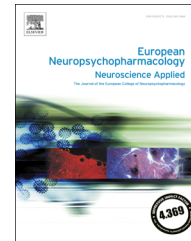




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# High occupational level is associated with poor response to treatment of depression

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Received 3 March 2016; received in revised form 26 April 2016; accepted 8 May 2016

## KEYWORDS

Workplace;  
Depression;  
Treatment response

## Abstract

Depression may be complicated by work-related stress and, in turn, depression is a leading cause of disability in workplaces. Though available effective treatments, only one third of patients reach full remission after a first treatment trial and nearly half of the patients are non-responders. Occupational level has been found to be a reliable predictor of health outcome in the general population. In the present study we tested the potential association of occupational level of those in work with response to treatment of depression in a large multinational sample.

Major depressive disorder patients ( $n=654$ ) stratified in three occupational levels (high, middle, low) were considered for the present study. Response to last treatment for current episode and treatment resistant depression, defined as non-response to 2 or more previous adequate treatment trials, were considered the outcome variables.

Depressed patients from the high occupational level had a higher level of educational achievement. They showed a significantly poorer response to the last treatment with lower remission rates and more treatment resistance than the other occupational level groups. They were treated less with Serotonin Reuptake Inhibitors (SRIs). Potential confounding factors did not influence the main effect. The present findings indicate that those working at a high occupational level may be a risk factor for

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poor response to medication for depression and this has potential implications for clinicians and their patients, for future research, for employers and for public policy.

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## 1. Introduction

Depression is predicted to be the leading cause of disability by 2020 (Mathers and Loncar, 2006) with substantial costs for health systems and, in working adults, indirect costs from lost working hours (*absenteeism*), loss of lifetime income, early retirement and, especially, loss of productivity (*presenteeism*) (Ekman et al., 2013; Thomas and Morris, 2003). Depression may be also causally related to or complicated by work-related stress in many cases (Tennant, 2001) and specific job-type related factors may mediate such an association (Hammig and Bauer, 2013). Though effective and, compared to older drugs, safer pharmacological treatments, are available for major depression, only one third of patients reach full remission after a first treatment trial (Trivedi and Daly, 2008) and nearly half of the patients are resistant to treatments (Schosser et al., 2012; Souery et al., 1999).

Social class based on occupational level (OL) has been found a reliable indicator of health and lifestyle outcomes (Borrell et al., 2000; Davey Smith et al., 1998; Drever et al., 2004; Muntaner et al., 2003; Pujol et al., in press; Rosengren et al., 1998), including mental health outcomes (Levy, 1974) and major depression (Bagley, 1973). OL refers to the stratification in which people are grouped into a set of hierarchical occupational categories, which differ for skills, responsibility, earnings, entry qualifications, prestige (Scott and Marshall, 1998) as well as psychosocial factors (Hammig and Bauer, 2013). OL has also been associated to treatment outcome in major depression (Cheng et al., 2007), but to date the consistency of this association is unclear.

The literature in the field has focused more on proxy measures of the broad construct of socioeconomic status, commonly defined by the social standing of an individual or group, usually based on a combination of education, income and occupation (American Psychological Association, 2007). Low socioeconomic status has been consistently associated with poor general health (e.g. Kunst et al., 2005) and poor mental health outcomes (e.g. Fryers et al., 2003). A number of studies have consistently found less response to antidepressant treatment (Cohen et al., 2006; Falconnier, 2009; Jain et al., 2013; Jakubovski and Bloch, 2014; Trivedi et al., 2006), more suicidal ideation (Cohen et al., 2009), longer duration of major depressive episodes (Gilmer et al., 2008), slower recovery (Kim et al., 2011) and more resistance to treatment (Rush et al., 2004) in individuals from low-income groups or low socioeconomic strata (Falconnier, 2009).

Nevertheless, although strongly correlated, income or socioeconomic level are different constructs from OL. To our knowledge, only one study by Cheng et al. (2007) evaluated occupational class in relation to treatment outcome for depression. The authors found individuals from low-occupational class having a higher probability of remission at discharge after treatment for a major depressive

episode as compared to individuals from middle-high occupational class. However, the authors gave only a cursory discussion of this finding and suggested it could be due to a possible bias.

Though a large literature supports socioeconomic status as a risk factor for poor response to medication for depression, the specific relationship between OL and treatment outcome is still unclear. Therefore, in the present study, we aimed to evaluate the relationship between OL, response to medication for depression and treatment resistance in a multinational European sample of major depressed subjects retrospectively evaluated.

## 2. Experimental procedures

### 2.1. Sample

The sample was recruited within a large multicenter, multinational study project, named the “*Patterns of treatment resistance and switching strategies in unipolar affective disorder*”, conceived in the context of the Group for the Study of Resistant Depression (GSRD). For recruitment details see Souery et al. (2007). Briefly, inclusion criteria were (i) meeting DSM-IV criteria for primary non-psychotic major depressive disorder (MDD) and (ii) at least one adequate treatment with drugs for depression for current or most recent episode. Adequacy of treatment was based on (1) duration of at least 4 weeks; (2) dosage equal or higher than that defined as effective. For the purpose of the present study, we considered only patients aged 18 or more, and in employment at the time of the evaluations. Being unemployed, without occupation, student, stakeholder, invalid or infirm were exclusion criteria, together with diagnosis of Bipolar disorder or Schizophrenia spectrum disorder. The study protocol was approved by the local ethical committees of the participating centers. Patients were included after signing an informed consent.

### 2.2. Evaluations

Clinical and socio-demographic variables were collected by clinical interviews, review of clinical charts and a specific questionnaire (see Souery et al., 2007). A questionnaire on treatment history was also employed and validated using patients' medical records. Treatment resistance was defined as non-response to 2 or more adequate trials with medications for depression - as described above. Severity of depression at the end of the last treatment was evaluated by the 17-item Hamilton depression rating scale (HDRS) (Hamilton, 1960). Current remission was defined as a score of 7 or less on the 17-item HDRS. Response to the last treatment was evaluated according to the clinician' judgment and HDRS score of 17 or less. Occupational level was coded according to Hollingshead's Occupational scale (Hollingshead, 1975), which consists of 7 occupational levels. We further collapsed the 7 levels of occupation into three occupational levels (OLs): high-OL which included workers from levels 1, 2 or 3; middle-OL, which included workers from levels 4 and 5; low-OL which included workers from levels 6 or 7.

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