Workplace Mental Health Indicators: An EAP's Perspective

Insights from the WarrenShepell Research Group

WarrenShepell

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Executive Summary

Emotional problems are a significant detriment to individual health and well-being. They are also injurious to organizational health as they impede employee performance and escalate benefits and insurance costs. These negative impacts are also set to increase in magnitude as global rates of emotional disorders continue to climb. Given this context, employers need to understand the nature of emotional problems, how they can be prevented, and the range and efficacy of various treatments.

This report offers a brief primer on three common emotional problems: **depression, anxiety**, and **anger**. We also conducted a study to examine EAP utilization trends in these symptoms among Canadian employees.

Among the findings:

- Depression symptoms were the most frequent of the three problems (over 6% of mainstream presenting issues)
- Depression symptoms were more prevalent among the youngest and oldest employees
- Anxiety symptoms were more prevalent (and are increasing) among 20-to-29-year-olds
- Anger symptoms were more prevalent among younger employee groups
- Reports of emotional problems generally decreased with age
- Males and females reported similar frequencies of depression and anxiety symptoms
- Males reported substantially higher frequencies of anger symptoms compared to females

Interpretations and implications of these findings are discussed. In addition, the reader is provided with practical knowledge for identifying and addressing emotional problems in the workplace. As a general conclusion, WarrenShepell believes that organizations with practices in place for preventing employee emotional problems and facilitating treatment will experience net gains in productivity. This conclusion is backed by a large body of research.

Emotional Problems

In 1997, the U.S. National Comorbidity Survey found that emotional problems accounted for the largest average number of lost work days and work cutback days when compared to other psychological problems (4 million workdays; 20 million work cutback days per year). These losses will likely increase. The World Health Organization predicts that by the year 2020, depression will be the second-leading cause of disability in the world, up from fourth place in 1996. Given the devastating impact of emotional problems on individual and family well-being and work productivity, it is critical for employers to understand the nature of emotional problems in more detail.

With this in mind, the purpose of this report is to provide employers with:

- A brief primer on the nature and treatment of emotional problems
- A snapshot of current trends in EAP access for emotional problems
- Implications of emotional problems for organizational health
- Practical solutions for addressing emotional problems at the organizational level

Depression

Depression is classified under the mood disorders in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). The most prevalent mood disorder is Major Depressive Disorder, which is characterized by sad or 'blue' feelings, low interest, appetite and sleep changes, fatigue, feelings of guilt or worthlessness,

difficulty concentrating, and recurrent suicidal thoughts and attempts. It is sometimes accompanied by psychotic features (i.e., similar to schizophrenia). Dysthymic Disorder, a less intense but more chronic mood disorder, must be present for two or more years. Adjustment Disorder with Depressed Mood accompanies specific psychosocial events (e.g., loss of a loved one). Bipolar Disorder, which includes a number of subtypes, entails chronic mood swings from depressed to manic episodes. The latter are characterized by feelings of great euphoria or expansiveness that can lead to significant distress and social impairments.

What causes depression? The known risk factors are many, including genetics, early childhood experiences, neurochemical imbalances, and psychosocial events. Everyone's 'path' to depression is different, and everyone's depression is moderated by individual coping styles and levels of social support. Negative, irrational beliefs about one's self, the world, and the future are well-known risk factors (i.e., the 'cognitive triad'). Dispositional styles of thinking are also implicated with depression. For example, pessimistic explanatory style and external locus of control involve perceptions of low control. These beliefs then lead to feelings of hopelessness. Some people have social traits that predispose them to depression such as excessive needs for autonomy or dependency. Other depressogenic personality traits include perfectionism, Type 'A' personality, and neuroticism - a disposition to feel negative emotion in all or most situations.

Major Depressive Disorder, considered the 'common cold' of mental disorders, affects as many Canadians as heart disease, diabetes, and thyroid conditions. Approximately 4.5% of Canadians are estimated to have experienced an episode, although rates are higher for women. Adolescent depression is also common, with as much as 20% of adolescents experiencing serious depression between 12 and 19 years of age. Major depression does not discriminate by ethnicity, education, salary, or marital status. About 3% of the general population has Dysthymic Disorder.

Anxiety

The anxiety disorders are broadly partitioned into panic and anxiety disorders, phobic disorders, obsessive-compulsive disorder, and post-traumatic stress disorder. The first class includes Generalized Anxiety Disorder. People with GAD experience chronic and excessive anxiety and worry more days than not, and in reaction to most events in life. They may also be restless, tired, irritable, and have difficulty concentrating and sleeping. Panic Disorder involves brief periods of intense fear or discomfort characterized by heart palpitations, sweating, trembling, shortness of breath, and fear of dying. Sufferers have persistent concerns about future attacks. As a result, they tend to avoid places and situations that are viewed as inescapable and likely to provoke an attack (i.e., Agoraphobia - an anxiety disorder on its own). Social Phobia (or Social Anxiety Disorder) involves a persistent, irrational fear and avoidance of social situations. A core component of Social Phobia is the fear of acting in embarrassing or humiliating ways. Other Specific Phobias are included among the anxiety disorders (e.g., flying, animals, needles).

Obsessive-Compulsive Disorder and Post-Traumatic Stress Disorder are also included among the anxiety disorders. The former involves persistent, uncontrollable thoughts and impulses (e.g., an obsession with germs leading to compulsive hand-washing). Compulsions are usually time-consuming and interfere with social and occupational functioning.

What causes anxiety disorders? Similar to depression, the known causes are a complex array of factors including evolutionary, developmental, and biochemical (e.g., overreactive 'fear circuits'). Phobias, for example, can be learned or conditioned in early childhood, although they are built on more adaptive behaviours (e.g., avoiding dangerous animals, heights). Situational factors can trigger anxiety disorders, such as life cycle transitions or perceived crises in the workplace (e.g., layoffs, transfers).

The percentage of Canadians that are estimated to have an anxiety disorder is 4.7%. The two most common disorders are Social Phobia (3.0%) and Panic Disorder (1.6%). All of these rates are higher for women and youth. Obsessive-Compulsive Disorder is believed to have a 1-2% prevalence in the general population.

Anger

Anger can be described as an aroused state of antagonism, usually toward someone or something that is perceived as threatening. A key component of anger is physiological arousal, involving activation of the cardiovascular, endocrine, limbic, and central nervous systems. People in a state of anger typically feel that they have been wronged, or that some personal goal or effort has been thwarted.

Anger is adaptive on its own. Its activation has evolutionary significance and enables individuals to survive in natural environments. As such, anger is not a 'diagnosis'. However, it is easy to understand how anger can lead to dysfunctional behaviour. If not checked, anger can lead to verbal and physical aggression. Anger is an emotion, whereas hostility and aggression are goal-directed behaviours (i.e., intent to harm) that people choose to engage in. For some people, well-developed cognitive 'schemas' can predispose them to anger and aggression, leading them to over-interpret and over-react to external (usually social) cues. Frequent rumination helps to maintain these schema. People with anger problems tend to have experienced early trauma in their lives, especially related to rejection, abandonment, and economic impoverishment. Some situational causes of anger and aggression in the workplace include job stress and conflicts, and job dissatisfaction.

Interrelationships Among Emotional Problems

Depression, anxiety and anger are not problems unto themselves. They are often 'co-morbid' or complicated with one another. This makes diagnosis and treatment more difficult. For example, chronic levels of stress and stress-linked hormones can lead to depression through changes in brain structure. Additionally, when people are stressed for long periods of time, they may begin to see the future as stress-filled and then yield to feelings of hopelessness. People who are depressed are often also anxious - over 50% of the time. One reason for this association is that depressed individuals often 'replay' memories of past loss. This leads them to become anxious about future loss and failure. Additionally, both problems share some of the same underlying emotions (e.g., general distress). Depression has also been linked to substance abuse (e.g., alcohol), anger, and personality disorders (e.g., Borderline Personality Disorder).

Anger, as an emotion, is a feature of many other mental disorders including Post-traumatic Stress Disorder, personality disorders (Paranoid, Borderline, and Antisocial), various forms of schizophrenia, and dissociative disorders.

Treatment for Emotional Problems

The treatment regimes for emotional problems are many and varied. Most of them involve drug therapy, psychotherapy, or a combination of both. Stand-alone psychotherapy is effective for mild cases of depression. Even for severe depression, psychotherapy is still advised to accompany anti-depressants. Severe and chronic depression usually warrants a combination of brief hospitalization, drug therapy, and psychotherapy. In general, although many doctors prescribe anti-depressants as a stand-alone treatment, experts advise at least brief forms of therapy as well. Research suggests that drug and psychotherapy combinations are more effective than either treatment alone. In one study, 85% of clients experienced significant improvement with this combination, compared to only half for either treatment alone. On another note, research suggests that 'self-help' methods built on proven therapies are also effective.

Psychotherapy appears to be an essential ingredient in depression recovery. It is likely more effective and less costly than drug therapy in the long run. Since anti-depressants do little to 'cure' underlying causes of depression, they must be taken indefinitely. When drug therapy is discontinued, depression often returns in a more severe form (i.e., rebound symptoms).

Psychotherapy has no direct side effects, and the positive effects can be sustained over many years.

Three psychotherapies are found to be effective for treating depression. Behaviour therapy stresses re-learning and reinforcing new, adaptive behaviours. Cognitive-behavioural therapy (CBT) includes aspects of behaviour therapy but also focuses on changing dysfunctional beliefs, attitudes and other habitual ways of thinking. CBT is also highly collaborative. Clients engage in behavioural 'homework' by placing themselves in various situations to test their irrational beliefs like scientists. Finally, interpersonal psychotherapy focuses on building social skills and solving problems in close relationships. Some of the problems addressed include grief, role conflicts, and role transitions. Each of these forms of psychotherapy are present-focused, unlike psychoanalysis, which often involves revisiting unresolved childhood conflicts. Also unlike psychoanalysis, these three therapies can be administered in brief formats (i.e., 20 sessions or less).

Cognitive-behavioural methods of psychotherapy are also effective for treating anxiety problems (e.g., Panic Disorder). CBT is often paired with stress management and relaxation training. 'Exposure' therapy, along with CBT, has been proven effective for Social Phobia. Anti-anxiety drugs or anxiolytics have also shown some efficacy for treating anxiety disorders (e.g., benzodiazepines). However, they can be addictive and can interact with certain foods and other medications. Anti-depressants tend to work well for Obsessive-Compulsive Disorder (e.g., Paxil).

Finally, cognitive-behavioural methods are also effective for treating anger disorders, especially when they incorporate self-monitoring techniques (e.g., biofeedback), relaxation, and social skills training. CBT helps dispositionally-angry individuals to process cognitive information more effectively in potentially-tense social situations.

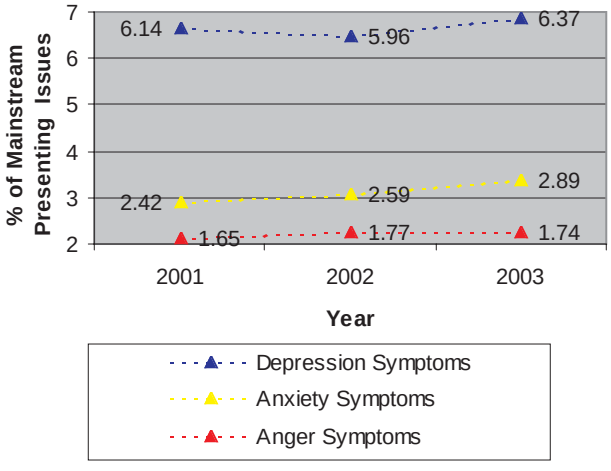
EAP Trends

An empirical study was conducted to examine trends in EAP access for depression, anxiety, and anger symptoms relative to other mainstream counselling presenting issues. Three years of WarrenShepell proprietary data were used (2001-03). Trends were examined both among all EAP accesses (i.e., total sample) and separately for different age and gender groups. The age groups of interest were: under 20 years, 20 to 29 years, 30 to 49 years, and 50 years and over.

Total Sample

On average, depression symptoms accounted for 6.16% of presenting issues from 2001 to 2003. Anxiety symptoms accounted for 2.63% while anger symptoms represented 1.72%. When broken out by year, accesses for these emotional issues were relatively stable over time (see Figure 1). Only anxiety symptoms showed a slight increase over time (2.42% in 2001 to 2.89% in 2003). While this increase should not be over-interpreted, it is understandable in light of on-going changes within the Canadian workplace (e.g., work intensification), increasing work-family conflict (e.g., double duties of childcare and eldercare), and recent world events (e.g., war, terrorism, corporate improprieties).

Figure 1. Total EAP Accesses for Emotional Problems



Age Groups

Trends in emotional problems are more evident when broken out by age group. Younger groups reported more depression symptoms than older groups (see Figure 2). The three-year averages were 10.60% and 7.85% for individuals under 20 years old and 20-to-29-year-olds (respectively). Depression symptoms dipped for 30-to-49-year-olds (three-year average 5.58%) but rose again for employees 50 years of age and over (three-year average 6.91%). The 20-to-29-year-olds showed a slight increase in depression symptoms over time (7.57% in 2001 to 8.36% in 2003).

Relative to other age groups, the 20-to-29-year-olds presented the most anxiety symptoms to EAP (three-year average 3.94%; see Figure 3). They were followed by 30-to-49-year-olds (three-year average 2.36%). Over three years, reports of anxiety symptoms increased for employees aged 20 to 29 years (3.43% in 2001 to 4.58% in 2003) and 30 to 49 years (2.21% in 2001 to 2.54% in 2003). Reports of anxiety symptoms varied over time for employees under 20 years old (three-year average 2.11%).

Predictably, reports of anger symptoms were highest among the youngest employees (three-year average 3.04% for individuals under 20 years old; see Figure 4). Reports of anger decreased with age in an almost linear fashion, with the oldest group reporting anger symptoms, on average, only 1.55% of the time.

Overall, the current findings suggest a mild to moderate age effect in emotional problems, with fewer reports of emotional problems as age increases. This is consistent with epidemiological research: It is estimated that 18% of Canadians aged 15 to 24 years have a mental disorder. This rate decreases with age - to 3% for Canadians 65 years and older. Depression and anger symptoms, in particular, characterized the emotional problems of employees under the age of 20, illustrating the 'sturm and drang' (storm and stress) period of adolescence. Depression and anxiety symptoms defined the 20-to-29-year-olds, with both problems increasing. The increase in depression symptoms within this age group may be due to the gradual influx of 'more depressed' younger employees into this category from year to year. However, the

Figure 2. EAP Accesses for Depression Symptoms By Age

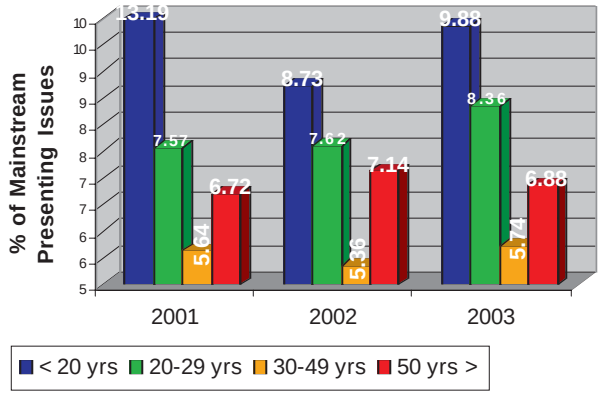


Figure 3. EAP Accesses for Anxiety Symptoms By Age

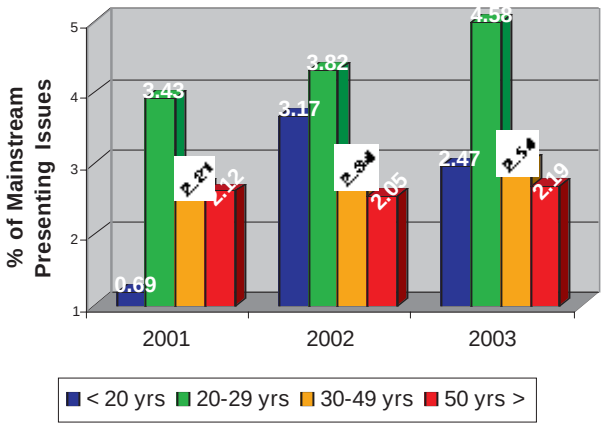
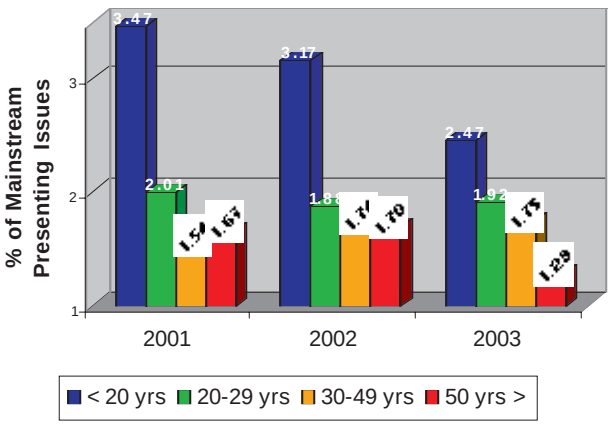


Figure 4. EAP Accesses for Anger Symptoms By Age



concurrent rise in both depression and anxiety symptoms for 20-to-29-year-olds may signal 'real' change, given the co-morbidity of these problems. Emotional problems tended to stabilize somewhat for 30-to-49-year-olds (relatively-speaking). Depression begins to emerge again as a theme for employees 50 years and older.

There are two broad explanations for the age-related findings. One is that people tend to become more stable with *maturation*. People achieve greater self-awareness and identity consolidation as they age, enabling them to make better decisions for themselves. Certain 'effective' traits also tend to also increase with age, such as conscientiousness and emotional stability. In general, older individuals tend to experience less upheaval in their social, occupational, and financial lives. The findings may also suggest a *cohort* effect, whereby age groups differ in their well-being not as a reflection of aging, per se, but as a reflection of the different cultural and historical events that shaped them in their separate generations. Since the current study is cross-sectional rather than longitudinal, it is impossible to assess the validity of these competing or complimentary explanations.

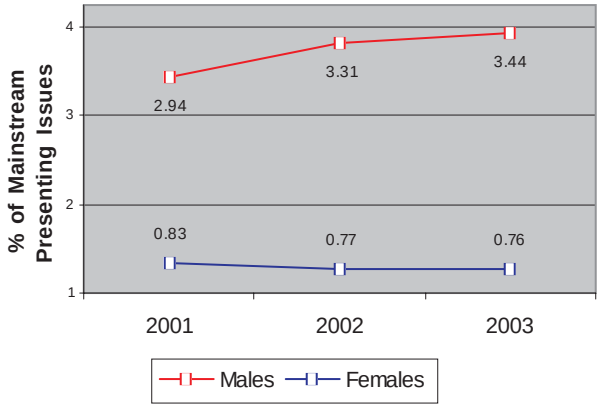
Gender

There were few gender differences in reports of depression and anxiety symptoms. Males and females showed similar three-year averages for depression (5.95% vs. 6.05%, respectively) and anxiety symptoms (2.61% vs. 2.62%, respectively). This is inconsistent with epidemiological research indicating higher rates of mood and anxiety disorders among females. There are a number of possible reasons for this discrepancy. First, epidemiological studies are based on DSM-IV diagnoses of clinical states while the current data are based on intake assessments conducted for the purpose of triaging clients. Second, participants in epidemiological studies are probability-sampled from the general population while EAP clients actively volunteer for counselling. Males with emotional problems may also feel more inclined to seek help from their EAP than consult a mental health professional (i.e., the 'solution' focus of EAP is more aligned with typical male coping styles). A diagnosis from the latter would contribute to epidemiological statistics.

Gender differences in anger symptoms were more apparent (see Figure 5). These symptoms accounted for a larger percentage of presenting issues for males compared to females (three-year averages 3.23% vs. 0.79%, respectively). While this difference is small in absolute magnitude, the ratio is 4:1. The are many factors that could account for this gender difference, including biological (e.g., hormones), environmental (e.g., gender-role socialization), and interactional factors (e.g., social reinforcement of biologically-based expressions of emotion). Anger as a presenting issue is also increasing among males (2.94% in 2001 to 3.44% in 2003). While this signals that males may be experiencing higher levels of anger in the workplace, it is unclear whether they are expressing it more often. It may be that as organizations become less tolerant of expressed anger, more males are willing (or are encouraged by others) to seek EAP for this problem before it becomes more salient and/or leads to aggression.

The gender difference in anger symptoms is consistent with published studies. A large body of research suggests that women, relative to men, are more likely to suppress their anger. However, other research suggests that women experience and express as much or more anger than men. It is now emerging that gender role identity, rather than gender itself, is related to the experience and expression of anger (e.g., women who have traditionally 'feminine' identities are more likely to suppress their anger).

Figure 5. EAP Accesses for Anger Symptoms By Gender



Implications of Emotional Problems for Organizational Health

Employee Performance

Understanding the nature of emotional problems is one thing. Making it relevant for organizations is another. Consider that 4.5% of the Canadian population is estimated to have Major Depressive Disorder. Also consider that the average client organization served by WarrenShepell has just over 500 employees. That translates to approximately 23 employees per organization who likely suffer from depression. Considering co-morbidity rates, at least 13 of these people may also have an anxiety disorder.

What may be happening to the performance of these employees? People with depression and anxiety symptoms have difficulty thinking, concentrating, and carrying out actions. For example, people with Bipolar Disorder are prone to mistakes and misjudgments during manic episodes. People with Panic Disorder suffer from 'anticipatory anxiety' which can also disrupt cognitive performance. In general, the negative emotions associated with anxiety leads people to feel that they are incapable. These thoughts interrupt task performance. When people are anxious or angry, they are also more vigilant of imminent threats, making it more difficult to produce creative or innovative solutions. In short, people with emotional problems have difficulties with problem-solving, decision-making, and meeting goals.

People with depression and anxiety also experience behavioural deficits in their performance. Depressed people commit to fewer and slower actions. People with Panic Disorder and Social Phobia avoid various situations and environments including ones that are critical for work performance (e.g., meetings, presentations, client contact). Additionally, individuals who suffer from Obsessive-Compulsive Disorder engage in time-consuming compulsions that cut down on work time.

Depression, anxiety and anger also lead to social deficits in performance. Both Major Depression and Dysthymic Disorder are associated with interpersonal styles and skills that can be disruptive to work relationships and erode team cohesion. The extreme behaviour and unpredictability associated with mania, for example, can cause significant fear and anxiety in co-workers. People who suffer from Bipolar Disorder are also likely to be irritable, stubborn, and aggressive. The avoidant behaviour associated with Social Phobia translates to decrements in social dimensions of performance and chronic underachievement of teams. Finally, people who are dispositionally angry are viewed as hostile, oppositional, and have difficulty gaining cooperation or social support from others. The stress and anxiety that anger breeds in others can affect co-worker performance and poison an organizational climate. Anger, of course, is a factor in workplace aggression and bullying.

With respect to depression, perhaps the most significant detriment to performance is a characteristic loss of positive affect - a state of 'adhedonia'. Positive affect is a major source of interest and motivation for individuals. When there is little interest and motivation, there is little engagement. Positive affect is a building block of human performance. It broadens our thought and action repertoire, improves our problem-solving, urges us to approach and persevere, and provides us with enduring psychological resources. This is the heart of the 'broaden-and-build' theory of psychologist Barbara Fredrickson, and one that is supported by many other researchers. Research on the 'happy-productive worker' shows that low positive affect impedes employee performance. In addition, a number of researchers believe that job satisfaction is largely a reflection of positive affect. The more positive affect - the less job dissatisfaction, absenteeism and turnover. Meta-analyses of hundreds of studies show that positive affect-driven job satisfaction connects to bottom-line organizational performance. So instrumental is positive affect to personal and organizational performance, that the Gallup Organization devoted an entire book to the topic of building positive affect in the workplace (i.e., *How Full is Your Bucket?*).

Managerial Performance

Managers are not exempt from emotional disorders and the impact that they have on performance. This is

demonstrated in an on-going research study conducted by Paul Fairlie, Director of Research at WarrenShepell, and Dr. J.P. Pawliw-Fry at the Institute for Health and Human Potential. The researchers found that depressed and anxious managers are also low-performing managers. Specifically, depression and anxiety symptoms are related to lower performance scores on leading and managing people, developing people, building and maintaining relationships, communication, peer and team effectiveness, problem-solving and decision-making, planning and organizing, and overall performance. The average correlation was 0.33, suggesting that at least 11% of managerial performance in organizations is under the control of emotional well-being.

A manager's problems are not his or her own to bear. Consider the following: Studies show that direct managers have the largest impact of any factor on employee job satisfaction. Additionally, the characteristics of leaders and managers have a formative impact on the climate and culture of organizations. Culture, in turn, has been shown to drive bottom-line performance. In other words, the emotional and performance problems of managers have a span of influence that is equal to their span of control. Call it 'viral' depression and anxiety.

The Cost of Emotional Problems

The discussions, above, suggest that emotional problems can erode individual performance. These performance deficits are also costly. Consider the following:

- Mental health disorders are the third-highest sources of direct health care costs, at $4.7 billion. Some of these costs are borne by employers.
- At least 6% of Canadians with a mental disorder or substance dependency reported at least one disability day in a two-week period when they were unable to work due to their emotional or mental health.
- Emotional problems are associated with the largest average number of lost work days and work cutback days in the United States and Britain.
- Depression accounts for a higher absenteeism rate than back pain, cardiovascular disease, hypertension, diabetes, and other mental conditions.
- Employees judged as 'high risk', both physically and mentally, had significantly higher health expenditures than low-risk employees. The expenditure difference between high- and low-risk employees was highest for those with depression.
- In a study of 150,000 employees, depression was found to be the most frequent diagnosis in health clams paid for by employers. Anxiety was ranked third. Bipolar Disorder was ranked fourth.
- Among major diseases, depression ranks second only to advanced cardiovascular disease in the total number of days that patients spend hospitalized or disabled at home.
- The MIT Sloan School of Management ranked depression among the most costly major health concerns, including cardiovascular disease, cancer, and AIDS. Depression is more widespread than all three.
- Chronic depression and anger are risk factors in cardiovascular disease, which escalates drug, short-term disability, and long-term disability costs.
- The annual cost of depression in the United States is estimated to be $43 billion - $23 billion of that due to absenteeism and lost productivity in the workplace.
- In general, there is a strong relationship between mood disorders, disability, and subsequent economic losses.

Employers, in general, appear to concur with these findings. In a recent WarrenShepell/Ipsos-Reid poll, HR practitioners cited stress, anxiety, and depression as the most serious issues affecting absenteeism and/or health benefit costs in their organizations.

Depression also has hidden costs, since many cases are undiagnosed and untreated. It has been estimated that depression costs employers up to $3,000 U.S. per year for each affected employee. But the figure doubles if

depression is left untreated. Clinical research suggests that untreated episodes of depression typically lasts six months or longer than treated episodes. This leads to long periods of 'presenteeism' where depressed employees 'show up' for work and turn in sub-par performance.

To return to an earlier point, it was mentioned that the average client organization served by WarrenShepell employs approximately 500 people. For an organization of that size, given current prevalence rates, and given median income in Canada, it is estimated that at least $120,000 in direct cost is lost annually in gross salary and wages as a function of depression. This estimate would increase substantially if other factors are taken into consideration (e.g., additive effects of other disorders, widespread impact of managerial emotional problems, team-based effects of individual problems).

Solutions for Emotional Problems in the Workplace

The average work week in Canada has increased from 42 to 45 hours per week over the past decade. Forty percent of employees work more than 50 hours per week, compared to 25% in 1990. Clearly, Canadians are spending a greater number of their waking hours in the workplace, including Canadians suffering from emotional problems. Thus, the responsibility for addressing the emotional problems of Canadians rests equally with citizens, governments, and employers. Given the impact that these problems have on organizational performance, employers need to identify ways of preventing emotional disorders before they take root and to facilitate access to proper treatment when they emerge. What can employers do to address emotional problems in their workforces?

Job & Organizational Design

Emotional problems are triggered as easily by work events as they are by non-work events. Thus, employers can go a long way to preventing the emergence of emotional problems by ensuring that work environments are healthy rather than toxic (i.e., promote engagement rather than mental illness). A large body of research suggests that personal control is one of the most critical factors in workplace mental health. When employees toil in jobs with little control, they lack the necessary environmental resources to cope with work stressors. Thus, employers should re-design jobs and organizational practices to maximize employee autonomy. This can be achieved by enabling greater decision latitude and input, utilizing a wider range of each employee's skills and talents, engaging in less micro-management and more delegation, and increasing employee ownership of projects and initiatives. Employees also perceive themselves as being more in control when they are given clear expectations for performance, receive regular and clear feedback, and when information is more freely shared across the organization.

Training Managers to Detect Emotional Problems

Managers should be trained to recognize symptoms of emotional problems among peers and direct reports and address them in an appropriate manner. These are symptoms that are considered out of the ordinary for people (i.e., significant change from regular behaviour). Table 1 lists some of the more common signs of employee depression.

Managers should also listen for frequent and consistent complaints of employee stress. While consistent work stressors may be partly to blame, constant stress is often the 'face' of more serious anxiety problems. Verbal admissions of stress are more acceptable for the workplace. Additionally, employees may not know the difference between stress and anxiety and will inappropriately label their problem.

Of course, in order for managers to detect emotional problems in their employees, they must know what is 'typical' behaviour for them. This is why it is crucial

for managers to get to know their direct reports as people with characteristic traits, skills, needs and values. Often, senior management promotes employees to managerial positions as a reward for task or technical performance in a previous job. What is sometimes lacking are the requisite interpersonal skills for effectively managing people. Organizations can help managers to better recognize and address emotional problems through assessment and development programs to build social competencies (e.g., interpersonal understanding). Managerial compensation could also be tied to more social dimensions of performance.

Employee Assistance Programs

It was concluded earlier that psychotherapy was effective for treating emotional problems. The following are some reasons why counselling within employee assistance programs may be a welcome addition to traditional psychotherapy.

First, the counselling methods practiced in EAPs tend to be 'short-term and solution-focused'. As such, they share similarities with problem-solving therapy, which is emerging as an effective therapy for mental illness, including depression. This approach involves five steps in effective problem-solving: problem orientation, definition, alternatives, decision, and implementation.

Second, employees who are reluctant to seek help for their emotional problems may view employee assistance programs as an attractive alternative to traditional forms of mental healthcare. It is well-known that the vast majority of people with psychiatric disorders do not seek professional help. It is estimated that only 32% of Canadians with mental disorders have talked to a health professional in the last 12 months (i.e., family physician, psychiatrist). In another study, it was found that 21% of Canadians with mental disorders did not seek help for their problems despite feeling a need to do so. Personal finances do not seem to have an impact on reluctance to seek help, as similar percentages of people seek help for mental health problems in Canada (i.e., universal health insurance) and the United States (i.e., no universal health insurance). Partly because of these factors, depression in North America is vastly undiagnosed and untreated. As much as two-thirds of approximately 17 million Americans are undiagnosed and untreated for depression each year.

Why do people avoid seeking help for their emotional problems? Some people prefer to manage problems on their own while others report that they just haven't 'gotten around to it.' Some other reasons include a failure to recognize symptoms, underestimating severity, limited access to help, reluctance to seek a mental health specialist due to stigma, and lack of health insurance.

Employee assistance programs can address many of these concerns, partly by creating awareness of emotional problems within employee populations (e.g., through seminars) and by offering comfortable alternatives to traditional psychotherapy at no direct cost to employees. For employees who are 'therapy-averse,' EAP counselling may be viewed more as a form of 'coaching' or 'guidance counselling.' While EAPs cannot replace other forms of clinical counselling, they may be effective for addressing mild to moderate emotional problems and act as key access points for employees who require more intensive help for severe forms of emotional distress.

As rates of global mental illness continue to climb, the need to address emotional problems at home and in the workplace has never been more pressing. However, there is hope, as effective treatments continue to emerge and become widely available. For example, despite its prevalence and associated costs, depression has become one of the most treatable mental illnesses. Seventy to eighty percent of sufferers are successfully treated and can return to work within a relatively short period of time. In addition, a recent, comprehensive literature review of over 50 studies on depression and work productivity has concluded that productivity gains from depression treatment can far exceed direct treatment costs. In summary, employers who 'choose' to bear the costs of depression over the competing costs of treatment are losing out.

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The WarrenShepell Research Group

The WarrenShepell Research Group has been formed to gather, analyze and provide commentary on organizational health trends that affect our clients, their employees and families. Collecting and disseminating data about mental health issues,linking with some of the industry's highest profile research institutes and individual scholars, and drawing from our 25 years of expertise in the industry, the WarrenShepell Research Group's mandate is to help our clients and the broader business community understand the intricacies and the impact of poor mental health, work/life imbalances and related issues in our workplaces and in our communities.

The findings contained in this report are based on WarrenShepell proprietary data. The findings are supported by information from a variety of academic, government, and private research institutions. Most references have been omitted for space considerations and are available upon request.

This study was conducted by Paul Fairlie, Director of Research with WarrenShepell. The WarrenShepell Research Group is overseen by Karen Seward, VP Research and Development. Questions or comments may be directed to Karen Seward at 1-800-461-9722.

Table 1. Common Signs of Employee Depression

- Sad expression
- Avoids eye contact
- Change in appearance (e.g., weight gain/loss, hygiene, clothes)
- Looks tired and fatigued
- Depressed speech (i.e., slow, flat, low volume)
- Physically agitated (e.g., fidgeting, pacing)
- Health complaints (e.g., headache, abdominal and joint pain)
- Loses concentration easily
- Low interest and morale
- Irritable or angry (e.g., outbursts, blaming others)
- Frustration over little things
- Admissions of guilt and self-blame
- Doesn't contribute or cooperate with others
- Isolates self from others
- Accidents and mistakes
- Absenteeism
- Tardiness
- Tasks take longer to perform
- Lower performance
- Alcohol and drug abuse