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LETTERS TO THE EDITORS

Preventing mental disorders and promoting mental health in the workplace

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Mental health problems, of which depression a paradigmatic example, are an increasing concern. Despite the generalization of mental health care in our environment, the incidence of depression continues to grow and it is now one of the leading causes of disability. Globally, its estimated cost is one trillion dollars per year, mainly due to decreased productivity from work absenteeism.[1]

Most mental health care is carried out in clinical settings, which limits early detection and the possibility of acting on the incidence of mental conditions. Thus, early intervention strategies are needed in the fields of prevention (primary and secondary) and mental health promotion. The work environment is considered the ideal place for these activities[1] since the general population spends a large part of their time there.

According to the World Health Organization, intensifying mental health care in the general population will result in a high economic return: for every dollar invested in depression and anxiety four dollars are saved, mainly through increased productivity at work.[1] Intervention costs could be shared with the private sector, since companies will be interested in the economic return.

Workplace interventions can impact work performance, which is a central domain of mental health promotion[2] and is affected by workload, lack of participation and control, monotonous and unpleasant tasks, poor interpersonal relationships, precarious working conditions, and lack of leadership and communication.[1] A number of interventions have been found to effectively reduce depressive symptoms and prevent their onset.[3,4] They involve different formats (individual, group, self-administered, face-to-face, or telematic) and content (psychoeducation, exercise promotion, and psychological therapies). However, further research is needed to determine which have the best results. Professional care in the workplace also allows early detection of mental disorders and referral for treatment.

In the context of the COVID-19 pandemic and due to its impact on the mental health of the working population, telehealth interventions may allow safer and more inexpensive interventions. A recent meta-analysis[5] found that the mental health of health care workers has been especially affected, and thus this group is of particular interest. One in four health professionals have suffered significant depressive symptoms during the pandemic, and more than one in three are suffering from burnout.[5] Other symptoms include insomnia, anxiety and post-traumatic features. They are being prioritized in public health policies.

In conclusion, interventions to prevent mental disorders and promote mental health in the workplace are cost-effective and could decrease the incidence of depression and reduce work absenteeism. During the COVID-19 pandemic, telehealth interventions for health professionals are highly important.

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Ibogaine microdosing in a patient with bipolar depression: a case report

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Ibogaine is a naturally occurring psychoactive alkaloid and belongs to the class of atypical psychedelics. It has been used to treat substance dependence and, experimentally, for other mental disorders, such as depression.[1-3] The most commonly used dose is between 15 and 20 mg/kg.[4] Recent studies reported on the effects of microdosing classic psychedelics, i.e., administration of less than 20% of the usual total dose in a semi-regular schedule.[5] Although there is a lack of robust research on ibogaine microdosing for psychiatric disorders, we report this practice in a patient with bipolar depression as a possibly innovative treatment alternative.

A 47-year-old woman with a 20-year history of bipolar disorder type II presented with an episode of severe depression of moderate severity (ICD-10 F31.4). At baseline assessment, the patient complained of sadness, low self-esteem, hopelessness, anxiety, difficulty in social interaction, significant weight loss, anorexia, prostration, insomnia, negativistic cognition, and difficulty working, which responded poorly to escitalopram 15 mg/day. She was referred for ibogaine microdose treatment at a private clinic upon her request. Two capsules of high-purity ibogaine hydrochloride obtained from a Canadian commercial vendor, containing 4 mg of ibogaine each (approximately 1% of a full conventional single dose), were administered twice a day for 60 days. The patient decided to taper off her medications (mood stabilizers and escitalopram) on her own. Alprazolam (2 mg/day) was continued.

After 15 days, we observed overall improvement compared to the initial assessment, as well as some functional recovery. She reported increased mental clarity, organized thinking, and positive prospects regarding the future. After 43 days, she reported a boosted appetite and initiative to engage in professional activities. Even 30 days after discontinuation of ibogaine (day 60), she had sustained improvement, which persisted through day 90. She resumed her routines and restored personal and social contacts. No manic switch was evident at any point during the follow-up period, and symptomatic improvement was clearly demonstrated in rating scales (Figure 1). After 15 days of treatment, BDI, BAI, and BHS scores reduced 35%, 39%, 60%, respectively; after 43 days, 85%, 52%, and 70% respectively; and, after 90 days, 90%, 56%, and 100% respectively compared to baseline. Daily ibogaine microdosing was associated with improvement of depressive and anxiety symptoms, but safety aspects must be considered. Cardiovascular and vestibular toxicity have been reported.[2]

One study related the use of ibogaine and other psychedelics to a significant reduction in symptoms of mental disorders, including depressive disorders.[3] Although the mechanism of action of ibogaine remains unclear, reports in the literature associate its effects with changes in prefrontal limbic circuits, triggering neuroplastic adaptations, and brain neurotrophic factors (which have raised interest in their own right as a potentially effective treatment for depression and other psychiatric disorders).[2] Hypothetically, ibogaine may exert its clinical antidepressant effect as a result of combined direct pharmacological action and a consciousness-expanding experience. A two-stage phase II randomized clinical trial to test ibogaine hydrochloride and the ibogaine analog 18-methoxycoronaridine for treatment of psychiatric disorders has been approved. Further trials are warranted to investigate the putative antidepressant effect of ibogaine microdosing.

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