

# Psychological disorders and work

J.M. Venter

## IOP2604 Course notes

### 1. Introduction

This document will only discuss psychological disorders most applicable to the work context. The following psychological disorders and their impact on work behaviour will be discussed:

- Bipolar and related disorders (Bipolar I, Bipolar II and cyclothymic disorder)
- Depressive disorders (MDD and PDD)
- Anxiety disorders (general anxiety disorder)
- Obsessive compulsive disorder
- Trauma related and stressor disorders (PTSD, adjustment disorders)
- Substance related and addictive disorders
- Personality disorders

### 2. Bipolar disorder

In this discussion we will focus on bipolar I, bipolar II and cyclothymic disorder. Before discussing each of the disorders some terminology needs to be explained:

- Manic episode:

The DSM 5 (2013, p. 124) describes a manic episode as “A distinct period of abnormally and persistently elevated, expansive or irritable mood and abnormally and persistently increased goal-directed activity or energy, lasting at least one week and present most of the day, nearly every day.”

Three of the following symptoms must be present during this time and four symptoms if the person's mood is just irritable. These symptoms must be present to a **significant degree** and must be a **noticeable change to the person's usual behaviour** (DSM 5, 2013):

- inflated self-esteem / grandiosity;
- Decreased need for sleep;
- More talkative than usual or pressure to keep talking
- Flight of ideas or subjective experience that thoughts are racing
- Distractibility
- Increase in goal-directed activity (socially, at school, at work, sexually or psychomotor agitation (purposeless non-goal-directed activity.
- Excessive involvement in activities that has a high risk for painful consequences (e.g., unrestrained shopping sprees, sexual indiscretion or foolish business investments).

The mood disturbance must be severe enough that it causes clear impairment in social or occupational functioning or requires hospitalisation to prevent the person from harming themselves and/or others.

The episode is not caused by substance abuse, medication or a medical condition.

- Hypomanic episode: A hypomanic episode is still an abnormal “high”, but it is not as high as a manic episode. The same criteria apply as for a manic episode, except that “The episode is not severe enough to cause marked impairment in social and occupational functioning or to necessitate hospitalization” (DSM 5, 2013, p. 125).
- Depressive episode:

Symptoms of a depressive episode consist of the following (DSM 5, 2013, p. 125):

1. Depressed mood most of the day, nearly every day, as experienced by the person (feels sad, empty or hopeless) or observed by others (appears tearful).
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by the person or observed by others).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month)
4. Insomnia (can't sleep) or hypersomnia (excessive sleep) almost every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not just feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Five or more of the above symptoms must be present during the same 2 week period. Symptom 1 or 2 must be one of the 5 symptoms present. The symptoms must be a change from previous functioning. The symptoms must cause significant distress or impairment in social, occupational or other important areas of functioning. The symptoms are not caused by substances or a medical condition.

Bipolar I disorder (previously called manic-depressive disorder) is recognised by the presence of manic episodes. Most individuals suffering from Bipolar I also have depressive episodes or hypomanic episodes that precede or follow the manic episode.

Bipolar II is recognised by the presence of a past or current hypomanic episode and followed by a past or current depressive episode.

The DSM 5 (2013, p.139) describes the criteria for cyclothymic disorder as follow:

- Numerous symptoms for hypomanic episodes and depressive episodes have been present for at least 2 years, but did not meet the criteria for a hypomanic episode or depressive episode.
- These symptoms have been present for at least half the time during the last 2 years and was never absent for more than 2 months at a time.
- The criteria for hypomanic episode, manic episode or depressive episode have never been met.
- These symptoms are not better explained by the schizophrenia spectrum or other psychotic disorders.
- The symptoms are not caused by a substance or medical condition.

Bipolar and related disorders have a high comorbidity with anxiety disorders, substance use disorders and sleep disorders, metabolic syndrome and migraines.

### 3. Depressive disorders

#### 3.1. Major depressive disorder

It is important to note that bipolar disorders and depressive disorders are separate diseases. In the DSM 5 these disorders are also now categorised separately. Neuroscience research has also shown that the neurobiology of bipolar disorders and depressive disorders are significantly different (DSM, 2013). The criteria for depressive episode must be met (see p.2). The occurrence of the depressive episode cannot be explained by any of the schizophrenia spectrum or psychotic disorders and there has never been a manic or hypomanic episode.

It is important not to confuse major depressive disorder with the response to significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, serious medical illness or disability). It is possible that great loss could trigger a major depressive episode that may go unnoticed during the grieving period. Some important differences between grief and a major depressive episode are that “self-esteem is usually preserved during grief, while in major depressive episode feelings of worthlessness and self-loathing are common” (DSM 5, 2013, p.161). Guilt in grief are usually focused on the deceased (e.g., not visiting enough) and is not generalised to the person’s entire self-esteem. In grief sadness comes in waves and is associated with thoughts and reminders of the deceased. In major depressive episode it is a “persistent depressed mood with the inability to anticipate happiness or pleasure” (DSM 5, 2013, p. 161).

Major depressive disorder has a very high comorbidity with anxiety disorders, borderline personality disorder, substance related disorders and eating disorders.

#### 3.2. Persistent depressive disorder

Persistent depressive disorder has fewer symptoms than major depressive disorder. The DSM 5 (2013, p. 168) describes the symptoms relevant to PDD as follow:

- Poor appetite or overeating
- Insomnia or hypersomnia
- Low energy or fatigue
- Low self-esteem
- Poor concentration or difficulty making decisions
- Feelings of hopelessness.

During the last 2 years the person has never been without 2 or more of these symptoms AND during these 2 years the person had a depressed mood for most of the day, for more days than not as indicated by their own experience or observation of others. These symptoms are not caused by substance use or a medical condition. Symptoms for cyclothymic disorder have never been present and the person has never had a manic or hypomanic episode. The symptoms are not better explained by the schizophrenia spectrum and other psychotic disorders. The symptoms cause significant distress or impairment in social and occupational functioning. The criteria for a full major depressive episode have not been met during the time of this illness.

#### 4. Anxiety disorders

There is a number of anxiety disorders listed in the DSM 5. For the purpose of this module we will only focus on general anxiety disorder. It is also important to note that obsessive compulsive disorders are no longer categorised with anxiety disorders, but in a separate category, obsessive-compulsive and related disorders.

##### 4.1. General anxiety disorder

General anxiety disorder is often described as anxiety that cannot be placed or attributed to something specific (Bergh, 2011). The criteria for general anxiety disorder as set out by the DSM 5 (2013) are as follow:

- Excessive anxiety and worry for more days than not, for at least 6 months about a number of activities or events.
- It is difficult for the individual to control the worry (the person cannot stop the chronic worrying)
- The anxiety or worry are associated with 3 or more of the following
  - Restlessness or feeling on edge
  - Easily fatigued
  - Difficulty concentrating or mind going blank
  - Irritability
  - Muscle tension
  - Sleep disturbance
- The anxiety, worry or physical symptoms causes significant distress or impairment in life roles or functioning
- The anxiety cannot be attributed to substance use or medication
- The anxiety is not better explained by another mental disorder

Refer back to “The well-being of neuroscience” in learning unit 1. Anxiety is experienced in increased levels of intensity in organisations by more and more people. If we take into consideration the myriad of stressors that people are exposed to in the South African context, organisational context and personal life we can certainly appreciate the notion that many of the minds in our organisations have become wired for anxiety. This however, does not mean that someone has general anxiety disorder, although if they are predisposed to anxiety or have been exposed to chronic stress for a long time, they may develop general anxiety disorder as the limbic system starts looping in an anxious neural pattern.

## 5. Obsessive compulsive disorder (OCD)

Someone with OCD experiences obsessions and/ or compulsions. Obsessions are described as intrusive or unwanted recurrent and persistent thoughts, urges or images that cause significant anxiety or distress. The person tries to ignore, suppress or neutralise these obsessions (DSM 5, 2013). Compulsions are described as “repetitive behaviours or mental acts that an individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly” (DSM, 2013, p.235). The purpose of these compulsions is to prevent or reduce anxiety or prevent stressful situations, but “these behaviours are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly obsessive” (DSM 5, 2013, p.237).

The DSM 5 (2013) lists the following criteria related to OCD:

- The obsessions are time consuming (more than 1 hour per day) or causes significant distress or impairment in important life roles such as social or occupational functioning.
- The symptoms cannot be attributed to substance use or medication.
- The disturbance is not better explained by another mental disorder.

## 6. Trauma and stressor related disorders

It is especially important for Industrial Psychologists to be sensitive to the effect of trauma on employee’s work behaviour and experience of the workplace. The UCT Centre for Justice and Crime prevention (2015) reported that every 1 in 5 children between the ages of 15-17 years old has already experienced some form of sexual, physical or emotional abuse, neglect, family or community violence in their lifetime.

These are only statistics from cases that was reported and excludes unreported cases of trauma. To get an idea of the prevalence of trauma in South Africa visit <https://www.dailymaverick.co.za/article/2015-09-29-factsheet-south-africas-201415-assault-and-sexual-crime-statistics/#.WIH2h01f3X4>.

Remember that trauma (especially abuse and neglect) changes the way that people make decisions, think and feel about their environments and attach in relationships, including their place of work (Fisher, 2014; Levine, 2015; van der Kolk, 2014). With such a high prevalence of abuse and violence in South Africa, it is of particular importance to consider the impact of trauma when we discuss psychological well-being in the workplace.

It is also important to note that people may experience different levels of psychological distress following a traumatic event, depending on many factors such as personal history, resilience, support structures etc.

## 6.1. PTSD

The DSM 5 (2013, p.271-272) has listed the following criteria for PTSD:

- Exposure to actual or threatened death, serious injury, sexual violence in 1 or more of the following:
  - Directly experiencing traumatic event
  - Witnessing, in person, the event(s) as it occurred to others
  - Learning that the traumatic event occurred to a close family member or close friend. In cases of actual or threatened death the event must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic events (e.g. emergency response units first on accident scenes, police officers repeatedly exposed to details of child abuse).
- Presence of one or more intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event occurred:
  - Recurrent, involuntary and intrusive distressing memories of the traumatic events.
  - Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event.
  - Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
  - Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
  - Marked physiological reactions to internal and external cues that symbolise or resemble an aspect of the traumatic event(s).
- Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred as evidenced by one or both of the following:
  - Avoidance or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
  - Avoidance or efforts to avoid external reminders (people, places, and conversations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:
  - Inability to remember important aspects of the traumatic event.
  - Persistent negative and exaggerated beliefs or expectations about oneself, others or the world.

- Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
  - Persistent negative emotional state.
  - Persistent inability to experience positive emotions
- Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred as evidenced by two or more of the following:
    - Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
    - Reckless or self-destructive behaviour.
    - Hypervigilance
    - Exaggerated startle response
    - Problems with concentration
    - Sleep disturbance
- Duration of the disturbance is more than 1 month.
  - The disturbance causes significant distress or impairment in important areas of functioning such as social and occupational functioning.
  - The disturbance is not caused by substance use or medication.

It is important to remember that people react differently to traumatic events. Sometime when people are exposed to traumatic events they may exhibit some of the symptoms of post-traumatic stress disorder, but not sufficient to be diagnosed as such. Depending on the symptoms individuals may then be diagnosed with acute stress disorder, which will not be discussed as part of this module.

## 6.2. Adjustment disorders

Adjustment disorders are common and very relevant to work context. The DSM 5 (2013, p. 286) lists the following criteria for adjustment disorders:

- The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- These symptoms or behaviours are clinically significant as evidenced by one or both of the following:
  - Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
  - Significant impairment in important areas of functioning such as social and occupational functioning.
- The stress-related disturbance does not meet the criteria for another mental disorder and is not just an exacerbation of an existing mental disorder.
- The symptoms do not represent normal bereavement.
- Once the stressor and its consequences have terminated, the symptoms do not persist for more than an additional 6 months.

In the work context we often observe adjustment disorders during mergers and acquisitions, when the business experiences significant difficulties, when people repeatedly fail to meet occupational goals or when there are seasonal business difficulties. Adjustment disorders can also occur when people are going through divorce or long term relationships are ended, dealing with persistent painful or progressively debilitating diseases or living in a crime-ridden neighbourhood (DSM 5, 2013, p. 287).

## 7. Substance related and addictive disorders

Substance use disorders include substances such as alcohol, caffeine, tobacco, cannabis (dagga), hallucinogenic substances, opioids, sedatives, stimulants, amphetamine, cocaine and gambling.

Each of these categories has their own set of diagnostic criteria. The following general criteria however apply (DSM 5, 2013):

- The substance is often taken in larger dosages and over a longer time period than intended.
- There is a persistent desire or unsuccessful efforts to cut down or stop using the substance.
- A great deal of time is spent to obtain the substance.
- Craving or strong urge to use the substance.
- Recurrent failure to fulfil obligations in important life roles such as work and family.
- Continued use despite persistent or recurring social, interpersonal or health problems caused or exacerbated by the substance.
- A need for significant increased amounts of the substance or more frequent use or a significant diminished effect with continued use of the same amount.
- Withdrawal symptoms if the substance is not used.

## 8. Personality disorders

“A personality disorder is an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment...This pattern is manifested in cognition, affectivity, interpersonal functioning or impulse control” (DSM 5, 2013, p. 645-646). Personality disorders are further divided into three clusters:

- Cluster A: Paranoid personality disorders
- Cluster B: Dramatic, emotional and erratic behaviours
- Cluster C: Anxious and fearful behaviours

The following provides a summary of personality disorders (Bergh, 2011):

Cluster A	Cluster B	Cluster C
<b>Paranoid:</b> distant, suspicious of others, regarding their motives as malevolent.	<b>Anti-social personality disorder:</b> disregard for others, violation of others' rights.	<b>Avoidant:</b> social inhibition, feelings of inadequacy; extreme sensitivity to criticism.
<b>Schizoid:</b> detached social relationships	<b>Borderline personality disorder:</b> unstable relationships, unstable emotions, low self-image, impulsive behaviours.	<b>Dependent:</b> Excessive need for nurturing; over dependent and clingy behaviours; separation anxiety.
<b>Schizotypal:</b> discomfort in social relationships, reduced ability to form close relationships and to maintain them; perceptual cognitive distortions; eccentric behaviours.	<b>Histrionic:</b> extremely emotional; attention seeking	<b>Obsessive-compulsive:</b> pre-occupied with perfection and being in control, very rigid in their application of rules with inflexibility even when flexibility is called for.
	<b>Narcissistic:</b> grandiosity in behaviour, ideas or fantasy; need for admiration; no empathy for others.	

The following video clips may help you to better understand some of the behaviours associated with specific mental disorders:

***OCD and anxiety disorder: Crash Course Psychology #29***

<https://www.youtube.com/watch?v=aX7jVXXG5o&index=29&list=PL8dPuuaLjXtOPRkzVLY0jJY-uHOH9KVU6>

***Depressive and bipolar disorder: Crash Course Psychology #30***

<https://www.youtube.com/watch?v=ZwMIHkWKDwM&list=PL8dPuuaLjXtOPRkzVLY0jJY-uHOH9KVU6&index=30>

***PTSD – Trauma and addiction: Crash Course Psychology #31***

<https://www.youtube.com/watch?v=343ORgL3kIc&index=31&list=PL8dPuuaLjXtOPRkzVLY0jJY-uHOH9KVU6>

***Personality Disorders: Crash Course Psychology #34***

<https://www.youtube.com/watch?v=4E1JiDFxFGk&index=34&list=PL8dPuuaLjXtOPRkzVLY0jJY-uHOH9KVU6>

**Reference list:**

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5<sup>th</sup> ed.). Arlington, VA: American Psychiatric Publishing.

Bergh, Z. C. 2011. *Psychological adjustment in the work context*. Pretoria: Unisa.

Levine, P.A. (2015). *Trauma and memory: brain and body in search of the living past*. California: North Atlantic Books

Fisher, S. (2014). *Neurofeedback in the treatment of developmental trauma*. New York: Norton

The Centre for Justice and Crime Prevention. (2015). *The Optimus study on child abuse, violence and neglect in South Africa*. Cape Town: UCT

Van der Kolk, B. (2014). *The body keeps the score*. UK: Penguin Books