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Research Paper

Depression And How Work Environment Contribute To It and the Remedies Thereof

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Abstract:
Depression is reported to be a major cause of illness-related sub-optimal work performance (presenteeism). However, the majority of studies examining presenters have relied on self-report measures of work performance. Furthermore, employers currently face a number of practical challenges in attempting to facilitate early identification of depression. Depressive symptoms are potential outcomes of poorly functioning work environments. Such symptoms are frequent and cause considerable suffering for the employees as well as financial loss for the employers. Accordingly good prospective studies of psychosocial working conditions and depressive symptoms are valuable. Scientific reviews of such studies have pointed at methodological difficulties but still established a few job risk factors. Those reviews were published some years ago. There is need for an updated systematic review using the GRADE system. In addition, gender related questions have been insufficiently reviewed.
Keywords: *Depression, mental disorders, work, employment, performance, presenteeism, mood disorders, prevention.*

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I. INTRODUCTION:

Depression is a common global mental health condition. Depression is an "illness that involves the body, mood, and thoughts" (National Institute of Mental Health, 2007a). Depressive disorders consist of a number of related conditions as described later within this paper. In the United States, it is estimated that approximately one out of every two American families will have a family member suffering from depression at some point in the developmental life cycle (Goldberg & Steury, 2001; National Institute of Mental Health, 2007a). Approximately 5 to 10% of the United States population suffers from depression at any given time. As many as 20% of U.S. adults will experience depressive symptoms with a lifetime incidence of depression estimated at 20 to 55 % of American adults (McClanahan & Antonuccio, 2004). It is thought that the approximately 30,000 suicides per year are likely associated with depression (Greenberg, Stiglin, Finkelstein, & Berndt, 1993).

Just as in the United States, depression is a common mental health problem from an international perspective. The World Health Organization reports that depression is the fourth leading cause of disease burden in the world and is expected to be the second leading cause of disease burden by 2020 (McClanahan, & Antonuccio, 2004; Williams & Strasser, 1999). In a survey involving fourteen countries in Africa, Asia, Europe, Latin America, and the Middle East, the World Health Organization's Collaborative Study of Psychological Problems in General Health Care documented depression as a major worldwide health care issue. Estimates of major depression for adults range from 2 to 4% in samples of adults assessed by the World Health Organization International Consortium in Psychiatric Epidemiology (2000; Wang, Simon, & Kessler, 2003).

Data reported for selected nations highlight depression as a global health issue. In research cited by Wang and Patten (2001) and Myotto (2009), 5% of Canadian adults experience depression and 10 to 11% will experience depression at some point during their life cycle. Australia recognizes depression as a major public health challenge for developed countries and initiated a national depression recognition and treatment initiative referred to as Beyondblue (Hickie, 2004). This initiative as part of Australia's National Mental Health strategy includes community, workplace, and health practitioner education and information strategies aimed at depression recognition, prevention and early intervention. McDaid, Curran, and Knapp (2005) describe depression as a major health problem in European Union nations. Nakao and Takeuchi (2006) cite evidence that

depression rates in Japan have increased dramatically. Accordingly, worldwide epidemiological estimates for depression appear to be similar to those reported in the United States (Andrade et al., 2003; Kessler, Merikangas, & Wang, 2008; Ormel, VonKorff, Ustum, Pini, Korten, & Oldehinkel, 1994).

Terminology:

Depression is a state of low mood and aversion to activity. Classified medically as a mental and behavioural disorder, the experience of depression affects a person's thoughts, behaviour, motivation, feelings, and sense of well-being. The core symptom of depression is said to be anhedonia, which refers to loss of interest or a loss of feeling of pleasure in certain activities that usually bring joy to people. Depressed mood is a symptom of some mood disorders such as major depressive disorder or dysthymia; it is a normal temporary reaction to life events, such as the loss of a loved one; and it is also a symptom of some physical diseases and a side effect of some drugs and medical treatments. It may feature sadness, difficulty in thinking and concentration and a significant increase or decrease in appetite and time spent sleeping. People experiencing depression may have feelings of dejection, hopelessness and suicidal thoughts. It can either be short term or long term.

Statement of the problem:

The globalization had created a rapid economic and social change, resulting in radical shifts in working environment and lifestyle patterns of the working people and their families. With the rushing need of expectation from the society and to satisfy the wants of the economy the private sector management wishes to get the work done by the employees. Employers and employees have to work collaboratively to complete the process of their managerial goal. Hence, came the need for micro management to make the employee complete the work perfectly.

Scope of the study:

Pressures in the workplace like fear of redundancy, long hours, dealing with difficult people or situations, or unreasonable targets causes depression. The study aims to study necessity of micro management and its impact as depression on the employees.

Overview of Depression as a Mental Health Condition:

Depression has been conceptualized as involving emotional states that can range from distress to despondency to melancholy. In this conceptualization, depression can be viewed as a normal feeling state and a common experience that affects an individual's physical, emotional, and cognitive functioning. Depression is also influenced by cultural, age, and gender factors. Depression can also be viewed as a symptom of another disorder. As a specific illness or disorder, the Diagnostic and Statistical Manual of Mental Disorders IV-TR (American Psychiatric Association, 2000) is widely recognized as the classification system that defines depression. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM; American Medical Association, 2008) and the International Classification of Diseases – Tenth Revision (ICD-10; World Health Organization, 2007) provide a disease classification system that allows for additional comparability of disease classification and morbidity/mortality statistics at an international level. These latter two classification systems differ slightly from the Diagnostic and Statistical Manual of Mental Disorders IV-TR with respect to classification of depressive disorders.

The Diagnostic and Statistical Manual IV-TR (American Psychiatric Association, 2000) classifies depressive disorders according to symptoms and duration. Within this framework, there are five principal depressive disorders: major depressive disorder, dysthymic disorder, adjustment disorder with depressed mood, adjustment disorder with mixed anxiety and depressed mood, and depressive disorder not otherwise specified. A provisional diagnostic category of minor depressive disorder as described by Morris and Hardesty (2002) is included within the Diagnostic and Statistical Manual IV-TR. The above references provide detailed descriptions of these depressive conditions.

Research suggests that depressive symptoms are mediated by gender and cultural considerations. Manifestation of symptoms and associated behavioral components, likelihood to participate in treatment, and relationship to other mental health conditions are different for men and women as well as within different cultures. American Psychological Association OnLine (2006), Cox, Ness, and Carlson (2008b), Mental Health America (2007), and National Institute of Mental Health (2006, 2007a) describe gender associated characteristics of depression. Cultural dimensions of depression are described by Inaba et al. (2005), Kawakami et al. (2005), Murray and Lopez (1997), Simon, Goldberg, VonKorff, and Ustun (2002), and Vasiliadis, Lesage, Adair, Wang, and Kessler (2007).

Personality with context to Depression:

Personality almost always means taking a large number of behavioural characteristics and reducing them to a more restricted set of qualities or attributes. Evidence about personality comes partly from what people do and say at various times, but it's also partly a matter of how people perform what they do - the style, their feelings and expression etc. that brings a unique and personal touch. The personality traits of hostility, anger and aggressiveness have long been suggested as risk factors for depression and as well as coronary heart disease.

An individual prone to develop clinical depressive illness display certain distinctive personality characteristics. An examination of the relevant literature, however, makes it clear that we are very far from consensus about the characteristics of such a putative personality pattern predisposing to depression. The issue is the important one for the understanding and treatment of depressive illness, for two main reasons. First, since an observable personality pattern represents to a large degree of crystallization of underlying psychodynamic processes, agreement on the characteristics of such patterns would offer significant aid to efforts to study psychological factors in the genesis of depression. Second, agreement on the existence of such patterns has a bearing on the investigation of genetic and biochemical factors in depression. Here the study is an investigation to find out the effect of some psychological variables like personality, hostility and occupational stress, in the genesis of depression in the workplace.

Hostility has been conceptualised as primarily a cognitive phenomenon involving cynical attitudes and mistrust of others, although it refers to a broader construct involving hostile attitudes, angry affect and aggressive behaviour. It appears to be an independent risk factor for poor health outcomes. Miller et al, (1996) Smith (1994) defined hostility as reflecting "devaluation of the worth and motives of others, an expectation that others are likely sources of wrong doing, a relational view of being in opposition toward others and a desire to inflict harm or see others harmed".

Depressive emotions may be recognized from a sad or tense facial expression, crying, anxiety, fear and sobbing, low voice, resistant, slow speech etc. Their emotions are usually focused on something which the individual's belief is related to some life situation or personal experience. Irritability on aggressiveness may be related to underlying anxiety or fear, or to resentment, hate or anger. Anger reactions are frequently the expression of fear which will be increased by critical attacks of others or be suppressed by the individual (patient) and then deepen the depressed mood because they feel guilty or rejected. These are certain traits in human character and personality that makes one authoritarian, aggressive or hostile.

Buss (1961) has contended that hostility may be regarded as a continued anger response that has some of the autonomic or postural aspects of anger. When an anger stimulus is presented to a person, it elicits an anger reaction process which involves evaluation of the stimuli in the form of a negative source. Hostility resembles anger in its orientation toward injury and punishment but differs in lacks of autonomic and postural components of anger. However, for some individuals the association between anger and hostility is close, and they only have to recall past humiliation and resentments in order to become angry.

The research evidence demonstrated the role of personality factors in the development of stress related diseases is impressive. However, it is important to keep in mind that personality characteristics are just some of the risk factors in overall picture of health and disease (Adler and Mathews, 1994).

Depression as a Major Workplace Problem:

As depression is commonly found in the general population, this condition overlaps with functioning within the workplace. Both internationally and in the United States, depression has important economic impacts relative to lost productivity within the workplace (Myette, 2008). Lost productivity involves presenteeism, in which the employee is present in the work setting but productivity is reduced due to health concerns or depressive symptoms, or in terms of absenteeism from work (Bender, 2009). In the United States, depression affects approximately 10 to 17.5 million employees (Johnson & Indvik, 1997a; Shoor, 1994). Estimates of annual costs to U.S. businesses as a result of depressive symptomatology range from 70 billion to 83.1 billion U.S. dollars (Byrne, Kacmar, Stoner, & Hochwarter, 2005; Greenberg et al., 2003; National Mental Health Association Fact Sheet, 2006; Wang, Simon, & Kessler, 2008). It is estimated that business and industry lost 12 billion dollars from lost productivity, 12 billion dollars from absenteeism, 26.1 billion dollars from direct treatment costs, and 5.4 billion dollars from mortality (Greenberg et al., 2003; Lerner et al., 2004). Birnbaum, Cremieux, Greenberg, and Kessler (2000) report that depressed workers' disability costs were 4.5 times greater than those for typical non-depressed employees.

In the European Union, it is thought that one-third of the workforce experiences a mental health disorder in which depression is a significant factor (McDaid et al., 2005). Early retirement, reduced opportunities for career development, reduced lifetime productivity, lost taxation revenue, hiring and training costs, reduced economic growth, higher social security payments, as well as absenteeism and presenteeism are elements of productivity losses consequential to depression and other mental health disorders within those

nations comprising this geographical region (McDaid et al., 2005). These authors provide estimates of the significant economic burden of depression in terms of lost productivity for the various European Union countries. Annual lost productivity estimates range from 1.44 billion Euros in the Netherlands to 15.46 billion Euros in the United Kingdom.

Lost productivity estimates due to depression are also reported for other world regions. In Canada, it is estimated that workplace costs due to poor mental health and attendant loss of productivity amounted to 1.5 billion Canadian dollars (Baba, Galperin, & Lituchy, 1999). Wang (2009) indicates that depressive symptoms in Chinese workers significantly impaired their work life quality. In a study involving nurses in several Caribbean nations, Baba et al. (1999) found depression to be a significant mental health issue within this occupational group with absenteeism, and turnover intention being significant problems associated with depressive symptoms for this sample.

Depression in the workplace presents multiple work behaviour performance and behavioral deficits (Lerner et al., 2004; National Institute of Mental Health, 2007b; Wallace, 2006; Wang et al., 2008). These include (a) inconsistent or reduced productivity, (b) absenteeism, tardiness, or frequent absence from the employee's work site, (c) increased errors, reduced work quality, (d) procrastination, failure to attain deadlines, (e) withdrawal from interaction, cooperation, or conflicts with co-workers, (f) over sensitivity, over-reactive emotions, (g) decreased interest in work or work tasks, (h) slowed behaviour or thought processes, (i) difficulty learning or remembering tasks associated with the work setting, (j) fatigue and impaired energy level, and (k) impaired attention, and (l) long term diminished educational and professional attainment.

Depressive symptoms may develop over time rather than presenting acute, fullblown manifestations of symptomatology. Wang et al. (2008), in reviewing crosssectional and longitudinal studies, report that changes in the severity of depressive symptoms also result in changes in work impairment severity. The employee may initially experience anxiety and mild depressive episodes ranging from several weeks to several months. Ultimately these symptoms develop into more severe depressive symptomatology. Unfortunately, depression presents during the employee's most productive years, namely ages 24 through 44 years of age (Byrne et al., 2005, Wang et al., 2008). Physical health problems may also be associated with the depressive condition (National Institute of Mental Health, 2007a).

Stressors and workplace conditions also contribute to depressive symptoms. Interpersonal conflicts, work demands, organizational politics, lack of faith in organizational management or leadership, and perceived control over job tasks and job environment are factors related to depressive reactions (Byrne et al., 2005; Melchior et al., 2007). These stressors combine into multiple work stressors that further compound their impact upon the employee's mental health functioning.

With the sustained economic recession, suicide has been increasing in Japan (more than 3000000 victims annually since 1998). Particularly among middle-aged employees. Development of preventive measures in needed, however, employees have limited knowledge of the basic information about suicide and depression. One office in Sitama prefecture, Japan, has been provided with a mental health support programme. An initial questionnaire survey was conducted in December, 1999. It contained demographic data and information about working styles and daily habits, including alcohol and tobacco use, quality of sleep, social support, the general well-being schedule, and knowledge attitude toward depression and suicide.

The workplace is an ever-changing panorama of policy, practice, politics and people. As part of the high performance requirements of the modern workplaces, employees may frequently find that improvements in mobile technologies keep them connected to work around the clock. Expectations and demands from both the workplace and our personal lives can cause significant collisions between work, life style and family. For many individuals depression may result. Depression affects employees at all organizations and on every rung of the corporate ladder. Workplace depression costs employer's billions each year. It ranks among the top three workplace problems and tends to affect people in their prime working years. American survey statistics show that 76% of the female employees are affected with clinical depression.

Treating Depression in the Workplace:

Counselors and other mental health providers can serve viable roles in assisting depressed employees. These roles include a consultative and collaborative role with employers, and a direct service role. Each of these intervention modes is described within this section. Collaborative Interventions Counselors can provide consultative, collaborative, and educational interventions within the workplace to address employee depression. Employer education regarding depression and manifestation of symptoms among employees can be provided. The mental health professional can provide psycho educational services to educate supervisors, employee assistance workers, and occupational health personnel regarding depression and its symptoms as a mental health problem in the workplace (Johnson & Indvik, 1997a, 1997b). The Australian program (Hickie, 2004) is a good example of workplace and community outreach initiatives to reduce the burden of depression.

The counselor can assist employers in identifying and implementing interventions to mediate negative work-related stressors, social and psychological factors, and physical aspects of the work setting that may contribute to depression such as those described by Couser (2008), Johnson and Indvik (1997a, 1997b) and Truax and McDonald (2002). Examples include unclear job expectations and descriptions, short work deadlines, routine, monotonous job responsibilities with few opportunities for creativity, limited social and psychological support from the work setting, or workplace depersonalization through technology, racism, sexism, and ageism factors. Counselors and employers can work together in a dual, collaborative stance to "depression proof" the work setting and promote a "healthy workplace". Byrne et al. (2005), Caruso (2008), Johnson and Indvik (1997a), Frew (2004), and Podratz and Tetrick (2004) describe modifications to workplace characteristics and employer practices that can be implemented to reduce workplace influences that may contribute to employee depression. Couser (2008) summarizes primary, secondary, and tertiary prevention risk reduction processes to reduce depression onset and associated risk factors as well as promote positive mental health within the workplace. These workplace remediation practices could also serve to enhance employee protective factors through stress, conflict, and time management interventions as well as training managers and supervisors in identifying and reducing workplace stressors.

Counselors can assist employers in enhancing employee trust of the organization. Byrne et al. (2005) describes the role of perceived organizational support among employees as a mechanism for assisting employers in supporting employees and building trust within the organization. Supervisors can be selected and trained to be viewed by employees as exemplifying the organization's character. From an international perspective, the World Health Organization has prepared guidelines for developing policies and strategies to improve the health of working individuals to include policies and strategies for dealing with depression in the work environment (Bender, 2009; World Health Organization, 2005a). Relative to the European Union, the World Health Organization developed a detailed action plan, which specifically called for strategies to "create healthy workplaces" (McDaid et al., 2005: World Health Organization, 2005b). Counselors and other mental health professionals, both in the United States and internationally, can collaborate and advocate with employers and policy makers in developing such a work environment. Counselors can assist in implementing or expanding an employee assistance program (EAP) to include programming to effectively deal with employee depression and other mental health conditions. McClure (2004) details considerations and strategies for implementing employee assistance programs within the work setting. Johnson and Indvik (1997a, 1997b), Rost, Smith, and Dickinson (2004), Turner (1995), and Wang et al. (2007) describe programs and policies that can be implemented to treat employee depression. Counselors can assist employers in identifying, developing, and implementing EAP programming, referral mechanisms, employee outreach, and policy considerations. Consultation to assist employers to implement company or industry wide employee self-help programs for depression can be provided by the counselor. Physical exercise, leisure and social activity development, time management, task approach, problem solving, communication, and coping skill development programs are examples of strategies that employers can implement within the work setting (Flynn, 1995; National Institute of Mental Health, 2007b). Counselors and other mental health providers can serve an important role in developing and implementing these programs.

The counselor can identify and assist the employer or human resources professionals in instituting various workplace accommodations to assist the depressed employee in adjusting to the workplace environment. Job analysis processes may be necessary to evaluate essential job functions and the work environment to identify appropriate accommodations. Prien, Goodstein, Goodstein, and Gamble (2009) describe job analysis procedures useful for the workplace setting. Podratz and Tetrick (2004) describe the job accommodation process and potential job accommodations that could be incorporated within the work setting.

Direct Service Interventions:

Counselors and other mental health providers can provide services directly to the depressed employee within the employment setting. The counselor can provide employee education regarding depression, the course of depressive symptoms, the impact of depression upon one's functioning, and treatment options. Several researchers (Johnson & Indvik, 1997a, 1997b; National Institute of Mental Health, 2007b; National Mental Health Association Fact Sheet, 2006; Stewart, Ward, & Purvis, 2004) suggest that such education should focus upon assisting employees to self identify depressive symptoms.

The mental health professional can develop services or refer depressed employees to employee assistance professionals (EAP) or other mental health practitioners to identify and treat personal or family related crises that may produce stress and depressive symptoms. Franche et al. (2006) describes the impact and possible interventions in remediating the so-called spill over from employee personal and family demands on workplace depression. The National Institute of Mental Health (2007a, 2007b) and Wallace (2006) describe protective factors within employees' personal and social milieu that can be utilized to treat depressed individuals. Counselors can institute or refer employees for treatment through short term, empirically based

treatments for depression. Caruso (2008) and Couser (2008) provide evidence that brief oriented cognitive behavioral and solution focused treatment processes is particularly efficacious in treating employee depression. Berndt, et al. (1998) cites evidence that reduction in the severity of depressive symptoms through various treatment modalities improves work performance.

Counselors and mental health practitioners can assist employers in implementing assessments measuring depression as an aspect of the work environment. Counselors can also work with other treatment specialists in establishing measures to evaluate the efficacy of treatment. The concept of broadband and narrow band assessment measures (Corcoran, 2004) has importance in assessing depression. Broadband instruments are global measurements that are designed to capture the broad spectra of psychopathology, behavioral, or emotional characteristics, but may not be sensitive to symptom changes that may occur due to treatment or environmental modifications. Narrow band assessment measures, on the other hand, are specific measurement devices assessing a single construct and focusing upon a confined number of conditions or symptoms. Both broadband and narrow band assessment measures can assess symptom severity and also serve as instruments to provide outcome information relative to interventions that may be instituted within the workplace to remediate employee depression. Resources to assist in the identification and evaluation of various assessment measures that may have utility in measurement of depression and evaluation of depression treatment outcomes are described in Cox (2007) and Cox, Ness, and Carlson (2008a, 2009).

Strategies for Reduction of Workplace Stress:

Following are some pressures decrease techniques for adapting up from stress at working environment:

- Some present-day care strategies were incorporated into various practices, for instance, yoga and thought. This causes us in clinical points of interest, for instance, it normalizes the beat, treats coronary sickness, diminishes the diligent distress, and improve snoozing disturbance. It furthermore helps with building our ability to center and grow obsession at workplace.
- A treatment which is known as stun treatment model has been introduced by the NHS (The National Health Service) to treat pity, stress, and disquiet. In this delicate electric heartbeat is used to animate the cerebrum as opposed to drug treatment.
- The Vacations, wearing activities, and sports should be given to labourers after unequivocal stretches to avoid the sensation of disengagement, napping, etc
- The Stress Management Counselling is another device to lessen pressure where proficient help and direction are given to trigger the individual and mental issues in the worker at working environment.
- Restructuring the working environment.
- Establish work plans which are viable with requests and duties of the work.
- We should clarify work revolution so; it will keep away from dull and repetitive work.
- There ought to be an unmistakable set of expectations and occupation advancement strategy and ways.
- There ought to be a decent correspondence channel among worker and their power figures.
- The association should lead a pressure the executive's workshop for their representatives consistently.
- Reorganising the compensation bundle.
- The association ought to offer a passionate help just as help in satisfying undertakings and other appointed obligations and exercises.
- The preparing techniques for the association ought to be changed and improved.
- The association should zero in on execution assessment frameworks which will assist with recognizing the strength and shortcoming of representatives and afterward give preparing appropriately. It will decrease the pressure just as will help in ability improvement to accomplish the hierarchical objectives.

WHO response:

At a global policy level, WHO's Global Plan of Action on Worker's Health (2008-2017) and Mental Health Action Plan (2013-2030) outline relevant principles, objectives and implementation strategies to promote good mental health in the workplace. These include: addressing social determinants of mental health, such as living standards and working conditions; activities for prevention and promotion of health and mental health, including activities to reduce stigmatization and discrimination; and increasing access to evidence-based care through health service development, including access to occupational health services.

To assist organizations and workers, WHO has produced the "Protecting Workers' Health" series which provides guidance on common issues such as harassment and stress that can affect the health of workers. As part of the Mental health Gap Action Programme (mhGAP), which provides tools for evidence-based health care, WHO's technical instruments for early identification and management of alcohol and drug use disorders and for suicide prevention can also be relevant for mental health in the workplace. WHO is developing and

testing IT-supported self-help tools to address common mental disorders, harmful use of alcohol and psychological distress in low-and middle-income countries

Outcome Measurement Findings for Treating Depressed Employees:

Employers may be reluctant to expend financial and personnel resources to treat workplace depression. There are several studies that report positive outcomes for treating depressed employees and present a cost effective rationale for providing such interventions. In a randomized clinical trial study, Wang et al. (2007) report positive workplace outcomes in treating 604 employees in a U.S. employment setting through a systematic program to identify and promote treatment for depression. This program included telephone outreach, case management processes, outpatient mental health services, and psychopharmacological treatments. A similar program sponsored by the National Institute of Mental Health entitled the Harvard Work Outcomes Research and Cost Effectiveness study has found significant increases in positive work outcomes using the before mentioned interventions along with the use of client psycho educational workbooks (Wang et al., 2008).

In a U.S. national sample of 198 workers, Lo Sasso, Rost, and Beck (2006) found workplace benefits stemming from enhanced depression treatment provided by primary care medical providers. Wang et al. (2008) summarize other outcome studies that present positive evidence to support the treatment of employee depression as a cost effective intervention within the business and industrial sector. However, even considering evidence that depression treatments can be effective and have beneficial implications for workplace productivity, Wang et al. (2003) cite evidence that only 17% of workers receive depression management and treatment that meets minimal standards of adequacy. Greenberg et al. (2003) indicate that for every two depressed employees receiving treatment, an additional three employees remain untreated.

II. CONCLUSION:

This paper has cited evidence that depression is a condition that negatively impacts global work environments. Appropriate treatment for depression can have positive benefits in reducing the negative symptoms associated with depression and improving productivity within the work setting. Several studies indicate that such treatment is a cost effective strategy that positively impacts employee productivity. The counselor or related mental health provider can serve an educative, collaborative, or direct service role in working with employees, employers, and policy development specialists in promoting what the World Health Organization describes as good mental health exemplified by "not merely the absence of depression, but a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (Couser, 2008, p. 423).

By positively managing and supporting employees' mental wellbeing, employers can ensure that staffs perform to their potential – allowing the business to achieve peak performance. A healthy workplace is one where individuals feel valued and supported, provides a positive workspace, and shows respect for other aspects of a person's life.

REFERENCES

[1]. A systematic review including meta-analysis of work environment and depressive symptoms. (2015, August 1). BMC Public Health. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-015-1954-4

[2]. Depression and work performance: An ecological study using web-based screening. (2011, May 1). OUP Academic. https://academic.oup.com/occmed/article/61/3/209/1511172

[3]. NIMH » depression. (n.d.). NIMH » Home. https://www.nimh.nih.gov/health/publications/depression

[4]. (n.d.). WHO | World Health Organization. https://www.who.int/classifications/icd/en/bluebook.pdf

[5]. Empirical evidence for definitions of episode, remission, recovery, relapse and recurrence in depression: A systematic review. (n.d.). PubMed Central (PMC). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7032752/

[6]. Depression (mood). (2004, July 18). Wikipedia, the free encyclopaedia. Retrieved October 22, 2021, from https://en.wikipedia.org/wiki/Depression_(mood)

[7]. (n.d.). American Counselling Association | A professional home for counselors. https://www.counseling.org/resources/library/vistas/2010-v-online/Article_04.pdf

[8]. (n.d.). https://www.apa.org. https://www.apa.org/

[9]. (n.d.).IJICC. https://www.ijicc.net/images/Vol_15/Iss_5/15574_Sajid_2021_E1_R.pdf

[10]. (n.d.). IJSTM: Home. https://www.ijstm.com/images/short_pdf/1513091879_ijstm_121.pdf

[11]. Mental health in the workplace. (n.d.). WHO | World Health Organization. https://www.who.int/teams/mental-health-and-substance-use/promotion-prevention/mental-health-in-the-workplace

[12]. Biji Mathew. (n.d.). Shodhganga@INFLIBNET: Workplace depression an analytical study. Chapter 1 & 2. Handle Proxy. https://hdl.handle.net/10603/61906