OCCUPATIONAL HEALTH

All in the mind?

Occupational Health 01 September 2005 00:00 This article first appeared in Occupational Health magazine.

Sharon Wilday & Alan Dovey take an in depth look at current research on the effects of signing an individual with anxiety and depression off work, and how it can cause more harm than good

The number of employees experiencing psychological problems due to occupational stress has increased rapidly in Western countries,1,2 with mental illness now cited as one of the top three causes of certified sickness absence.3

Cognitive behavioural therapy (CBT) has been shown to be an effective intervention for anxiety and depression,4 as well as for occupational stress.5 However, research into CB interventions on employees with occupational stress is scarce, and is an area recommended for further exploration.5

Current CB thinking on anxiety and depression suggests that the way in which an individual responds to their symptoms is a major factor in their course and severity.6,7,8 Yet a review of the literature pertaining to the effect of taking sickness absence reveals a paucity of published material on the topic.5,9

This article considers the potential role of sickness absence in the maintenance and outcome of mental health severity - from a CB perspective - for individuals with anxiety and depression.

It examines the following three areas of the potential impact of sickness absence: the absence of the benefits of employment, the development of sick role behaviour, and an avoidant coping.

Absence of employment
Work is said to play a 'major role in a person's past, an intrinsic part of their present and a potential mould for their future'.10 Moos outlined the benefits of employment as multi-faceted, suggesting that a job can "provide structure for a person's life, a sense of satisfaction and productivity from completing meaningful tasks, a feeling of belonging to a valued reference group, a basis of self-esteem and personal identity and a way to earn one's economic place in society".11

Research into sick role behaviour shows that the degree to which illness is understood by society, and consequently the societal norms for its management, play an essential role in the individual's coping responses to illness and their ultimate period of delay in seeking professional help.12 Again, the literature is scarce but an early study suggests that the sick role (as defined by society) is believed to qualify a sick person with the right to relinquish their usual responsibilities and even their self-responsibility, depending on the extent of the illness.13

The study also found that individuals with mental health problems often tried independent coping strategies, attempted to withdraw from situations, and/or attempted to deny the presence of the problem for an extended period of time prior to seeking professional help, compared to individuals with physical illnesses.

Despite the time that has passed since this research, it is clear that the current understanding of mental health within society remains poor, and that the stigma around it still exists.3

The kind of coping behaviour used by individuals with occupational stress problems often involves avoidance tactics, known as the 'transactional model'.14,15 The transactional model is defined as "cognitive and behavioural efforts to master, reduce or tolerate the internal or external demands created by the stressful encounter".16 This concept - based on a proposal by Lazarus17 - suggests this kind of 'coping' is one of avoidance.18,19 This means that sickness absence becomes a means of avoidant coping behaviour for the afflicted individual.

Maintenance factors: a cognitive behavioural perspective
Research into CBT refers to the intrinsic role of a 'maintenance cycle' within both anxiety and depression.20 Beck proposed that the maintenance factors of emotional disorders fall into three categories: cognition, behaviour and emotion.8 Greenberger and Padesky say that in addition to these, physiological and environmental factors also play a maintenance role.21

The symptoms of anxiety and depression, as well as the responses by individuals to these symptoms, can cause them to fall into these five categories: cognitive, behavioural, emotional, physiological and environmental. Each of these components is reciprocal and therefore a change in one area can influence another,8,21,22 a concept supported by empirical research.25

Figure 1 highlights this basic maintenance cycle.

Anxiety maintenance
Anxiety is an emotional response activated by fear-based cognition. So when an individual perceives a situation as threatening, has a view of themselves as vulnerable, the world/others as threatening and the future as unpredictable,25 their behavioural response will be to avoid exposure to perceived danger.6,22,24,26,27

This behaviour is actively reinforced if there is a reduction in anxiety symptoms, which will occur initially as a result of the avoidance of the feared situation.6,27

However, this behaviour ultimately maintains anxiety because it prevents the disconfirmation of potentially faulty negative beliefs, which were responsible for the initial onset of anxiety.8,22

Figure 2 highlights an example of anxiety maintenance within the workplace. When the employee with anxiety is signed off sick from work, there is an initial feeling of relief, associated with not having to face difficult situations within the workplace (initial reduction of anxiety symptoms). This may develop or enhance the inaccurate perception of the linear relationship between work (environment) and anxiety (emotion).

However, where the anxiety is based on inaccurate negative cognitions (congruent with high emotional arousal), the absence of exposure to the environment at work leaves the negative cognitions unchecked and serves to give rise to further negative emotions (ultimate maintenance and/or increase in anxiety, fear, agitation, apprehension). This is further enhanced when the employee experiences distress at the thought of going back to that environment.

It is natural for an employee to want to avoid returning to work on the basis of this increased distress and to seek further sick leave. However, returning to work is what is needed to help break the maintenance of anxiety when the perception of the environment is inaccurate.

Sickness absence could serve as an avoidant behavioural response. This is further influenced by the societal perception of sickness behaviour, whereby the individual is likely to not only avoid work but many other daily activities, further exacerbating the potential for avoidant coping and the continuation of anxiety symptoms. It is therefore probable that in the absence of treatment intervention, the removal of the employee from work would serve to maintain the disorder of anxiety.

Depression

Depression is an emotional response activated by loss-based beliefs. Depressive cognitions consist of a view of the self, the world/others, and the future as negative.7 These negative cognitions then further interact with the individual's lowered physiological drives, emotional and behavioural responses. Specific behavioural responses include decreased levels of motivation to develop and pursue goals and the consequential reduction in activity levels, apathy, lethargy and avoidance behaviour.7,28,29

The symptoms of depression are also believed to interfere with normal relationships because the depressed individual tends to isolate themselves from others,31 leading to the experience of rejection, which can further exacerbate negative self perceptions and maintain depression.31,32,33

Figure 3 highlights an example of depression maintenance within the workplace. When signed off from work, the employee with depression experiences an instant loss of structured and goal-directed activity, which, coupled with the associated loss of social contact, can have a huge negative impact on their already negative view and, hence, the severity of the depression.

The consequential reduction of other general activity levels (sick role behaviour) and/or a low level of motivation (symptom of depression) to develop new routines to fill the void of time that was previously structured with the activity of employment, can have a reinforcing effect on depressive symptoms.

Conclusion

This review considered the potential impact of sickness absence as a maintenance factor for anxiety and depression from a CB perspective.
For anxiety, the most significant coping behaviour is avoidance, as it tends to lead to an initial decrease in symptoms but ultimately maintains the anxiety because it prevents the disconfirmation of potentially faulty negative beliefs, responsible for the initial onset of the anxiety.6,22

For depression, the most common coping behaviour is also avoidance, which leads to a reduction in general and/or social activity levels. This behaviour ultimately serves to reinforce the activating cognitions and consequently increases depressive symptoms.7,28

As a result of this review, sickness absence for individuals with anxiety and/or depression may act as a potential maintenance factor, suggesting that signing off an employee with symptoms of anxiety and/or depression without any other intervention can actually be contraindicating to their condition. Such a finding in the context of the current surge of occupational mental health and corresponding utilisation of sickness leave is extremely concerning.

However, although this review has focused on the negative implication of sickness absence on the symptoms of anxiety and depression, it does not underestimate the need for sickness absence in certain cases. It seems clear though that to use sickness absence more positively, we need to further understand some of the processes by which it can impact upon an individual.

The current Health & Safety Executive initiatives actively promoting the awareness of mental health in the workplace for both employers and employees are helpful,3 and may help to tackle the current problems pertaining to the societal view of mental health and the sick role. However, in light of this review, such isolated initiatives may be insufficient and further research into the efficacy of interventions for this group need to be considered. For example, the specific role of early intervention to either replace or complement sickness absence for those who are unable to continue to function at work is a priority.34,35

This review also highlights the importance of informed debate to occur with regard to:

- The importance of addressing CB maintenance factors for sickness absence through a structured CB approach, including implementation of a graded 'return to work plan' as an early intervention strategy rather than a later intervention
- The working relationship between the employee, OH, managers, HR, GPs, external and/or internal consultants, as well as other healthcare providers, to encourage a multi-professional team management approach
- The interpretation of the Disability Discrimination Act (DDA),36,37 with respect to making reasonable adjustments at work, because it could serve as a form of safety-seeking behaviour or even direct avoidance in relation to mental health if not interpreted accurately and based on an accurate assessment. Further papers will attempt to address this complex,

but interesting, area.35

Alan Dovey is clinical lecturer in cognitive behaviour therapy (CBT) at the University of Birmingham. Sharon Wilday is a CB psychotherapist and honorary clinical lecturer at the University of Birmingham

REFERENCES

1. Health & Safety Executive (1999). *The Labour Force Survey*. Eurostat Ill Health Module
2. Murphey, LR (1996) 'Stress Management in Working Settings: A Critical Review Of The Health Effects', *American Journal of Health Promotion*, 11: 112-135. In Van der Klink, JJL, Blonk, RWB, Schene, AH and Van Dijk, FJH (2001) 'The Benefits of Interventions for Work Related Stress', *American Journal of Public Health*, 91 (2): 270-275
3. Doherty, N and Tyson, S (2001). *Mental Well-Being In the Workplace.* HSE Publications. Bedford
4. Howard, KI, Moras, K, Brill, PL, Martinovich, Z and Lutz, W (1996) 'Evaluation of Psychotherapy: Efficacy, Effectiveness and Patient Progress', *American Psychologist*, 51: 1059-1064
5. Van der Klink, JJL, Blonk, RWB, Schene, AH and Van Dijk, FJH (2001) 'The Benefits of Interventions for Work Related Stress', *American Journal of Public Health*, 91 (2): 270-275
6. Salkovskis, PM (1991) 'The Importance of Behaviour in the Maintenance of Anxiety and Panic: A Cognitive Account', *Behavioural Psychotherapy*, 19: 6-19
7. Beck, AT, Rush, AJ, Shaw, BF and Emery, G (1979) *Cognitive Therapy of Depression*. New York: The Guildford Press
8. Beck, AT (1976) *Cognitive Therapy and the Emotional Disorders*. London: Penguin Books
9. Cooper, CL, and Sadri, G (1991) 'The Impact of Stress Counselling at Work', *Journal of Social Behaviour and Personality*, 6:411-423
10. Cooper, CL and Baglioni Jr AJ (1988) 'A Structural Model Approach Toward the Development of a Theory of the Link Between Stress and Mental Health', *British Journal of Medical Psychology,* 61: 87-102
11. Moos, RH (1988) Psychosocial Factors in the Work Place. In: Fisher, S, and Reason, J (eds). *Handbook of Life Stress, Cognition and Health*. (p344). Portsmouth, UK: Wiley and Sons.
12. Blackwell, BL (1967) 'Upper Middle Class Adult Expectations About Entering the Sick Role for Physical and Psychiatric Dysfunctions', Journal *of Health and Social Behaviour*, 8: (2) 83-95
13. Parsons, T (1951) The Social System. Glencoe: The Free Press. In Blackwell, BL (1967) 'Upper Middle Class Adult Expectations About Entering the Sick Role for Physical and Psychiatric Dysfunctions', *Journal of Health and Social Behaviour*, 8: (2) 83-95
14. Cooper, CL (2001) *Managerial, Occupational and Organisations Stress Research*. Wiltshire, UK: Cromwell Press
15. Cooper, CL, Dewe, PJ and O'Driscoll, MP (2001) *Organisational Stress - A Review and Critique of Theory, Research and Applications*. California, US: Sage Publications
16. Folkman, S (1984) 'Personal Control and Stress Coping Processes: A Theoretical Analysis', *Journal of Personality and Social Psychology*, 46:839-852. In Cooper, CL (2001) *Managerial, Occupational and Organisational Stress Research* (p160). Wiltshire, UK: Cromwell Press
17. Lazarus, RS (1996) Psychological Stress and the Coping Process. New York: McGraw-Hill. In Cooper, CL, Dewe, PJ and O'Driscoll, MP (2001) *Organisational Stress - A Review and Critique of Theory, Research and Applications*. California, US: Sage Publications
18. Code, S and Langan-Fox, J (2001) 'Motivation, Cognitions and Traits: Predicting Occupational Health, Well-Being and Performance', *Stress and Health,* 17:159-174
19. Ferguson, E and Cox, T (1997) 'The Functional Dimensions of Coping Scale. Theory Reliability and Validity', *British Journal of Health Psychology*, 2: 109-129
20. Persons, JB, Davidson, J and Tompkins, MA (2001) *Essential Components of Cognitive Behavioural Therapy for Depression*. Washington DC, US: American Psychological Association
21. Padesky, CA and Greenberger, D (1995) *Clinician's Guide to Mind Over Mood. London,* UK: The Guilford Press
22. Wells, A (1997) *Cognitive Therapy of Anxiety Disorder*. Chichester: Wiley and Sons
23. Salkovskis, PM (1996) *Frontiers of Cognitive Therapy.* New York: The Guilford Press
24. Blackburn, IM and Davidson, KM (1995) *Cognitive Therapy for Depression and Anxiety.* Cambridge UK. Blackwell Science
25. Persons, JB and Miranda, J (1992) 'Cognitive Theories of Vulnerability to Depression: Reconciling Negative Evidence', *Cognitive Therapy and Research*, 16 (4): 485-502
26. Wells, A and Matthews, G (1994) *Attention and Emotion. A Clinical Perspective*. Hove, UK: Erlbaum
27. Wells, A, Clarke, DM, Salkovskis, P, Ludgate, J, Hackman, A and Gelder, MG (1995) 'Social Phobia: The Role of In-Situation Safety Behaviours in Maintaining Anxiety and Negative Beliefs', *Behaviour Therapy*, 26: 163-171
28. Teasdale, JD and Barnard, PJ (1993) *Cognition, Affect and Change: Re-modelling Depressive Thought*. Hove: Erlbaum
29. Lewinsohn, PM, Hoberman, HM and Rosenbaum, M (1988) 'A Prospective Study of Risk Factors for Unipolar Depression', *Journal of Abnormal Psychology*, 97: 251-264
30. Carnelley, KB, Pietromonaco, PR and Jaffe, K (1994) 'Depression, working Models of Others, and Relationship Functioning', *Journal of Personality and Social Psychology*, 66 (1): 127-140
31. Hobfoll, SE and Schroeder, EE (2001) 'Distinguishing Between Passive and Active Prosocial Coping: Bridging Inner-City Women's Mental Health and AIDS Risk Behaviour', *Journal of Social and Personal Relationships*, 18(2): 201-217
32. Hammen, CL, Burge, D, Daley, SE, Davila, J, Paley, B and Rudolph, DD (1995) 'Interpersonal Attachment Cognitions and Prediction of Symptomatic Responses to Interpersonal Stress', *Journal of Abnormal Psychology*, 104 (3): 436-443
33. Gilbert, P (1984) *Depression: From Psychology to Brain State*. London: Lawrence Erlbaum Associates
34. Wilday, S and Dovey, A (2002) Occupational Mental Health. The Role Of Sickness Absence. A Cognitive Behavioural Perspective. MSc Dissertation Birmingham University (Unpublished)
35. Dovey, A and Wilday, S (2005) Planning a Graded Return to Work Programme to Aid Recovery in Occupational Mental Health. A Cognitive Behavioural Perspective. In progress
36. *Disability Discrimination Act* (1995) London. The Stationery Office
37. Disability Discrimination Act 1995 (1996) *Guidance on Matters to be Taken into Account*

Determining Questions Relating to the Definition of Disability. London: The Stationery Office

www.PersonnelToday.com
Tuesday, 23 November 2010