatic Symptom and Related Disorders" and coded as follows: Somatic Symptom Disorder with predominant pain. It can be specified as persistent, (if present for more than 6 months) and graded as mild, moderate, or severe.

Appendix II

1. Principles in the selection of an Antidepressant:

    a. Previous response and side effects.
    b. Co-morbidity
    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 Selective Serotonin Reuptake Inhibitor (SSRI) such as Citalopram, Sertraline, or another drug from a different class, such as Venlafaxine (an SNRI) or Wellbutrin (an NDM). All antidepressants have side effects and a response is not usually seen for four to six weeks after initiation.

3. Augmenting medications are sometimes prescribed to boost the response of an antidepressant. Such booster agents include Lithium and atypical antipsychotics (e.g aripiprazole).

Appendix III

The following questions were submitted by the OICs:

1. **Is there a distinction between "Depression" and "Depressive disorder"?. A short statement would be helpful to explain any difference in substance or usage.**

Terms such as Major Depression, Major Depressive Disorder and Depressive Disorder may be used interchangeably in clinical reports. According to the DSMs IV and 5 the most appropriate term is Major Depressive Disorder. There are specific criteria

required to support such a diagnosis. The term “Depression” may appear in reports as a symptom of Major Depressive Disorder and “depression” may also be a symptom of other disorders.

2. When is Depression likely to cause lost time from work?

Depression as a symptom is not likely to cause lost time from work. Lost time from work by an individual diagnosed with a Major Depressive Disorder (MDD) will depend on several factors, such as the severity (mild to severe). Some forms of MDD may be associated with other conditions for example Chronic Pain, which can impact functioning. Moderate to severe forms of MDD can affect the cognitive functioning of the individual which will compromise functioning at work.

3. When is pain likely to be a factor in the development of Depression?

There is a category in the DSM 5 called “Depressive Disorder due to another medical condition”. “The essential feature of a MDD due to another medical condition is a prominent and persistent period of depressed mood or markedly diminished interest or pleasure in all, or almost all activities that predominates in the clinical picture and is thought to be related to the direct physiological effects of another medical condition”. (DSM 5 pg. 181). There must be evidence that the mood disturbance is temporally associated with the Chronic Pain, that is, the MDD did not predate the diagnosis of Chronic pain. Pain Disorder as a condition in DSM IV is no longer listed in DSM 5. In DSM 5 “Somatic symptom Disorder describes patients who complain of one or more somatic symptoms that are distressing or result in significant disruption of daily life”. The diagnosis of “Pain Disorder” (DSM IV) has been replaced in DSM 5 with “Somatic Symptom Disorder with predominant Pain”. MDD and Pain Disorder/Somatic Symptom Disorder with predominant pain can co-exist. In these instances, adjudication will be determined by the respective policies.

4. It appears that some psychological testing directly asks the respondent whether he or she feels for example sad, hopeless. What weight should be given to such reports compared to a more comprehensive psychiatric assessment?

The Diagnosis of MDD is based on the presence of 5 (or more) specific symptoms (see above). The latter include subjective responses such as pervasive depressed mood, loss of interest and insomnia. Objective symptoms include sad or depressed facial expression, tearfulness, weight loss or gain, very slow movements and cognitive changes. It is essential that the mental status examination validate the respondent’s symptoms both subjectively and objectively. Psychological tests for MDD are based on the DSM criteria.

5. Status of the General Assessment of Functioning Scale (GAF).

In the DSM IV the Diagnoses were provided on a Multi axial system.

Axis 1. The predominant clinical condition e.g. MDD

Axis 2. Personality disorder and Mental Retardation.

Axis 3. General Medical conditions.

Axis 4. Psychosocial issues e.g. marital discord and environmental problems.

Axis 5. The GAF Scale. (0-100)

The DSM 5 abandoned this system including the GAF. Many experts believe that the GAF has little clinical validity. It is difficult to calculate the appropriate GAF score to reflect the level of disability. GAF scores should be interpreted with great caution. DSM 5 suggests the use of the World Health Organization's Disability Assessment Schedule 2.0 (WHODAS 2.0) (see above).

6. What weight should be given to health practitioners, for example reports from non psychiatric psychologists, counsellors, social workers, family doctors?

Reports from Psychologists are usually based on the same diagnostic criteria as those used by Psychiatrists. Reports from Psychiatrists should be thorough and detailed and should reflect an in-depth understanding of the patients' entire life history. These reports should provide a fulsome discussion of the patient's predisposing, precipitating, and perpetuating circumstances. Unlike Psychologists, the Psychiatrist is best positioned to address the impact of organic or other medical conditions on the patient. Most other mental health practitioners are not permitted to make diagnoses and usually work under the supervision of a Psychiatrist.

Reports from Family Doctors may be the only reports available. In those situations, any Psychiatric diagnosis must be based on the same criteria used by Psychiatrists and Psychologists. In Australia, reports from family doctors are given the same weight as those from Specialists by work place adjudicators.

7. Some Psychiatric reports refer to "adequacy of treatment". Where a condition does not resolve after, for example two years of treatment, should the adequacy of treatment be considered a factor in the development of the worker's condition? What factors make a patient refractory to treatment?

The most important step in the treatment of ANY medical condition is applying a correct diagnosis. This is especially true in Psychiatry where mis-diagnosis is not unusual. The situation is further complicated by the fact that that there may be two

or more diagnoses present at the same time. This is known as “co-morbidity”. Thus, it is vital that prior to evaluating “adequacy of treatment”, we must be certain that the diagnosis is accurate. For example, treatment with antidepressants will never cure a person whose Depression is associated with a toxic work environment, or a difficult relationship, nor a person who is feigning symptoms or a person whose Depression is part of a Bipolar Mood Disorder. Bipolar patients require, not antidepressants, but mood stabilizers. There are treatment guidelines for Major Depressive disorders (MDD). Physicians should be aiming for good response to the best treatment and expect a response in weeks, not months. Most antidepressants are equally effective when used at an adequate dose and for a sufficient duration, that is at least six weeks. At that point the treatment should be reassessed and other interventions would be considered generally. An important step in the effective treatment of MDD is returning the person to the workplace as soon as possible, preferably on a graduated basis. Some patients with MDD may show treatment refractoriness. Warning signs of refractoriness include inadequate treatment or delayed treatment, incorrect diagnosis, non-compliance with treatment, a toxic work place or the presence of co-morbid conditions.

8. What cultural factors affect the presentation and assessment of Depression?

In several non-Western Cultures, Depression can present with somatic complaints such as pain, fatigue, dizziness, palpitations and sleep disturbances. However, the psychological symptoms of Depression can be elicited with careful enquiry. It is no longer felt that Somatoform disorders in non-industrialized countries are the cultural equivalent of Depression. Recent studies suggest that in all countries somatic symptoms are prominent in Depression. As well, in all cultures Depression is commoner in women and in those with low socio-economic status. In some cultures, for example, Eastern cultures, shame and stigma can influence the experience of Depression and the motivation to seek help.

When a Psychiatric report provides a Diagnosis of a Major Depressive Disorder it should include comments on relevant cultural factors. The latter can certainly influence response to treatment.

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