Psychiatry and the workplace: key issues for best outcomes

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My perspective

- Treating general psychiatrist (various settings)
- Special interest in posttraumatic stress
- Approved Medical Specialist providing independent psychiatric assessments

Case example 1

- John a 50yr old teacher with 25yrs experience finds he cannot face returning to work for several months after an incident when he was struck on the side of the head, "out of the blue" by a student with known history of aggression. He was very disappointed at the lenience shown to the student by the Principal after a meeting with the family. He had been "shaken up" separating students fighting a few weeks previously.

Case example 1….cont.

- John developed feelings of anxiety associated with constant rumination on these issues. He slept badly, waking often and experiencing regular nightmares relating to the incident. He avoided going out in case he bumped into students from his school. He felt panicky if he saw students walk past his house. John felt anxious to the point of retching when he went to the school to drop off paperwork……

Case example 2

- Sue a 50 yr old admin assistant moved to a new office a year ago. Since being there she describes bullying and intimidation at the hands of her new supervisor, Bill, on a regular basis. This includes comments that she is "useless" and "a waste of space" although at other times he is quite pleasant to her especially in front of senior colleagues. Sometimes he makes sexually inappropriate remarks which she finds degrading though he seems to think she just "can't take a joke"

Clinical example 2 ....cont.

- She doesn't want to complain formally as she doesn't want to risk aggravating the situation. She becomes increasingly stressed, anxious especially coming to work in the mornings. Her sleep pattern is poor, she has frequent palpitations and nausea and her work performance is deteriorating due to poor concentration. She is socially isolating herself and able to enjoy activities less and less. She recently got to the point she could not face going into work and has not worked for several weeks…

Mental health in Australia

- @45% adult Australians experience a common MH condition in their lifetime (NSMHW 2007)

- Cost of MH services in Australia $6 billion per annum

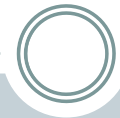
Mental health claims and the workplace

- Costs industry $10 billion per annum in lost productivity (Safe Work Australia 2013)
- Stress claims @10% WC claims in Australia
- Those with high levels of responsibility for well being of others at highest risk
- MH claims are the most expensive type of WC claim
- Women>men
- Professionals> non-professionals.
- Women 3x claims for harassment/bullying
- Work pressure the most common cause in industries with highest claim rates

Work outcomes research and cost benefits study

- 60 organisations/92000 employees
- 6.7% employees have clinical level depression
- Affects performance
- 65% not seeking treatment
- At increased risk of sig performance issues/WC claim
- Health outcomes known to be worse following an accepted WC claim

MH issues at work



- Threats/violence
- Witnessing/experiencing disturbing/dangerous events
- Interpersonal stress/bullying/intimidation
- Workload
- Accidents (with or without physical injury)
- Physical injury > secondary MH issues

Key factors in RTW (APS)

- Compensation status impacts RTW outcomes but mechanisms not well researched
- Early identification of psychosocial issues (eg performance issues, workplace conflicts, financial issues, pre-existing psych issues etc) and addressing them in co-ordinated manner improves RTW outcomes
- Evidence that treating RTW as a primary treatment modality improves outcomes up to 50% (Bernacki et al 2005)
- In Victoria GP first certificates most likely to say unfit for MH claims (Collie et al 2013 MJA) and claim duration longer on average
- Clinicians becoming combative vs collaborative with employer, rehab provider etc worsens outcomes

Early expert treatment

- GPs prescribe 86% antidepressant prescriptions
- (In my experience) referral to psychology and /or psychiatry often delayed
- Psychological treatment can be very helpful (and evidenced based) but is often delayed, unfocussed or protracted)
- Psychiatric expertise can optimise prescribing and coordinate overall biopsychosocial treatment

What is normal?

- Mood?
- Worry/anxiety?
- Behaviour?

What is normal?

- Out of proportion to circumstances (severity)
- Prolonged response
- Causing reduced function eg work, personal/social life
- Concern to self or others

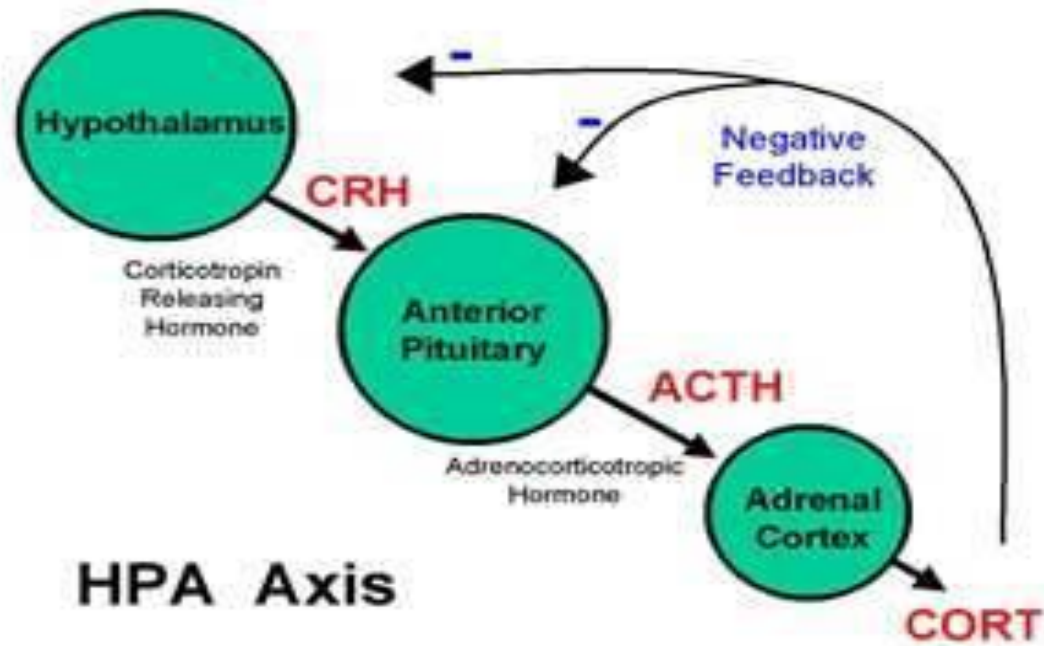
Defining stress and trauma

- **Stressor**: failure of an organism to respond adequately to physical, mental or emotional demands, whether actual or imagined.

- **Cognitive**: worry, procrastination, pessimism
- **Physical**: headaches, chest pain, bowel changes
- **Behavioural**: pacing, tics, avoidance, withdrawal
- **Emotional**: irritability, anxiety, depression

Stress response

- Key to survival – adaptive in short term
- Increase in sympathetic drive/ decrease in paraympathetic
- Corticosteroids and noradrenaline release


Hypothalamus
CRH
Corticotropin
Releasing
Hormone
Anterior
Pituitary
ACTH
Adrenocorticotropic
Hormone
Adrenal
Cortex
CORT
Negative
Feedback
-
-
HPA Axis

General Adaptation Syndrome

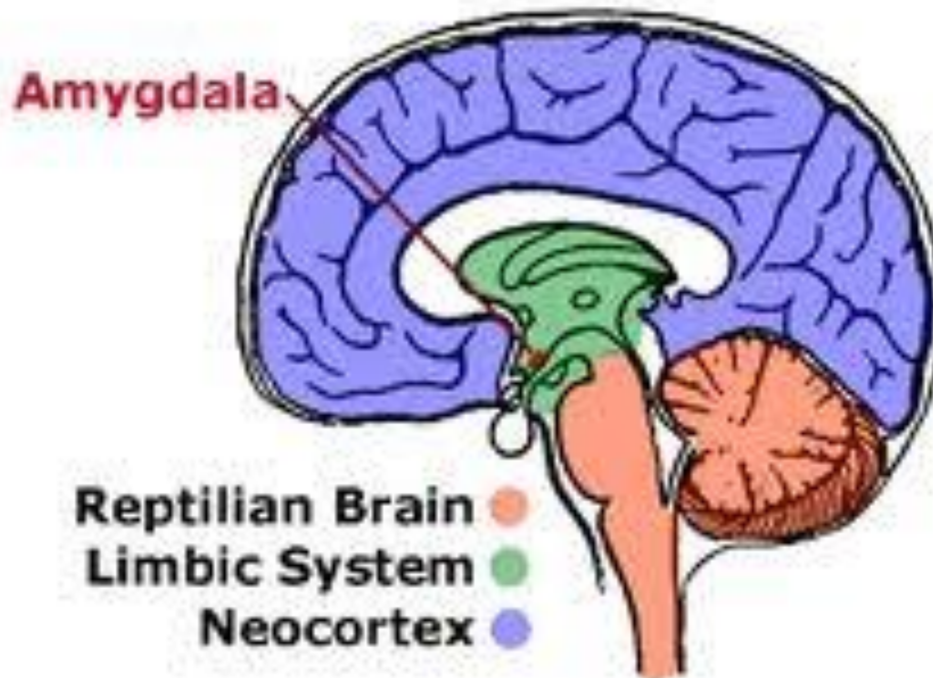
- **Alarm phase**: acute response – NA, cortisol, SNS
- **Resistance phase**: adaptation, attempts to cope
- **Decompensation phase**: inability to maintain normal function, can result in disease/impairment

Chronic stress

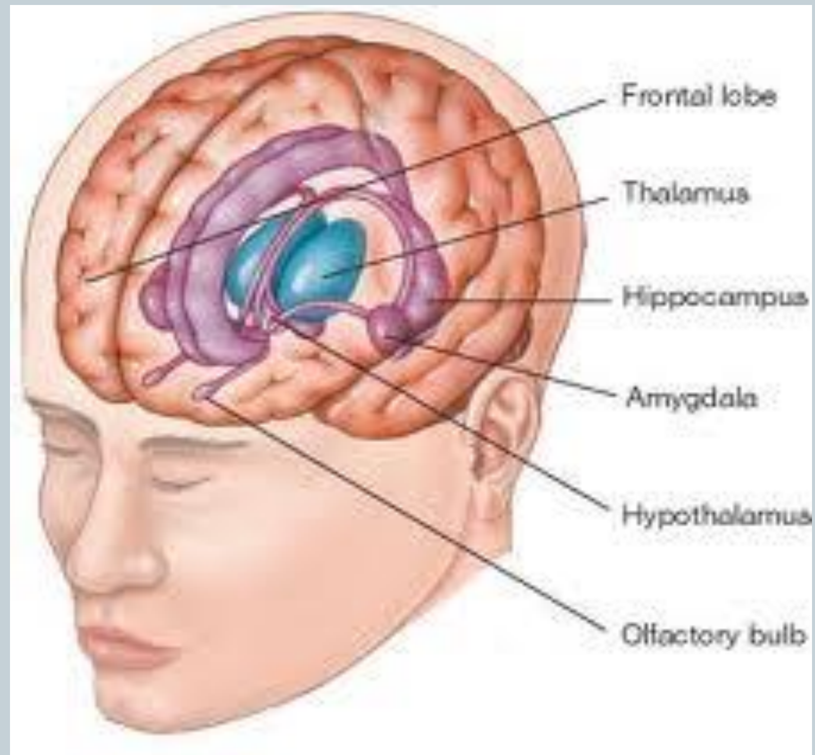
- Chronic increase in NA, cortisol
- Imbalance of autonomic system
- Impact across physiological systems eg blood pressure, glucose regulation, muscular tension, regulation of immune system, pain regulation, learning and memory, regulation of affect

The triune brain

- Low – reptilian – brainstem
- Mid – mammalian – limbic structures
- Higher – human – cortex (esp. frontal)


The Evolution-Designed Brain
Amygdala
Reptilian Brain
Limbic System
Neocortex

Limbic system



DSM IV Disorders

- PTSD
- Acute Stress Disorder
- Adjustment disorders
- Major Depression

What is a traumatic event?

- Experiencing or witnessing event(s) involving actual or threatened death or serious injury or threat to the physical integrity of self or others
- Response of intense fear, helplessness or horror (DSM IV definition for PTSD)
- Therefore may/may not be concurrent physical trauma
- Lesser events may still produce a psychological response

Posttraumatic Stress Disorder

- Usually develops within 6 months of trauma – can be delayed in onset
- Reliving traumatic memories: flashbacks & nightmares
- Emotional numbing/blunting with avoidance and withdrawal
- Hypervigilance/increased startle response/irritability/sleep disturbance
- Memory impairment

PTSD issues

- Re-experiencing criteria (B) unique to PTSD
- Otherwise high symptom overlap with depressive and anxiety disorders
- Co-morbidity high

Consider…

- Apparently "lesser" events can have significant impact
- Context of event
- Personality
- Past experiences
- Previous mental disorder
- Significance/meaning of event is key

Rates of PTSD

- Lifetime prevalence: 5% men,10% women
- Traumatized: 8% men, 20% women (NCS)

Pathologies of trauma

- PTSD
- Other anxiety disorders
- Depression
- Substance misuse/dependence
- Psychosis
- Range of physical illnesses

Treatment: Posttraumatic stress disorder

- Treatment usually at specialist level
- Psychological treatments internationally recognized as first line
- Trauma - focused CBT
- EMDR
- Medication – antidepressants, anxiolytics, antipsychotics

CBT

- CBT: based around exposure theory, behaviour modification and cognitive restructuring
- Established evidence base for PTSD treatment via clinical trials

EMDR

- EMDR: Eye movement desensitization and reprocessing
- Established evidence based Rx for PTSD
- Recommended by international guidelines
- Standardized 8 phase protocol
- Mechanism of action uncertain ? More than exposure ? Importance of eye movements/bilateral sensory stimulation

PTSD Checklist Scores

80
70
60
50
40
30
20
10
0

Pre EMDR
Post EMDR
6mth Post EMDR
12mth Post EMDR

Pt 1
Pt 2
Pt 3
Pt 4
Pt 5
Pt 6
Pt 7
Threshold

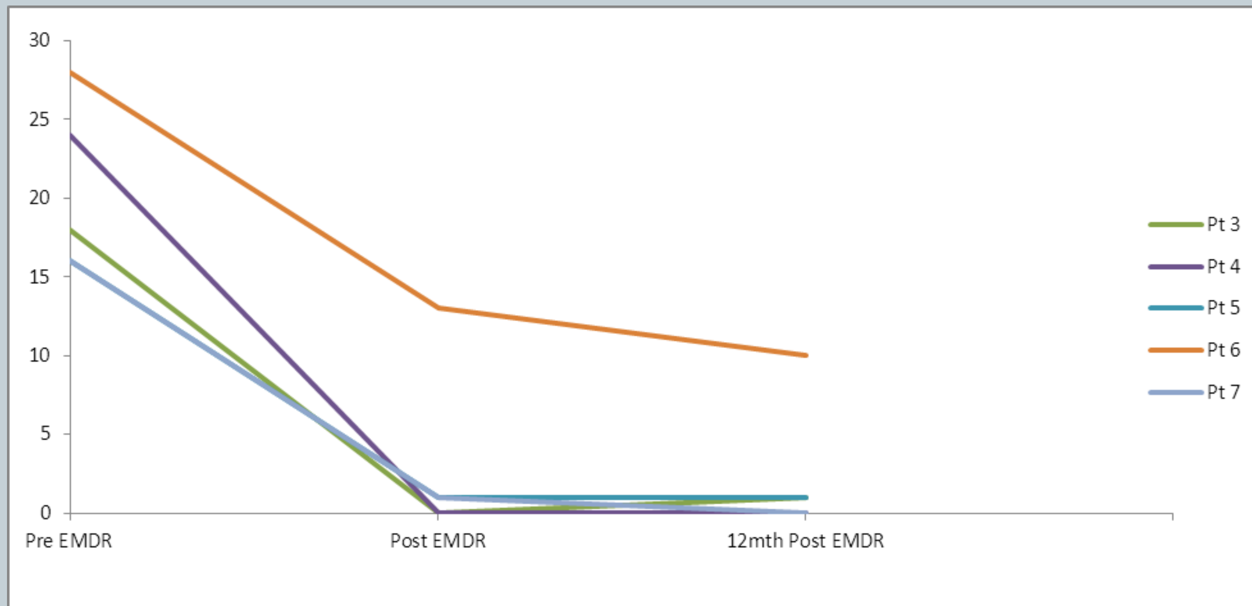
Hamilton Depression Scores

25
20
15
10
5
0

Pre EMDR
Post EMDR
12mth Post EMDR

Pt 3
Pt 4
Pt 5
Pt 6
Pt 7

Hamilton Anxiety Scores



Adjustment disorders

- Follows significant life change or stressor
- Weeks/months duration
- Resolves when stressor removed
- Depressed mood
- Anxiety
- Insomnia
- Headaches/abdominal distress/chest pain etc
- Impaired social functioning

Treatment: adjustment disorder

- Problem solving
- Education
- Relaxation strategies
- Antidepressant medication
- Short term hypnotic medication
- Psychology/psychiatry referral for persistent or deteriorating symptoms

Major Depression

- Pervasive low mood (more than 2 weeks)
- Anhedonia (loss of pleasure)
- Appetite and weight changes
- Poor sleep
- Low energy/motivation
- Poor concentration
- Low libido
- Poor functioning
- Frequent tearfulness
- Guilt/worthlessness
- Suicidal ideas/intent

Depression - causes

- Hereditary predisposition
- Personality factors (eg obsessional, perfectionistic)
- Psychosocial stressors (personal, work related)

Treating depression

- **Safe?? Hospital needed??**
- Antidepressants eg SSRIs, SNRIs – take weeks to work and usually continued for 12 months at least. Mood stabilisers, other biological treatments.
- Psychological – eg supportive therapy, CBT based approach, interpersonal therapy
- Psychosocial strategies – problem solving eg relational, accomodation/finances, **work issues**

Other disorders

- Alcohol or drug misuse/dependence
- Dissociative disorders
- Psychosis (delusions/hallucinations)

Other issues of note…

- Workers compensation/insurance processes
- Loss of role/identity
- Attitudes of family/friends/colleagues
- Pain/disability
- Personality/cognitive style
- Other options

Key factors

- Perceived threat
- Unpredictability
- Resilience vs vulnerability (past experiences, personality, previous illness)
- Perceived support from management/colleagues
- Social supports
- Appropriate treatment

Summary

- Mental health claims more likely to be of long duration
- Effective evidence-based psychological/psychiatric treatment exists but is often delayed/not forthcoming
- Every effort should be made by all parties to attempt early RTW by identifying and addressing psychosocial barriers and implementing early treatment.

“Mind body reprogramming”

- Self -help tools for effective stress reduction in personal and working life
- Based on EFT (acupoint tapping technique) and guided visualisation

- Info and materials: jonlaugharne.com