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Work stress precipitates depression and anxiety in young, working women and men

[Maria Melchior](#),^{1,2,3,*} [Avshalom Caspi](#),^{1,2} [Barry J. Milne](#),¹ [Andrea Danese](#),¹ [Richie Poulton](#),⁴ and [Terrie E. Moffitt](#)^{1,2}¹MRC Social, Genetic and Developmental Psychiatry Centre King's College, University of London, Institute of psychiatry, London, GB²Department of Psychology University of Wisconsin-Madison, WI, US³Santé publique et épidémiologie des déterminants professionnels et sociaux de la santé INSERM : U687, IFR69, Université Paris Sud - Paris XI, Université de Versailles-Saint Quentin en Yvelines, Hôpital National de Saint-Maurice 14, Rue du Val D'Osne 94415 ST MAURICE CEDEX, FR⁴Dunedin School of Medicine University of Otago, NZ* Correspondence should be addressed to: Maria Melchior maria.melchior@st-maurice.inserm.fr

Abstract

Background

Rates of depression have been rising, as have rates of work stress. We tested the influence of work stress on diagnosed depression and anxiety in young working adults.

Methods

Participants are enrolled in the Dunedin Study, a 1972–73 longitudinal birth cohort assessed most recently in 2004–2005, at age 32 (n=972, 96% of 1,015 cohort members still alive). Work stress (psychological job demands, work decision latitude, low work social support, physical work demands) was ascertained by interview. Major depression and generalized anxiety disorder were ascertained using the Diagnostic Interview Schedule and diagnosed according to DSM-IV criteria.

Results

Participants exposed to high psychological job demands (excessive workload, extreme time pressures) had a twofold risk of major depression or generalized anxiety disorder compared to those with low job demands (Relative Risks adjusting for all work characteristics: women: 1.90 (95% CI 1.22–2.98); men: 2.00 (95% CI 1.13–3.56). Analyses ruled out the possibility that the association between work stress and disorder resulted from study members' socioeconomic position, a personality tendency to report negatively, or a history of psychiatric disorder prior to labor-market entry. Prospective longitudinal analyses showed that high-demand jobs were associated with the onset of new depression and anxiety disorder in individuals without any pre-job history of diagnosis or treatment for either disorder.

Conclusions

Work stress appears to precipitate diagnosable depression and anxiety in previously-healthy young workers. Helping workers cope with work stress or reducing work stress levels could prevent the occurrence of clinically-significant depression and anxiety.

In the United States and the European Union, 30–40% of workers are exposed to work stress, and these rates appear to have increased since the 1990s (National Institute of Occupational Health and Safety, 1999; European Foundation for the Improvement of Living and Working Conditions, 2005). Stressful work conditions predict poor mental health and there is growing concern that such conditions contribute to the population burden of psychiatric morbidity ([Parkes, 1990](#); [Phelan *et al.* 1991](#); [Bromet *et al.* 1992](#); [Stansfeld *et al.* 1997](#); [Niedhammer *et al.* 1998](#); [Stansfeld *et al.* 1999](#); [Mausner-Dorsch and Eaton, 2000](#); [Tennant, 2001](#); [Paterniti *et al.* 2002](#)). Yet, inference from past research is limited by several methodological shortcomings, which we aimed to address using data from a birth cohort followed from childhood to adulthood.

With notable exceptions ([Bromet *et al.* 1988](#); [Mausner-Dorsch and Eaton, 2000](#); [Cropley *et al.* 1999](#); [Shields, 1999](#); [Wang *et al.* 2004](#)), past research has focused on symptoms of psychological distress ([Phelan *et al.* 1991](#); [Bromet *et al.* 1992](#); [Niedhammer *et al.* 1998](#); [Tennant, 2001](#); [Paterniti *et al.* 2002](#); [Stansfeld *et al.* 1997](#); [Stansfeld *et al.* 1999](#)), showing elevated rates in workers who report high job demands, low job control or insufficient work social support. However, the relationship between these work conditions and clinically-significant psychiatric disorders associated with healthcare and lost productivity costs is not known. Here, we study the risk of psychiatric disorder assessed using standardized diagnostic instruments. Additionally, past research has primarily focused on depressive symptomatology ([Phelan *et al.* 1991](#); [Bromet *et al.* 1992](#); [Niedhammer *et al.* 1998](#); [Tennant, 2001](#); [Paterniti *et al.* 2002](#); [Wang *et al.* 2004](#)), while there is evidence of strong comorbidity and shared risk factors between major depression and generalized anxiety disorder ([Mineka *et al.* 1998](#); [Moffitt *et al.* 2007](#)). Thus, workers exposed to stressful work conditions could be at increased risk of depression or anxiety and in this study we examine both major depressive disorder and generalized anxiety disorder.

We address three additional methodological problems. First, the effects of work stress on mental health need to be separated from the effects of low occupational status ([Stansfeld *et al.* 1999](#); [Paterniti *et al.* 2002](#)) and our analyses are adjusted for participants' socio-economic position. Second, the association between work stress and mental health may be due to reporting bias wherein depressed or anxious workers describe their job characteristics in a negative light ([Stansfeld *et al.* 1997](#); [Paterniti *et al.* 2002](#)), and our analyses control for participants' negative affective style. Third, individuals who experience depression and anxiety disorders in childhood are at increased risk of psychiatric disorder in adulthood ([Kim-Cohen *et al.* 2003](#)) and could be selected into stressful jobs. Thus, the association between work stress and mental health problems in adulthood could be spurious, reflecting past psychiatric disorder. To our knowledge this hypothesis has not yet been tested and we examine it 1) by controlling for participants' prospective psychiatric diagnoses prior to their labor-market entry (ages 11–18) and 2) by testing the association between work stress and new cases of depression and anxiety at age 32.

Methods

Study population

Participants are members of the Dunedin Multidisciplinary Health and Development Study, a longitudinal investigation of health and behaviour in a complete birth cohort ([Moffitt *et al.* 2001](#)). Study members (n=1,037; 91% of eligible births; 52% male) were born in Dunedin, New Zealand, between April 1972–March 1973 and participated in the first follow-up assessment at age 3. The cohort represents the full range of socioeconomic status in the general population of New Zealand's South Island and is primarily white. Assessments have been carried out at ages 3, 5, 7, 9, 11, 13, 15, 18, 21, 26 and 32. Data are collected at the study Research Unit during a full day of individual data collection. Each phase of the study was approved by the Otago Ethics Committee and study members gave informed consent before participating.

This investigation is based on participants who completed the age 32 assessment (n=972; 96% of the 1,015 study members still alive in 2004–2005). Homemakers (65 women and 4 men) and participants with incomplete work data (6 women and 6 men) were excluded from the analysis, yielding a sample of 891.

Measures

Psychiatric diagnoses

Psychiatric disorders were assessed using the Diagnostic Interview Schedule for Children (DISC ([Costello et al. 1982](#))) at ages 11–15 years and the Diagnostic Interview Schedule (DIS ([Robins et al. 1989](#); [Robins et al. 1995](#))) at ages 18–32 years, with a reporting period of 12 months at each age. At each assessment, participants were interviewed privately by trained research interviewers who had a tertiary qualification in psychiatry, psychology or a related discipline. Interviewers were blinded to participants' other data.

Psychiatric disorders were diagnosed using the then-current *Diagnostic and Statistical Manual of Mental Disorders, Version 3 (DSM-III)* ([American Psychological Association, 1980](#)) at ages 11–15 years, the then-current *DSM-III-R* ([American Psychological Association, 1987](#)) at ages 18 and 21 years, and the *DSM-IV* ([American Psychiatric Association, 1994](#)) at ages 26 and 32 years.

Attesting to the validity of *major depressive disorder (MDD)* and *generalized anxiety disorder (GAD)* diagnoses at age 32, mean impairment ratings on a scale from 1 (some impairment) to 5 (severe impairment) were 3.57 (SD = .99) in participants with MDD and 3.62 (SD = .95) in those with GAD; 62% and 49% of those with MDD and GAD said they had received mental-health services in the past year, and 31% and 25% said they took medication for their disorder. Past-year prevalence rates of MDD and GAD in the Dunedin study are comparable to past-year prevalence rates in the U.S. National Comorbidity Study Replication (NCS-R) ([Kessler et al. 2005](#)).

Juvenile psychiatric disorders included depression, anxiety disorders, conduct disorder and attention deficit-hyperactivity disorder between ages 11–18. Variable construction details, reliability, validity, and evidence of impairment for diagnostic groups have been described elsewhere ([Moffitt et al. 2001](#); [Kim-Cohen et al. 2003](#)). Juvenile depression or anxiety disorders were combined into a juvenile internalizing disorders category, and conduct or attention deficit-hyperactivity disorder into a juvenile externalizing disorders category ([Krueger et al. 1998](#)).

New cases of MDD-or-GAD at age 32 were defined as 1) met diagnostic criteria for MDD or GAD at age 32 assessment and 2) had no prior diagnosis of MDD or GAD made by the study and 3) had no experience of MDD- or GAD-related hospitalization, medication, or outpatient psychotherapy prior to the date they began the job held at age 32. Self-reports of MDD and GAD-related treatment were recorded on a life history calendar ([Caspi et al. 1996](#); [Belli et al. 2001](#)), on which jobs were also recorded, thereby allowing us to ascertain timing.

Work characteristics

At age 32, participants' exposure to work stress was ascertained using questions derived from the work of Karasek, Theorell and Johnson ([Karasek and Theorell, 1990](#); [Johnson et al. 1989](#)): *psychological job demands* (i.e. workload and time pressures, 6 items), *work decision latitude* (i.e. control over the content and execution of work tasks and level of skills required, 10 items), and *work social support* (i.e. feedback and support from colleagues and supervisors, 6 items) ([Table 1](#)). Additionally, we also assessed *physical work demands* (i.e. work-related physical efforts and hazards, 6 items). All items were scored as no -0, sometimes -1, or yes - 2. Summing all relevant items, we constructed subscales of decision latitude (0–20), psychological job demands, work social support and physical work demands (0–12); each scale was standardized and divided into tertiles ([Stansfeld et al. 1997](#)). The internal consistency reliability was confirmed by satisfactory Cronbach's alpha coefficients (decision latitude: 0.72, psychological job demands: 0.68, work social support: 0.74, physical work demands 0.88). Correlations between work characteristics were 0.07–0.23.

Socioeconomic position

Socioeconomic position at age 32 was measured using New Zealand's Socioeconomic Index ([Davis et al. 2003](#)). This occupation-based classification matches each job with a socio-economic rank of 0–100, based on the level of education required and average earnings. Following Statistics New Zealand, we divided this index into quartiles ([Statistics New Zealand, 1999](#)). Typical occupations in each group are: quartile 1 (lowest): laborer, cashier, housekeeper, personal care worker, textile or food machine operator, salesperson; quartile 2: secretary, industrial plant operator, metal moulder, motor vehicle driver, forestry worker; quartile 3: technician, primary school teacher, nurse, sales associate, electrician, railway driver, animal farmer; quartile 4 (highest): manager, legislator, physician, high school teacher, university professor.

Negative affectivity

Negative affectivity was rated by the mental-health interviewer, who described the study member using the neuroticism scale from the Big Five Inventory ([John and Srivastata, 1999](#)). The negative affectivity score, ranging from 4 to 25, was standardized and studied as a continuous variable.

Statistical analysis

To study associations between work characteristics and psychiatric disorder, we calculated risk ratios (RR) associated with psychological job demands (intermediate or high vs. low), decision latitude (intermediate or low vs. high), work social support (intermediate or low vs. high) and physical work demands (intermediate or high vs. low), using Cox regression models with robust variance in which the time of follow-up was held constant ([Barros and Hirakata, 2003](#)). We chose this statistical method over logistic regression because depression and anxiety are frequent, causing odds ratios to overestimate relative risks by more than 10%.

First, we examined unadjusted relationships between each work characteristic and MDD and GAD. Next, we simultaneously included all work characteristics into a single statistical model. Then, we successively adjusted for socio-economic position, negative affectivity, and juvenile psychiatric disorders. Our final model included all four work characteristics, socio-economic position, negative affectivity, and juvenile psychiatric disorders.

Additionally, we studied associations between work characteristics and new cases of MDD or GAD at age 32.

The contribution of work characteristics to the overall burden of depression and anxiety was estimated by the attributable risk fraction ($[\text{RR}-1]/\text{RR}$ [no. exposed cases/no. cases]) ([Hanley, 2001](#)).

Women and men work in different types of occupations and differ with regard to their baseline risk of depression and anxiety and analyses were stratified by sex.

Data were analyzed using the SAS statistical package (version 9.1; SAS Institute, Cary, NC). The combined effects of multiple work characteristics were estimated using the `lincom` function in STATA (version 9; STATA Corp, College Station, TX).

Results

Among the 406 women and 485 men who were employed at age 32, men reported higher psychological job demands ($p=0.0002$), lower work social support ($p=0.0349$) and higher physical work demands ($p<0.0001$) than women ([Table 2](#)). [Table 2](#) also shows background factors and mental-disorder outcomes by sex.

Of the four work characteristics examined, only psychological job demands were consistently associated with MDD, GAD and MDD-or-GAD in women and in men ([Table 3](#)). Compared to participants who reported the lowest level of exposure, those with high levels of psychological job demands were 1.83 (women) to 2.78 (men) times more likely to meet criteria for MDD, 2.06 (men) to 2.76 (women) times more likely to meet criteria for GAD, and 2.00 (women) to 2.28 (men) times more likely to have either diagnosis. Hence, our remaining analyses focused on psychological job demands. MDD and GAD are highly comorbid (46% of MDD cases also met criteria for GAD and 54% of GAD cases also met criteria for MDD) and the effects of work stress were comparable and statistically significant when both disorders were analyzed separately (supplementary tables available upon request). Hence, we used the combined MDD-or-GAD diagnosis as our main study outcome.

Findings in women

As shown in [Table 4A](#), controlling for all work characteristics, high psychological job demands were associated with women's increased risk of MDD-or-GAD (Model 1, RR: 1.90, 95% CI 1.22–2.98). In Model 2, we found an increased risk of MDD-or-GAD among women who belonged to the lowest socio-economic group, but adjusting for socio-economic position had essentially no effect on the association between high psychological job demands and MDD-or-GAD (RR: 1.95, 95% CI 1.29–3.05). In Model 3,

negative affectivity was significantly associated with MDD-or-GAD, but only partly accounted for the increase in risk associated with high psychological job demands (RR: 1.79, 95% CI 1.16–2.76). As expected, Model 4 showed continuity between internalizing disorders prior to entering the labor force and MDD-or-GAD at age 32. However, juvenile psychiatric disorders did not account for the association between high psychological job demands and MDD-or-GAD (RR: 1.82, 95% CI 1.18–2.81). In the fully-adjusted model (Model 5), women reporting high psychological job demands were 75% more likely to suffer from MDD-or-GAD than those who reported the lowest level of job demands.

Findings in men

The results in men were similar ([Table 4B](#)). Controlling for all work characteristics, high psychological job demands were associated with men's increased risk of MDD-or-GAD (Model 1, RR: 2.00, 95% CI 1.13–3.56). In Model 2, we found no association between men's socio-economic position and the risk of MDD-or-GAD and socio-economic position did not contribute to the association between high job demands and MDD-or-GAD (RR: 2.00, 95% CI 1.13–3.55). In Model 3, negative affectivity was associated with MDD-or-GAD, but only partly accounted for the effect of high psychological job demands (RR: 1.84, 95% CI 1.09–3.11). In Model 4, internalizing disorders prior to entering the labor force were associated with MDD-or-GAD but only modestly contributed to the association between high job demands and MDD-or-GAD (RR: 1.94, 95% CI 1.11–3.42). In the fully-adjusted model (Model 5), men reporting high psychological job demands were 80% more likely to suffer from MDD-or-GAD than those who reported the lowest level of job demands. Additionally, in the fully-adjusted model, men who reported low work social support were also at increased risk of MDD-or-GAD (compared to the high work social support group: RR: 2.10, 95% CI 1.25–3.53).

Psychological job demands predict new cases of adult-onset MDD-or-GAD

At age 32, 50 women and 52 men of the Dunedin cohort experienced MDD or GAD for the first time. Because of the small number of cases, this analysis combined women and men. The new case incidence of psychiatric disorder was elevated among participants who reported high psychological job demands (compared to those with low work demands: RR: 1.83, 95% CI 1.14–2.93, [Figure 1](#)). Overall, 45% of new cases were attributable to high job demands.

Effects of multiple work stressors

Combined exposure to multiple work stressors can be especially detrimental to mental health ([Cropley et al. 1999](#); [Mausner-Dorsch and Eaton, 2000](#)). In the Dunedin study, adjusting for socio-economic position, negative affectivity, and juvenile psychiatric disorders, high psychological job demands were associated with an especially high risk of MDD-or-GAD when combined with low work social support (RRs: women: 2.24, 95% CI 1.30–3.86; men: RR: 3.77, 95% CI 1.79–7.94). In an additive model, simultaneous exposure to high psychological work demands, low work decision latitude, low work social support, and high physical job demands was estimated to confer a risk of 2.10 (95% CI 1.06–4.17) in women and 6.32 (95% CI 2.69–14.87) in men.

Discussion

In a birth cohort of 32-year old working women and men, we found a graded relationship between psychological job demands and the risk of depression or anxiety; in study members exposed to high psychological job demands the risk was two times higher than in those with low demands. The combination of multiple work stressors conferred an even higher risk, especially in men.

Our findings are novel in two ways. First, whereas most prior studies focused on symptoms of psychological distress ([Phelan et al. 1991](#); [Niedhammer et al. 1998](#); [Paterniti et al. 2002](#); [Stansfeld et al. 1997](#); [Stansfeld et al. 1999](#)), we found that psychological job demands contribute to an increased risk of two common psychiatric disorders: major depression and generalized anxiety disorder. Hence, work stress is associated with psychiatric outcomes of clinical significance that bear great healthcare and societal costs. Second, we accounted for participants' history of psychiatric disorder prior to labor-market entry, attempting to rule out the possibility that the association between work stress and mental disorder reflects the selection of individuals with preexisting disorder into more stressful jobs. In addition, in our study

work stress predicted the first onset of depression and anxiety among individuals with no prior history of these disorders. Thus, it appears that work stress precipitates the occurrence of psychiatric disorder in previously-healthy individuals. The mental health effects of work stress, an environmental exposure, may vary according to genetic susceptibility. Future research may seek to examine the genetic sources of this variability in response.

Job demands that exceed the individual's coping abilities are probably perceived as stressful and could influence the risk of psychiatric disorder through biological, psychological, psychosomatic and behavioural mechanisms. As suggested by animal and human studies, biological mechanisms could involve the dysregulation of stress hormones (i.e. glucocorticoids)([de Kloet et al. 2005](#)). Persistently-elevated stress hormone levels may have direct neurotoxic effects on the brain, particularly in the hippocampus([Sapolsky et al. 1986](#)) and can induce down-regulation of the glucocorticoid receptor, which impairs affect regulation([Avitsur et al. 2001](#); [Pariante and Miller, 2001](#)). Psychological mechanisms include feelings of helplessness, which may result from individuals' perceived inability to influence their condition([Abramson et al. 1978](#)). In addition, work stress may lead to symptoms of fatigue, difficulty sleeping, poor concentration, and distress ([Schwarzer, 1998](#); [McEwen, 1998](#)). Finally, behavioural mechanisms linking work stress to poor mental health might include an inability to engage in leisure activities and to maintain strong social networks ([Berkman and Glass, 2000](#)).

Our results need to be interpreted in light of several limitations. First, work stress levels and psychiatric disorders were ascertained concurrently and it may be that depression influenced participants' ratings of their work characteristics. To address this concern, we followed the lead of other researchers who faced a similar issue and our analyses controlled for negative reporting style ([Stansfeld et al. 1999](#)). Moreover, if depression influenced participants' work assessments, the effect should have been similar across all four measures of work stress, resulting in an association between all four types of work stress and depression or anxiety. Yet we found that high psychological job demands were uniquely associated with mental disorders, suggesting that job demands influence the occurrence of depression and anxiety rather than vice versa. Second, our study is restricted to one cohort in one particular country. However, New Zealand is comparable to other industrialized countries in terms of labor-market characteristics (70% of workers are employed by the service industry) ([Statistics New Zealand, 1999](#); [OECD, 2006](#)), levels of work stress ([Paterniti et al. 2002](#)), and rates of major depression and generalized anxiety disorder ([Kessler et al. 2005](#)). Third, we relied on self-reports of work stress, which may be biased by personality (negative affectivity) that is also associated with the risk of psychiatric disorder. Work stress can also be assessed by supervisors or co-workers, but such objective measures are generally less accurate than self-reports ([Stansfeld et al. 1999](#)). Furthermore, with regard to mental-health outcomes, individual perceptions of the work environment may be especially relevant. In our study, negative affectivity was associated with depression and anxiety, but did not account for the increased risk of mental disorder among participants exposed to high psychological job demands. Fourth, the gaps between Dunedin assessment windows may have led us to undercount cases and overestimate the number of new diagnoses at age 32. However, undercounting is probably trivial because only 4% of cohort members who reported that they received mental-health services between our diagnostic assessment years had never been diagnosed by the study.

A key strength of our study is that study members were 32 years old when work characteristics and depression and anxiety were assessed. This is an age when individuals settle into their professional careers and are less likely to have selected out of stressful jobs than older workers (on average, Dunedin study members were employed in their current occupation for one and a half years). It is also a period of elevated risk for psychiatric disorders ([Kessler et al. 2005](#)). Thus, our results suggest that work stress may precipitate common mental disorders, which are a major cause of morbidity (as assessed by disability-adjusted life years - DALYS), poor quality of life, as well as social impairment and lost work productivity ([World Health Organization, 2001](#)), setting in motion a cycle from work demands to mental disorders to lost work productivity.

As shown by worksite intervention trials that increase workers' ability to manage their workload, institutional-level decreases in work demands could help reduce rates of depression and anxiety in the working population ([Melin et al. 1999](#)), although institutional-level changes may be difficult to implement. At the individual level, effective coping skills and relaxation techniques may help workers better manage work stress and reduce the risk of psychiatric disorder ([Beck et al. 1979](#); [Mino et al. 2006](#)). In our study of

young workers, 45% of new cases of depression and anxiety were attributable to work stress, suggesting that young adulthood is an especially propitious life stage for preventing new cases of common mental disorders.

Recent trends indicate that prevalence rates of depression and anxiety are increasing, but causes of this historical change are not well understood ([Kessler *et al.* 1994](#); [Twenge, 2000](#)). Simultaneously, rates of work stress have also been rising (European Foundation for the Improvement of Living and Working Conditions, 2005; National Institute of Occupational Health and Safety, 1999), and deteriorating work conditions could contribute to an increased risk of mental disorders at the individual as well as the societal level.

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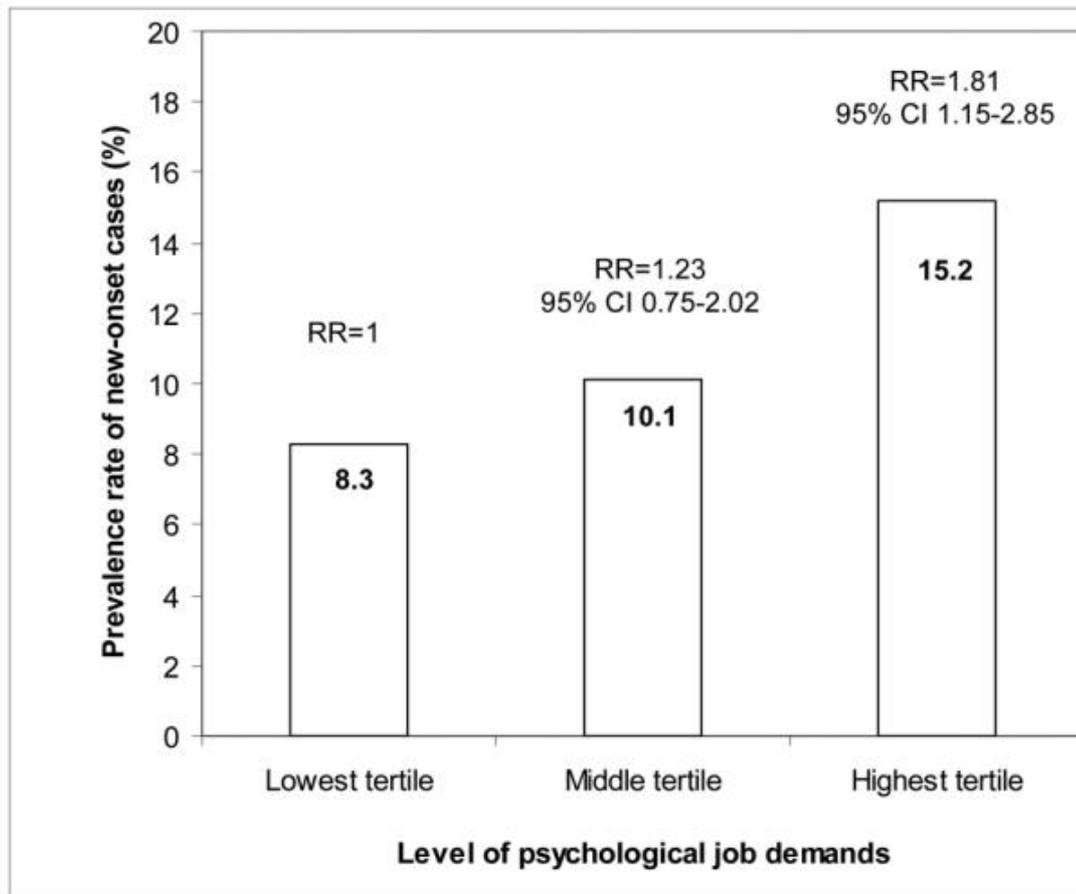
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Figures and Tables

Figure 1



Psychological job demands and new cases of major depressive disorder (MDD) or generalized anxiety disorder (GAD) at age 32 (women and men, n=891, 102 cases).

Table 1

Work characteristics measured in the Dunedin study¹.

<p><u>Psychological job demands</u></p> <p>Do you have to work longer hours than you'd like?</p> <p>Do you have to work under the pressure of time?</p> <p>Do you have too much work to do everything well?</p> <p>Is your job hectic?</p> <p>Are you often unclear about what you have to do?</p> <p>Do you have to work too hard?</p> <p><i>Lowest tertile: women: 0–3; men: 0–3; Intermediate tertile: women: 4–5; men: 4–5;</i> <i>Highest tertile: women: 6–12; men: 6–12</i></p>
<p><u>Work decision latitude</u></p> <p>Do you do the same things over and over?</p> <p>Is your work boring?</p> <p>Do you watch the clock while at work?</p> <p>Do you have to come up with creative solutions?</p> <p>Does your job help you learn new things that could lead to a better job or a promotion?</p> <p>Do you get to decide when to take a holiday?</p> <p>Do you get to decide when to take a break?</p> <p>Do you get to decide what time to come to work and when to leave?</p> <p>Do you get to decide what kind of tasks you do?</p> <p>Do you get to decide how to do them?</p> <p><i>Lowest tertile: women: 0–10; men: 0–10; Intermediate tertile: women: 11–14; men: 11–14;</i> <i>Highest tertile: women: 15–20; men: 15–20</i></p>
<p><u>Work social support</u></p> <p>Do you get helpful feedback about your job performance?</p> <p>Do you ever get praised for your work?</p> <p>Do you get help and support from your colleagues?</p> <p>Do you get help and support from your immediate supervisor?</p> <p>Are you treated fairly at work?</p> <p>Is your workplace friendly?</p> <p><i>Lowest tertile: women: 0–8; men: 0–8; Intermediate tertile: women: 9–11; men: 9–11;</i> <i>Highest tertile: women: 12; men: 12</i></p>
<p><u>Physical job demands</u></p> <p>Do you sweat daily from physical effort?</p> <p>Do you get dirty?</p>

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¹Each item was scored as no (0), sometimes (1), or yes (2).

Table 2

Work, socioeconomic and mental-health characteristics of Dunedin study participants at age 32.

	Women (n=406)	Men (n=485)	p-value
Work characteristics			
Psychological job demands (z-score, SD):	-0.13(1.00)	0.11(0.98)	0.0002
Work decision latitude (z-score, SD):	-0.04(1.01)	0.03(0.98)	0.2100
Work social support (z-score, SD):	0.07 (0.99)	-0.06(0.99)	0.0349
Physical work demands (z-score, SD):	-0.33(0.84)	0.27(1.03)	<0.0001
Weekly hours of work (mean, SD)	35.6(14.2)	46.9(14.4)	<0.0001
Socioeconomic group (%): 4 (highest)	36.0	36.1	
3	27.1	24.7	
2	17.2	20.8	
1 (lowest)	19.7	18.4	0.5386
Personality and mental-health characteristics			
Neuroticism (z-score, SD):	0.12(0.98)	-0.10(0.9)	0.0007
Juvenile internalizing disorders (11–18) (%)	39.2	24.7	<0.0001
Juvenile externalizing disorders (11–18) (%)	12.7	31.6	<0.0001
Major depressive disorder (MDD at 32 (%)	19.7	11.7	0.0010
Generalized anxiety disorder (GAD) at 32 (%)	16.5	10.3	0.0064
MDD-or-GAD at 32(%)	25.6	17.9	0.0054
New case of MDD-or-GAD at 32 (%)	13.8	9.5	0.0442

Table 3

Work characteristics and major depressive disorder (MDD), generalized anxiety disorder (GAD) or MDD-or-GAD at age 32 in the Dunedin study (Risk Ratios, 95% Confidence Intervals).

	WOMEN (n=406)			MEN (n=485)		
	MDD 80 cases	GAD 67 cases	MDD-or-GAD 104 cases	MDD 57 cases	GAD 50 cases	MDD-or-GAD 87 cases
Psychological job demands: Lowest tertile	1.0	1.0	1.0	1.0	1.0	1.0
Middle tertile	1.55(0.88–2.73)	1.99(1.00–3.98)	1.71(1.05–2.79)	1.49(0.67–3.30)	1.11(0.51–2.45)	1.35(0.74–2.43)
Highest tertile	1.83(1.16–3.02)	2.76(1.50–5.07)	2.00(1.30–3.10)	2.78(1.32–5.84)	2.06(1.00–4.25)	2.28(1.31–3.97)
Work decision latitude: Highest tertile	1.0	1.0	1.0	1.0	1.0	1.0
Middle tertile	0.58(0.26–1.31)	0.38(0.14–1.02)	0.56(0.29–1.11)	0.96(0.47–1.92)	1.24(0.65–2.37)	1.12(0.67–1.87)
Lowest tertile	1.35(0.90–2.03)	0.84(0.52–1.35)	1.15(0.81–1.62)	2.06(1.19–3.58)	1.17(0.56–2.44)	1.91(1.23–2.96)
Work social support: Highest tertile	1.0	1.0	1.0	1.0	1.0	1.0
Middle tertile	0.85(0.52–1.39)	1.05(0.59–1.89)	1.04(0.68–1.60)	1.18(0.60–2.33)	1.13(0.53–2.42)	1.37(0.78–2.41)
Lowest tertile	1.20(0.76–1.90)	1.86(1.10–3.14)	1.49(1.00–2.21)	1.89(0.99–3.62)	2.18(1.08–4.39)	2.27(1.33–3.86)
Physical work demands: Lowest tertile	1.0	1.0	1.0	1.0	1.0	1.0
Middle tertile	0.88(0.49–1.58)	0.92(0.47–1.81)	0.84(0.51–1.39)	1.19(0.61–2.31)	1.03(0.48–2.18)	1.02(0.59–1.75)
Highest tertile	1.46(0.93–2.82)	1.73(1.04–2.87)	1.44(0.99–2.09)	1.51(0.83–2.74)	1.67(0.89–3.16)	1.62(1.03–2.57)

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Table 4A

Psychological job demands and major depressive disorder (MDD) or generalized anxiety disorder (GAD) at age 32 in women of the Dunedin study (multivariate Risk Ratios, 95% Confidence Intervals).

	Model 0 n=406	Model 1 n=406	Model 2 n=406	Model 3 n=401	Model 4 n=402	Model 5 n=398
Psychological job demands: Lowest tertile	1.0	1.0	1.0	1.0	1.0	1.0
Middle tertile	1.71 (1.05–2.79)	1.72(1.05–2.81)	1.71 (1.05–2.77)	1.57(0.98–2.52)	1.60(0.99–2.60)	1.47(0.92–2.34)
Highest tertile	2.00(1.30–3.10)	1.90(1.22–2.98)	1.95(1.29–3.05)	1.79(1.16–2.76)	1.82(1.18–2.81)	1.75(1.14–2.68)
SES: 4 (highest)	-	-	1.0	-	-	1.0
3	-	-	1.43(0.91–2.26)	-	-	1.46(0.94–2.27)
2	-	-	1.05(0.60–1.83)	-	-	1.04(0.61–1.78)
1 (lowest)	-	-	1.96(1.20–3.19)	-	-	1.94(1.19–3.15)
Neuroticism score (per sd):	-	-	-	1.55(1.33–1.81)	-	1.50(1.28–1.76)
Internalizing disorders ages 11–18: no	-	-	-	-	1.0	1.0
yes	-	-	-	-	1.64(1.19–2.26)	1.44(1.05–1.99)
Externalizing disorders ages 11–18: no	-	-	-	-	1.0	1.0
yes	-	-	-	-	1.02(0.69–1.51)	0.97(0.65–1.47)
Work decision latitude: Highest tertile	-	1.0	1.0	1.0	1.0	1.0
Middle tertile	-	0.55(0.27–1.13)	0.55(0.27–1.12)	1.10(0.72–1.67)	0.53(0.26–1.10)	1.00(0.66–1.52)
Lowest tertile	-	1.16(0.82–1.66)	1.06(0.73–1.54)	1.19(0.80–1.80)	1.03(0.72–1.48)	0.98(0.63–1.51)

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Table 4B

Psychological job demands and major depressive disorder (MDD) or generalized anxiety disorder (GAD) at age 32 in men of the Dunedin study (multivariate Risk Ratios, 95% Confidence Intervals).

	Model 0 n=485	Model 1 n=485	Model 2 n=485	Model 3 n=481	Model 4 n=481	Model 5 n=477
Psychological job demands: Lowest tertile	1.0	1.0	1.0	1.0	1.0	1.0
Middle tertile	1.35(0.74– 2.43)	1.24(0.69– 2.24)	1.24(0.68– 2.22)	1.22(0.72– 2.08)	1.21(0.68– 2.15)	1.22(0.72– 2.00)
Highest tertile	2.28(1.31– 3.97)	2.00(1.13– 3.56)	2.00(1.13– 3.55)	1.84(1.09– 3.11)	1.94(1.11– 3.42)	1.80(1.06– 3.06)
SES: 4 (highest)	-	-	1.0	-	-	1.0
3	-	-	0.84(0.48– 1.46)	-	-	1.00(0.56– 1.77)
2	-	-	0.98(0.55– 1.77)	-	-	1.04(0.60– 1.80)
1 (lowest)	-	-	0.99(0.55– 1.75)	-	-	0.92(0.51– 1.66)
Neuroticism score (per sd):	-	-	-	1.98(1.66– 2.36)	-	1.97(1.64– 2.36)
Internalizing disorders ages 11–18: no	-	-	-	-	1.0	1.0
yes	-	-	-	-	1.57(1.07– 2.32)	1.21 (0.83– 1.43)
Externalizing disorders ages 11–18: no	-	-	-	-	1.0	1.0
yes	-	-	-	-	1.12(0.76– 1.66)	0.97(0.66– 1.43)
Work decision latitude: Highest tertile	-	1.0	1.0	1.0	1.0	1.0
Middle tertile	-	1.08(0.65– 1.79)	1.07(0.64– 2.43)	0.67(0.39– 1.15)	1.04(0.62– 1.72)	0.69(0.39– 1.20)
Lowest tertile	-	1.55(0.97– 2.50)	1.52(0.94– 2.45)	1.84(1.09– 3.11)	1.52(0.94– 2.45)	1.38(0.88– 2.15)
Work social support:	-	1.0	1.0	1.0	1.0	1.0

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