International Handbook of Occupational Therapy Interventions

Chapter 39
Reintegration to Work of People Suffering from Depression

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Employees suffering from depressive disorder, treated by occupational therapy, increase their chances of going back to work again.

Abstract Employees suffering from depression have a high risk of becoming unemployed. A combination of treatment focused on depression and on work rehabilitation is effective. Occupational therapy and the Program for Mood Disorders at the Department of Psychiatry of the Academic Medical Centre in Amsterdam, The Netherlands, have developed three modules focused on work reintegration for clients suffering from depression. The modules have been investigated in a randomized controlled trial and seem to be effective in work reintegration.

Keywords Depression • Occupational rehabilitation • Work

Definitions

According to the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition, major depressive disorder (unipolar depression) "is influenced by both biological and environmental factors." It is characterized by the symptoms "depressed mood (such as feelings of sadness or emptiness), reduced interest in activities that used to be enjoyed, sleep disturbances, significant reduction in energy level, *cognitive impairments*, i.e., difficulty concentrating, holding a conversation, paying attention, or making decisions that used to be made fairly easily, suicidal thoughts or intentions" (American Psychiatric Association, 2000).

Work is a paid daily activity (Jacobs, 1991). *Work restarting* means that employees start working after a period of absenteeism caused by a depressive disorder.

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Background

Absenteeism from work is related to mental health problems in about 30% of cases. Of these, about one third are caused by mood disorders, especially depression (Schene et al., 2007). Depression causes absenteeism from work and, even more important, *presenteeism*, that is, loss of productivity while the employee is still at work but impaired by his or her mental health symptoms.

Work and depression have a complex relationship. Work-related problems can be one of the determinants of depression, while depression impairs work functioning and therefore contributes to problems or dysfunction in the work setting. The work burden plays a role in the pathogenesis of depression.

Work burden is determined by (1) the physical work load, that is, the *job strain*; (2) *psychological demands*, such as stress-factors at work; (3) the worker's *decision latitude* for organizing and take control over his or her work performances; and (4) available *social support* of colleagues, management, and the social support system around the worker (Bakker, 2003; Karasek and Theorell, 1990; Rasker et al., 2005).

A high work load in combination with a stressful home situation causes a higher risk of getting depressed (Croon et al., 2000). People with depression suffer more often from a lack of social support or are victims of bullying (de Roos and Sluiter, 2004). A self-perception of belonging to a lower status career and less capacity to fit into the work organization contributes to a higher risk of depression (de Roos and Sluiter, 2004).

In contrast, presenteeism may provoke problems at work caused by the following:

- *Cognitive limitations*, characterized by problems in concentrating on the work tasks, planning the performance of the work tasks, and limited capability to cope with complex stimuli.
- *Emotional restrictions cause* feelings of inferiority and guilt, and loss of interest and initiative. These symptoms create problems in executing daily activities at work, for example, accepting too much work while having difficulties in solving problems.
- *Social restrictions* are difficulties in dealing with colleagues, which are caused by a lower mood, introverted behavior, or social anxiety of the employee with a depression.

The interventions for the above problems are the following: (1) the focus for clients with *depression and work relationship problems* is on the clients' cognitive, emotional, and social restrictions; and (b) the focus for clients who are *restarting work* is on the issues of work load, capacity to organize, social support, and perspective of the client's role in the organization.

Purpose

The main purpose of the intervention is to enable clients to restart work as soon as possible and to function with more satisfaction. Being ready to restart work increases the chances of being employed, and clients suffering from depression

who have restarted work report fewer symptoms of depression compared with clients who did not start working (de Vries et al., 2002).

Method

Candidates for the Intervention

The intervention is aimed at adult clients with depressive disorder, who are able to function in a work environment for a few hours a week. Excluded are clients with a psychotic depression or those who abuse alcohol or drugs.

Epidemiology

Mental disorders, particularly depression, are the most frequent source of occupational disability worldwide and are expected to increase. Employers are increasingly aware of the productivity costs associated with mental disorders and the importance of fostering a mentally healthy work force (Stuart, 2007). The total economic burden of depression in the year 2000 in the United States was $83.1 billion. Of this total, $26.1 billion was direct medical costs, $5.4 billion was suicide-related mortality costs, and $51.5 billion was workplace costs ($36.2 billion work absenteeism and $15.3 billion presenteeism) (Greenberg et al., 2003).

Depression was the third highest total cost of medical conditions studied that affected U.S. employees. Only hypertension and heart disease were more costly (Goetzel et al., 2004). For example, U.S. Air Force workers ($n = 209$) who reported depression symptoms were on sick leave significantly more days (2.0 days for any depression symptoms, 4.7 days for severe depression symptoms, vs. 0.15 days for no depression) (Planz, 2006).

Almost 4% of employed people of ages 25 to 64 had had an episode of depression in the previous year. Cross-sectional analysis indicates that these workers had high rates of reducing work activity because of a long-term health condition, having at least one mental health disability day in the past 2 weeks, and being absent from work in the past week. Thus depression was associated with reduced work activity (de Vries et al., 2002).

Settings

The intervention is developed to use in a psychiatric hospital, but can be used in a work setting or in a work-training center. The main condition is the ability of the client to work a few hours in his or her former work setting.

Professionals Involved into the Process of Restart Work

Most important is the *clients'* responsibility for restarting their work, reintegration at work, and performance of work tasks. Apart from health care services, other services are involved in the work restarting process. This rehabilitation approach combines care and work.

The *employer* is responsible for reintegration at the work setting. The *occupational physician* of the company is responsible to ascertain whether the client is able to return to work. The *general practitioner* is responsible for some aspects of health care and prevention. Referral to a psychiatrist also occurs. The *social worker* or alternative health care practitioners are cooperating with the employer and the occupational therapist (OT). The *OT* recommends to the client one of the interventions focused on work. The initial role of the OT is to coordinate the involved professionals and to administer the rehabilitation program.

A reintegration process succeeds only if the people involved have a common goal. In such a situation, it is important to know who is responsible for each part of the process. Furthermore, all involved professionals are informed about the client's progress and the results of each professional's contribution. All involved professionals should agree that the plan is appropriate for the client.

Results

Clinical Application

Analysis of Working Problems

This part of the intervention focuses on investigating the client's patterns of working and determine which work tasks cause problems. The intervention consists of five individual sessions over a 4-week period and includes the following:

The *register and intake session* gives the client the opportunity to express his or her attitudes about work and willingness to restart working. The OT explains the content, options, and goals of the occupational therapy intervention.

Work anamnesis intervention is a consultation with the client in which the OT systematically analyzes the clients education and work history. The client's coping with stressful situations is especially noted.

The *video observation* entails recording the client's performance of work tasks in a simulated work situation. These recordings are discussed with the client regarding his or her experiences of the current work load, relationships with colleagues, and the appropriateness of the work. The main goals are to analyze the problems in the present work situation, and to ascertain if there is an ineffective pattern to the way the client copes with stressful situations.

Depression and the Work Relationship

This part of the intervention focuses on investigating the patterns that cause stress in the working situation, and is directed at relieving the stress and giving the client an opportunity to take control over his or her working situation. This part takes about 6 months and consists of 20 group sessions, one each week; 10 individual sessions, one every second week; and three follow-up sessions over the course of half a year.

The *goals are* (1) reintegrating clients at work, (2) improving their ability to cope effectively with stress situations at work, (3) increasing their work satisfaction, and (4) preventing a new depressive episode.

In the *group sessions*, the OT presents themes such as working stress, capacities and incapacities, perfectionism, prevention, and conflicts at work. The clients' are given homework to do. Every group or individual session addresses (1) the work performance, (2) the patterns of coping behavior, (3) the home situation, and (4) the reintegration at work. Work performance is related to all aspects of functioning at work. Coping patterns are determined for each stressful situation. A work reintegration plan is created.

The *individual session* focuses on the client's personal and working situation regarding the progress of the interventions.

Restarting Work in Spite of Depression

This part of the intervention focuses on restarting work despite the clients' depressive disorder. It includes eight group sessions, four individual sessions, and one follow-up session. The clients need to be able to work for at least 2 hours a week in order to attend this part of the intervention. The client practices the new skills at the workplace.

The intervention assumption is that the remission of psychiatric symptoms will occur after restarting work. The intervention is based on the principle of individual placement support (IPS), meaning that the client should first work and then get training (Burns et al., 2008).

The intervention emphasizes the clients' ability to resume work through *adjustments of the work environment*, such as physical and psychological demands, decision latitude, and the social support of the coworkers and the employer. The adjustments are made on the basis of the client's experience at work and the effect of the depressive symptoms on the work capacity. The intervention also emphasizes the clients' participation in real or simulated work tasks.

The group meetings discuss issues relating to the clients' perceptions regarding the following:

- Cognitive, physical, and emotional aspects of the work.
- *The arrangement boundary*, that is, clients' opportunity to organize and arrange the work to enable them to do the work in the manner of their choosing.

- *The social support* provided by colleagues, their *personal perspectives, and* the clients' fitting into their work environment.
- The *home situation*, such as leisure time, chores, and responsibilities.

The Individual Sessions

The first session focuses on the client's specific problems. The second session is attended by the client and the employer, so that the employer can learn about the consequences of the depressive disorder for the work performance and information about the content of the intervention program. The client is asked to discuss with the employer his or her experience of the work load.

Evidence-Based Practice

The effectiveness of these occupational therapy modules has been evaluated in a randomized controlled trial (Schene et al., 2007). The results showed that the addition of occupational therapy to treatment (1) did not improve the outcome of the depressive disorder, (2) resulted in a reduction in sick-leave days during the first 18 months, (3) did not increase work stress, and (4) had a 75.5% probability of being more cost-effective than the treatment alone.

Nieuwenhuijsen et al. (2008), in a Cochrane review (n = 2,556) (one study concerned adjuvant occupational therapy), showed that "there is no evidence of an effect of medication alone, or psychological interventions or the combination of those with medication, on sickness absence of depressed workers."

Research with Web-based self-help interventions aimed at decreasing symptoms of depression, anxiety, and work-related stress (burnout) showed a statistically and clinically significant effect on symptoms of depression and anxiety. These effects were even more pronounced for participants with more severe baseline problems and for participants who completed the course. The effects on work-related stress and quality of life were less clear (van Straten et al., 2008).

Discussion

Depressive disorders have impact on absenteeism from work and the reduced work productivity of presenteeism. Interestingly, the epidemiologic aspects have been studied widely, while interventions to reduce the consequences are very limited.

The clinical experiences are that clients with minor or less severe depressive disorders are mostly able to continue working, albeit at a lower productivity level, but those clients with severe depressive disorders lose their jobs and never return to the

workplace. Therefore, occupational therapy interventions have an additive value over regular treatments among those clients who have to reduce their working hours or stop working for a shorter period. Here it is important to refine occupational therapy interventions and evaluate the effectiveness in terms of absenteeism and presenteeism.

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