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Research report

Long-term work disability and absenteeism in anxiety and depressive disorders

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ABSTRACT

Background: This longitudinal study aims to compare long-term work disability and absenteeism between anxiety and depressive disorders focusing on the effects of different course trajectories (remission, recurrence and chronic course) and specific symptom dimensions (anxiety arousal, avoidance behaviour and depressive mood).

Methods: We included healthy controls, subjects with a history of – and current anxiety and/or depressive disorders with a paid job ($n=1632$). The Composite International Diagnostic Interview was used to diagnose anxiety and depressive disorders and to assess course trajectories at baseline, over 2 and 4 years. The World Health Organization Disability Assessment Schedule II and the Health and Labour Questionnaire Short Form were used to measure work disability and absenteeism. Symptom dimensions were measured using the Beck Anxiety Inventory, the Fear Questionnaire and the Inventory for Depressive Symptomatology.

Results: A history of – and current anxiety and/or depressive disorders were associated with increasing work disability and absenteeism over 4 years, compared to healthy controls. Long-term work disability and absenteeism were most prominent in comorbid anxiety–depressive disorder, followed by depressive disorders, and lowest in anxiety disorders. A chronic course, anxiety arousal and depressive mood were strong predictors for long-term work disability while baseline psychiatric status, a chronic course and depressive mood were strong predictors for long-term work absenteeism.

Limitations: Results cannot be generalized to other anxiety disorders, such as obsessive compulsive disorder, posttraumatic stress disorder and specific phobias. Self-reported measures of work disability and absenteeism were used.

Conclusions: Our results demonstrate that depressive syndromes and symptoms have more impact on future work disability and absenteeism than anxiety, implying that prevention of depression is of major importance.

1. Introduction

Anxiety and depressive disorders have a major impact on daily functioning (Alonso et al., 2004; Bijl and Ravelli, 2000b; Stein et al., 2005; Olfson et al., 1997; Mendlowicz and Stein, 2000; Hendriks et al., 2014; Iancu et al., 2014). Subjects with anxiety and depressive disorders experience more disability at work and more work loss days (absenteeism) (de Graaf et al., 2012; Stewart et al., 2003; Kessler and Frank, 1997; Adler et al., 2006). This loss of productivity is a burden for subjects themselves, for their families and social support system, and for the society at large, which includes increased use of health care services (Druss et al., 2000; Buist-Bouwman et al., 2005; de Graaf et al., 2012). The risk for enduring work incapacity demonstrates the urgency to further explore the relationship between anxiety and depressive disorders, and work disability and absenteeism (Ahola et al., 2011; Mykletun et al., 2006; Bültman et al., 2008).

To date, most knowledge about work disability and absenteeism is derived from cross-sectional and short-term treatment studies. Cross-sectional studies showed that depressive disorders have more impact on work disability and absenteeism than anxiety disorders (Plaisier et al., 2010; de Graaf et al., 2012; Alonso et al., 2004;

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Merikangas et al., 2007). However, it remains unclear whether these differences remain present over a longer period. Anxiety disorders are more chronic in nature than depressive disorders (Penninx et al., 2011; Merikangas et al., 2003). Consequently, it is likely that over a longer time subjects with anxiety disorders experience at least as much work disability and absenteeism as subjects with depressive disorders. Nevertheless, this does not make depression a less important target for intervention because research about this topic is lacking. Little is known about differences and commonalities in work disability and absenteeism between comorbid anxiety–depressive disorders and pure anxiety disorders and pure depressive disorders. Research indicated that subjects with a comorbid anxiety–depressive diagnosis have more severe symptoms, more disability, a longer duration of illness and are less likely to respond to treatment than subjects with a single anxiety or depression diagnosis (Vollrath and Angst, 1989; Bijl and Ravelli, 2000a,; Hecht and Wittchen, 1990: Roy-Byrne et al., 2000; Bruce et al., 2005; Ormel et al., 1994). Anxiety disorders and depressive disorders are highly comorbid disorders (Kesler et al., 2005). According to DSM-IV-TR, diagnostic criteria overlap with regard to symptoms like irritability, trouble with concentration, sleeping problems, restlessness, and fatigue (APA, 1994). Furthermore, there is overlap in treatment, including use of antidepressants and psychological interventions. Anxiety and depressive disorders often arise sequentially within the same patient and the order is more likely to start with anxiety, depression commonly arising later (Merikangas et al., 1996; de Graaf et al., 2002).

Besides baseline psychiatric status, it remains unclear to what extent the course of anxiety and depressive disorders influences the outcome in terms of long-term work disability and absenteeism. To our knowledge, associations between anxiety and depressive course trajectories and long-term work disability and absenteeism have not yet been investigated. Previous investigations point out that a chronic course in anxiety and depressive disorders is associated with a poor outcome and more comorbidity (Fichter et al., 2010; Merikangas et al., 2003; Rherbergen et al., 2011; Hendriks et al., 2013). Therefore, we expect that a chronic course is associated with more long-term work disability and absenteeism.

Considering the baseline clinical situation, specific clinical features, such as symptom severity or the prominence of a specific dimension of symptoms (like anxiety arousal, avoidance behaviour and depressive mood) may also provide important information about the prognosis of work disability and absenteeism (Hendriks et al., 2013). In order to better understand underlying symptoms like anxiety arousal, avoidance behaviour and depressive mood driving work disability and absenteeism patterns, it is important to examine their role in a prospective longitudinal design. Knowledge about these factors may help identifying subjects at risk for long-term work disability and absenteeism and to design interventions (both at organizational level and individual level) to prevent them.

This longitudinal study among a large cohort of working subjects aims to investigate: 1) differences in subsequent long-term work disability and absenteeism between subjects with a history (lifetime but not 6-month recency) of anxiety and/or depressive disorder, and subjects with current anxiety disorders, depressive disorders and comorbid anxiety–depressive disorders at baseline and healthy controls; 2) differences in subsequent long-term work disability and absenteeism for different psychiatric course trajectories (remission, recurrence and a chronic course) for subjects with anxiety and/or depressive disorders; and 3) the role of specific symptom dimensions that are common across anxiety and depression, such as anxiety arousal, avoidance behaviour and depressive mood, in subsequent long-term work disability and absenteeism.

2. Methods

2.1. Study sample

The Netherlands Study of Depression and Anxiety (NESDA) is a naturalistic cohort study to examine the long-term course and consequences for different aspects of life (such as mental and physical health, demographic, psychosocial and lifestyle aspects) of anxiety and depressive disorders. A more detailed description of the design and sampling of NESDA is provided elsewhere (Penninx et al., 2008). In short, a total of 2981 subjects aged 18 through 65 years were included. The research protocol was approved by the ethical committees of participating universities, and all respondents provided written informed consent. The sample consists of subjects with a current or lifetime diagnosis of anxiety or depression, and healthy controls. In order to recruit a sample that reflects the entire range of psychopathology, recruitment took place in the general population (564 subjects), general practices (1610 subjects) and mental health care organizations (807 subjects). The NESDA community sample builds on two cohorts that were already available through prior studies. The first cohort is from the Netherlands Mental Health Survey and Incidence Study (NEMESIS), a community-based study (Bijl et al., 1998). The second cohort exists of participants of the Adolescents at Risk for Anxiety and Depression (ARIADNE) study (Landman-Peeters et al., 2005), a prospective cohort study among 528 biological children (aged 13–25 years) of parents who were treated for depressive or anxiety disorder as outpatient at a mental health organization. Primary care patients were recruited from 65 general practitioners (GPs) in the vicinity of the field sites (Amsterdam, Groningen, Leiden). In selecting these GPs, attention was paid to the use of an appropriate electronic patient record databases which allows uniform data extraction for research purposes. The specialized mental health patients were recruited from outpatient clinics of regional facilities for mental health care around the three research sites. Subjects were excluded when they had a primary diagnosis of psychotic, obsessive compulsive, bipolar or severe addiction disorder, or when they were not mastering the Dutch language. Baseline measurements (T0) took place between September 2004 and February 2007 and included an assessment of demographic and personal characteristics, a standardized diagnostic psychiatric interview and a medical assessment. Two (T1) and four years (T2) after the baseline measurement, an extensive face-to-face follow-up assessment was conducted. This assessment was comparable to the baseline assessment. For the present study, we included healthy controls, subjects with a history (lifetime but not 6-month recency) of anxiety and/or depressive disorder at baseline and subjects with a 6-month recency diagnosis at baseline and with a paid job for at least 8 h a week at baseline (Fig. 1). We made a distinction between full time and part time employment. In the Netherlands a job for 36 h a week is considered as full time employment (www.rijksoverheid.nl). In total 1632 subjects met these criteria at T0; 403 healthy controls, 373 subjects with a history of anxiety and/or depressive disorder, 287 subjects with a 6-month anxiety disorder, 242 subjects with a 6-month depressive disorder and 327 subjects with a 6-month comorbid anxiety–depressive disorder. At T1, 1420 subjects (87.0%) had a follow-up assessment, and 1266 subjects (77.6%) had a follow-up assessment at T2.

2.2. Psychiatric status

The Composite International Diagnostic Interview (CIDI version 2.1) was used to diagnose the presence of an anxiety disorder (social anxiety disorder, panic disorder with or without agoraphobia, generalized anxiety disorder) or depressive disorder (dysthymia, major